



Unfamiliar Territory

Adult services ‘thinking family’

Lauren Herlitz and Sarah Jones

Creating opportunities for people caught up in a cycle of crisis, crime and mental illness, to transform their lives



Revolving Doors Agency is an organisation that is concerned with the welfare of adults with multiple needs who are - or have been - in contact with the criminal justice system.

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A summary of the findings from this report can be downloaded from Revolving Doors Agency's website:

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I. Introduction

This report is the culmination of a one year research project looking at the capacity of statutory and voluntary organisations to implement the principles of Think Family in their work with adults with multiple needs.

RDA's previous research and experience with service users has shown that there is a group of people who have common mental health problems and multiple needs who are repeatedly in contact with the criminal justice system. Their needs often include: homelessness; lack of legitimate income; drug and alcohol use and family breakdown. The interrelation of multiple unmet needs frequently results in a cycle of crisis and crime. This group is often excluded from avenues of help because of the complexity of their needs, challenging behaviour and/or not meeting the threshold of individual services. This exclusion ultimately results in disproportionate costs being felt elsewhere in the system.

RDA is focused on improving responses to people as described above. In partnership with service users, service providers, commissioners and policy makers, RDA works to create opportunities for people to break out of the cycle of crisis and crime affecting their lives and the lives of others.

The genesis of this project and the focus on families began in 2006 when Revolving Doors Agency consulted with a wide range of funders, stakeholders and service users¹ to formulate its new strategic plan. One of the resulting objectives was to develop new approaches to practice with adults with multiple needs; specifically that RDA would research, develop and pilot new approaches to promoting their social inclusion.

During this consultation, RDA identified four areas which were key to promoting the social inclusion of the most marginalised in the criminal justice system. One of the areas identified, and particularly emphasised by the service users, was improving family ties and social networks. This subsequently led to the development of this project, which has been kindly funded by The Tudor Trust and The Monument Trust.

This research constitutes the first phase of a larger three phase plan to develop and test responses that aim to improve responses to adults with multiple needs and their families.

The three phases are:

- **Research** – develop an understanding of the current situation and scope the case for improved support and intervention from services.
- **Development** – design and develop responses that can better support service users and their families and establish the case for and validity of these in three local areas.
- **Practice** – establish and deliver responses in partnership with local service delivery agencies. Evaluate the impact of responses and use the evidence to shape relevant policy.

The experiences of RDA's service users suggest that individual and family members' needs are often treated separately and in isolation, within specific service delivery 'silos'. Statutory support from children's services is frequently viewed with considerable distrust by service users and is largely focused on child protection. In the voluntary and statutory sectors, there are advice services for families but there are very few that attempt to deal with family issues in a complete and sustained way – especially when an adult service user is the focus of attention. This can undermine any

¹ Until 2006, RDA ran its own Link Worker schemes and had a service user group that was closely involved in the development of our work. Although we no longer run services ourselves, we continue to involve service users through our national Service User Forum. See <http://www.revolving-doors.org.uk/serviceuserinvolvement.htm> for further information.

attempt at providing a holistic response, breaking families down into artificial categories, such as ‘the offender’, ‘the family’, ‘the child’, rather than viewing them as one unit.

In January 2008 the Government launched its Think Family initiative, which aimed to provide both a theoretical imperative and a practical show case for working with families with multiple needs. Within this context, RDA developed a methodology to test the principles and potential impact of such an approach for adults with multiple needs and their family members. Those who work in adult services are critical to the implementation of Think Family. Thus, this research focuses on practitioners’ experience of and attitudes towards working with families.

Section **two** of the report will cover the methodology and background to the research in more detail, including the limitations of the data and any implications of this on the subsequent findings. Section **three** provides a brief introduction to family policy and the Think Family agenda. Section **four** covers the relevant literature in the area and focuses on the views of practitioners from the perspective of undertaking family work within various settings. This provides a theoretical backdrop for the development of the research tools and is used extensively within the discussion of findings. Section **five** presents the findings from the practitioner focus groups and is presented as five distinct themes with associated sub-themes. It is this work that provides the bulk of the evidence for the subsequent development recommendations. Section **six** documents the response of the RDA service user forum to the research findings and their advice to help practitioners to help them. Section **seven** is a discussion of the findings, the service user views and the literature. It puts the evidence into the context of the research aims and summarises the main findings. The report ends with a number of recommendations/proposals for future development.

For further information on the project as it progresses and on RDA’s work more generally, please visit our website - www.revolving-doors.org.uk.

2. Methodology

The findings presented within this report are based on several different qualitative research methods:

- The development of three illustrative service user case studies
- Focus groups comprising front-line practitioners from both statutory and voluntary services
- A service user focus group to review and comment on the findings.

Each of these elements is explained further in the sections below.

In addition to the empirical research, the literature and policy reviews provide a background to work with families and partners, specifically identifying existing research findings on practitioners' views and experiences of family work.



2.1 Terminology

Adults with multiple needs

Our previous research and experience with service users has shown that there is a group of adults who have common mental health problems and multiple needs who come repeatedly into contact with the criminal justice system. Their needs often include: homelessness, lack of legitimate income, drug and alcohol use and family breakdown. They are often excluded from avenues of help because of the complexity of their needs, challenging behaviour or the fact that they do not meet the threshold of individual services.

Family

The term 'family' typically refers to people related by heredity, such as parents, children and siblings. For the purposes of this report, 'family work' is used in a broader sense, to encompass working with both families and partners.

Partner

'Partner' refers to a service user's boyfriend, girlfriend, or spouse. It can also include ex-partners with whom the service user has a continued link, for example, through mutual concerns for their children.

Practitioner

Within this research, 'practitioner' is an umbrella term for anyone that works with adults with multiple needs, for example, housing workers, drug and alcohol workers, and mental health practitioners. This covers a wide spectrum of individuals from those who have completed professional training to those who hold no formal qualifications and have trained in role. It does *not* cover professionally trained practitioners whose specific remit is to work with families, for example practitioners in children's services or family therapists.

Family work

Family work can take place at a number of different levels including:

- Engaging with family members in pursuit of the objectives of the work with the service user
- Helping the family to actively engage with the service user, for example through home and joint visits
- Working with agencies who have responsibility for other family members
- Referral and signposting
- Active 'therapeutic' work

The views practitioners hold about family work, and their development needs in relation to it, are influenced by their previous experience, training, professional knowledge, theoretical stance, and their organisation's support, remit and approach.

2.2 Development of the methodology

In order to define the scope of the research, a launch meeting was arranged where key members of relevant organisations could come together to consider the following questions in relation to research on families and socially excluded groups:

- Are there any groups who might be considered under researched?
- Are there any groups who continue to fall through the gaps in services for families?
- Are there any groups who are considered particularly difficult to work with in terms of family work?

The participants provided much interesting debate around the questions above, however the prevailing view was that the needs of different groups were well known but not enough was understood about how the system works around them to improve outcomes. The view was expressed that research generally should shift the focus away from the *needs* of service users and towards how services and systems - the 'institutional furniture' - could move around them to produce positive outcomes.

In January 2008 the Government launched the Think Family initiative (see the policy review section) which outlines several principles that should be applied by both statutory and voluntary organisations in their work with 'families at risk':

- There should be no 'wrong door' to services – any service should be a gateway to broader support;
- The needs of the family should be considered as well as the needs of the service user – a 'whole family' approach;
- The focus should be on a family's strengths and building their capacity to take on responsibility;
- The level of support given should be relative to the family's needs.

This resulted in the obvious question of how this would work for adults with multiple needs, and perhaps more importantly what implications this would have for the (often voluntary sector) practitioners who would be charged with putting the idea of Think Family into practice.

Linking the principles of Think Family with stakeholders' views, we developed a methodology to test the potential of this approach to improve services for adults with multiple needs and their family members and/or partners. The aims of the research were to establish:

- Practitioners' views on the barriers and opportunities of the Think Family approach;
- Best practice examples and ideas to take this work forward;
- Service users' views of the principles of Think Family.

The work began with reviews of relevant literature and policy to both highlight existing work and to inform the development of the research tools. The process for completing these is described below and discussed later in the report.

2.3 Policy review

The aim of the policy review was to provide a background on the development of Think Family and to place 'family' within the broader political agenda. This is only an introduction to policy in the area. Given the wide ranging issues faced by adults with multiple needs and the number of policy areas that they could touch upon – for example, criminal justice, mental health, substance use, housing, family and children's policy – it has only been possible to provide a brief overview to add some context to the current research.

The policy review was informed by examining a number of sources as referenced in the policy section. The review can be found in section 3.

2.4 Literature review

The aim of the review was to identify research which explores practitioners' perspectives on:

- Family work with adults with multiple needs

- Adopting new ways of working with adults with multiple needs. (For example, Hinton et al, 2001, interviewed hostel workers about their experiences in learning to make health advice and promotion a part of their role.)

The resulting literature review is an introduction to the issues that practitioners might face in their work with this group. This account helped to inform the research tools and the subsequent discussion of the findings.

We were not looking at research focusing on the service users' or families' perspectives. Due to the time constraints of the review only literature published from 2000 onwards was considered. The websites of organisations providing direct services to adults with multiple needs, or campaigning on their behalf, were searched and any literature which appeared to meet the aim was recorded. A list of the websites can be found in appendix I. Literature was included if it could be accessed at the British Library or downloaded free from the internet.

The integrated catalogue of the British Library was also searched using the terms below.

- ("complex needs" or "multiple needs" or "multiple disadvantage" or "dual diagnosis" or "multiple problems" or "multi-agency") AND (practitioner or professional)
- ("complex needs" or "multiple needs" or "multiple disadvantage" or "dual diagnosis" or "multiple problems" or "multi-agency") AND (family OR families OR carers)

Bibliographies and reference pages were also explored to highlight further literature that would fit the aims of the review.

The vast majority of literature identified in the search focused on the service users' or families' perspectives, or provided guidance for practitioners rather than exploring their views and experiences of working with families.

There was a significant body of literature looking at the practitioners' perspective on multi-agency working, a key aspect of family work. Where this literature was identified within the search process, it was also included.

The full literature review can be found in section 4.

2.5 Development of case studies

A case study approach was adopted to inform the practitioners' focus groups. Case studies were compiled which illustrate the range of issues that adults with multiple needs might typically experience. They were *not* developed to present the situation and needs of *any one* particular service user but were instead created using examples from several different service users in similar situations. Some specific detail (for example, alcohol related medical problems) were expanded upon with desk-based research².

The case studies were developed through individual and group interviews with service users and their families. Service users were identified through voluntary sector service providers who had expressed an interest in assisting with the project during the launch meetings detailed earlier. Further contacts snowballed from there.

² The full case studies can be found in appendix 2 and a more detailed overview of the issues portrayed is provided at the beginning of the analysis.

When completed, the case studies were presented in the form of a recent family assessment, as this was thought to be the clearest way to present in-depth information on the whole family. The format is based on the Common Assessment Framework used in children's services.

2.5.1 Case studies

Sarah has one young child and one teenage child, both of whom are cared for by their maternal grandparents. Sarah is currently in prison and has a history of drug use.

This case study was developed with the support of Adfam³, an organisation with a long history of delivering support services to individuals and their families who have experience of the criminal justice system and problems related to substance use.

Three families were interviewed in order to develop this case study. One was a grandmother who was part-time carer for her grandchild whilst her son was in prison. Secondly we spoke to a couple whose daughter had been in prison on a number of occasions, and their granddaughter. Thirdly we interviewed another set of grandparents, their two grandchildren whose mother was currently in prison, and the grandchildren's uncle. These grandparents had raised their grandchildren from birth.

All the interviews were carried out in the interviewees' homes.



Dan has two teenage children who live with his wife, from whom he is separated. He is a problem drinker and living in a hostel.

Service users from Crisis⁴ helped to create Dan's case study. With the support of researchers at Crisis, we carried out a group interview at the Skylight centre in East London. The group was attended by four men with children who had experience of homelessness; two of the men were recovering from problematic alcohol use.

³ www.adfam.org.uk

⁴ www.crisis.org.uk. Crisis is an agency providing support for single adults with housing problems.

Through another organisational contact, we interviewed a member of Al-Anon⁵ about his experiences growing up with a parent who was a problem drinker. This interview was carried out at his work premises.

Karen has three young children and they are living in temporary accommodation. Karen is suffering from depression.

The Kings Cross Homelessness Project (KCHP), run by P3⁶, assisted us in identifying service users leading to the development of Karen's case. They provided details of four women with children living in temporary accommodation.

It was difficult to organise and carry out these interviews. One woman cancelled her appointment when we arrived and found it difficult to arrange another date. Another woman was difficult to contact by phone and cancelled on the day of the appointment. Another was taken seriously ill. We were able to interview one woman at her home; she too had previously cancelled the first appointment we made as her child was taken ill. These experiences gave us an insight into some of the problems practitioners might face in organising appointments with families in difficult circumstances.

A fourth case study was planned around the issues of male prisoners and their partners but we were not able to complete the necessary interviews due to there being insufficient time available for the fieldwork phase to complete the prison ethics and operational procedures.

Research ethics

Interviewees signed consent forms to indicate that they understood the purpose of the research and were happy to be recorded. Interviewees received shopping vouchers as a thank you for taking part. They were contacted about the progress of the research and given the opportunity to see the final case study before this was used in the subsequent phase of the research. Participants were also invited to take part in a discussion (together with other service users) on the findings of the research (see section 2.7).

2.5.2 Interview guide

All interviewees were asked about their current family situation, relationships with family members and significant others, including friends. They were also asked about a range of other needs including finances, housing and contact with services (see appendix 3 for a copy of the interview schedule).

Initially the schedule was developed so that the interviewee could draw on their experiences to create the case study him or herself by putting together a story about a fictional person. However, this proved too difficult in practice as interviewees either made up a story that differed significantly from their own and lacked the necessary detail, or told exactly their own story using a different name which became confusing and interrupted their ability to tell their story. The schedule was then amended to focus purely on the interviewee's own experiences.

This process provided a good example of how research with adults with multiple needs does not always go to plan and requires constant flexibility within the constraints of good research practice.

⁵ www.al-anonuk.org.uk. Al-Anon is a support service for relatives of individuals with alcohol problems. The interviewee had previously been a member of Alateen, www.al-anon.alateen.org/alateen.html.

⁶ www.p3charity.com/kchp

In order to check the validity and consistency of the final draft case studies, they were reviewed by two practitioners and members of staff at Revolving Doors who had previously worked as practitioners.

2.6 Focus groups with practitioners

The original aim for the focus groups was to bring together a group of practitioners from different agencies, both statutory and voluntary, as appropriate to each case study. The focus groups were designed to replicate relationships in multi-agency settings so that these interactions could also be analysed.

For example, Sarah's case could involve any of the following practitioners:

- A prison officer
- A worker from the Drug Intervention Programme
- A voluntary agency who liaises with the prison and with families
- A teacher or school counsellor
- A GP
- A voluntary agency working in substance use
- A voluntary agency working with grandparents
- A mental health worker from the Child and Family Mental Health Service
- A family therapist
- Children's services

Potential participants were contacted through various methods, including professional networks, RDA contacts, and snowballing (asking individuals to identify other practitioners who may be interested in participating). Practitioners from the following networks were contacted:

- Parental Mental Health and Child Welfare Network (PMHCW)⁷
- Action for Prisoners Families and Friends⁸
- Clinks⁹

In addition to these networks, over 50 individual contacts were pursued from the following statutory services: mental health, housing, education, health, substance use, prison and the following voluntary services: criminal justice, substance use, housing, family support. Information about the research and a request for participants was also displayed on the RDA website. Within the research timetable almost two months was given to the task of finding participants.

Practitioners were invited to attend either an online focus group or a face-to-face group. Focus groups took place in the evening outside work hours. We hoped to carry out focus groups in both rural and urban locations to compare experiences. However, as the practitioners who expressed interest were mainly based in London and due to time and resource constraints, each group was held in London.

There were three face-to-face focus groups (one for each case study) and two online focus groups (looking at Sarah's and Karen's cases). Although dates were offered for an online group for Dan's case, unfortunately no practitioners expressed an interest in attending.

In total, of the 28 practitioners who originally expressed an interest in participating, 13 people, representing a broad range of services, actually took part. In each focus group at least one or more practitioners cancelled shortly before the group took place. Again, this demonstrates the reality of

⁷ www.pmhcnw.org.uk

⁸ www.prisonersfamilies.org.uk

⁹ www.clinks.org

researching a complex topic involving both practitioners and service users. Unfortunately project deadlines did not allow us to repeat the cycle of participant recruitment.

Practitioners completed consent forms to agree they understood the purpose of the research and for the groups to be recorded. Each received shopping vouchers as a thank you for taking part.

Online focus groups

A message board with information on the research and instructions for using the website was set-up for participants, along with a chat room. Each participant had a username and password and could only access messages for their own focus group.

Online focus groups run at a considerably slower pace than face-to-face focus groups, as it takes time for participants to type and wait for each others' responses. Due to technological constraints and the need for other participants to view the response, the amount of information participants could share on their 'turn' was limited to three sentences or less,

Depending on a participant's typing ability and the speed and capacity of their home computer, they might respond to questions as if they were completing a group survey, or they may interact as if they were speaking.

The information obtained from these groups provided an oversight of key issues but no single issue could be explored in depth.

2.6.1 Participants in each focus group

This section outlines the professional experience of the focus group participants¹⁰. Unless specifically noted that a practitioner works with families, it can be presumed that the participants work mainly with adult service users.

2.6.1.1 Sarah's case study

Face-to-face focus group

- **Carl** currently works with families in adult mental health services (MHS) and had previously worked for children's services.
- **Adam** is a drug and alcohol worker for a voluntary organisation and has not worked in any other field.
- **Yvonne** works for a criminal justice voluntary organisation and has not worked in any other field.
- **Sophia** works with families for a voluntary organisation focused on drug and alcohol use.

Online focus group

- **Judy** is a social worker in adult MHS.
- **Anne** works in adult MHS.

2.6.1.2 Dan's case study

Face-to-face focus group

- **Rob** works in adult MHS and previously worked in adult social care.

¹⁰ Pseudonyms have been used

- **Ian** works for a training organisation for the NHS providing training in mental health, housing and substance use. He previously worked for a voluntary organisation focused on vulnerable people with multiple needs and in adult MHS.

2.6.1.3 Karen's case study

Face-to-face focus group

- **Chrissy** works with families for a voluntary organisation focused on criminal justice and had previously been a social worker in children's services.
- **Julie** works for a statutory housing organisation.

Online focus group

- **Lidia** works with families for a voluntary organisation focused on drug and alcohol use.
- **Carolynne** works as a mental health officer for a voluntary housing organisation.
- **Sam** works in statutory health services.

2.6.2 Interview guide

The aim of the focus groups was to find out about practitioners' attitudes towards, and experiences of, working with the family members and partners of *adult* service users. The interview guide for the face-to-face focus groups covered the following areas:

Introduction:	The kind of work practitioners' agencies already carry out with families
Case study:	The needs of the service user and their family and what agencies can support them
Benefits and costs (using case study):	The benefits and costs of carrying out work with the families of service users The benefits and costs of <i>not</i> carrying out work with them How the benefits and costs are weighed up
Multi-agency working:	Practitioners' experiences of multi-agency work

A reduced version of the guide was used for the online focus group, where participants needed more time to respond. Questions about multi-agency work were not included and fewer probes were used to explore the benefits and costs. A full copy of the interview guide can be found in appendix 4.

2.6.3 Analysis

All focus groups with practitioners were transcribed and then analysed with the assistance of the qualitative software package NVivo. The data was systematically coded and then analysed for themes.

The number of participants involved meant that the interactions between practitioners could not be analysed. While issues specific to each case study have been highlighted in the report, separate themes for each case study could not be reliably drawn from the amount of data available.

2.7 Service user focus group

Following the identification of key findings from the focus groups, service users and family members who were interviewed for the case studies were invited to a discussion of the results. The invitation was also extended to service users from RDA's Service User Forum¹¹. The aims of the discussion were:

- To feed back the findings from the practitioner focus groups
- To check whether they reflected service users' experiences
- To consider the guidance and support that practitioners might need to work more effectively with adults with multiple needs

Six service users and one family member attended the focus group. They listened to, and commented on, the research findings and took part in discussions on the following topics: risk, information sharing and confidentiality, and initial engagement of the family. These topics were derived from the initial analysis of the data.

2.8 Project advisory group: the Parental Mental Health and Child Welfare Network (PMHCWN)

The PMHCWN is a development network set up to promote joint working between health and social care staff working with parents with mental health problems or their children. The research methodology was presented to members of the PMHCWN steering group in September 2008. The initial findings were presented in November 2008.

Organisations attending the steering group were the Care Services Improvement Partnership (CSIP)¹², Family Action¹³, St Michael's Fellowship¹⁴, Tower Hamlets Adult Mental Health Services, the CAPE mental health project jointly run by Oxleas NHS Foundation Trust and Greenwich Children's Services, and service users from mental health services.

Support was also received from the Social Care Institute for Excellence (SCIE)¹⁵, an independent charity set up to identify and promote best practice for the social care work force. SCIE is currently developing national guidance on parental mental health and child welfare, which these research findings will potentially feed into.

¹¹ The RDA Service User Forum brings together service users from a range of relevant backgrounds and organisations to develop and inform policy. It also provides opportunities for involvement in research, consultation and recruitment activities and other organisational matters.

¹² www.csip.org.uk

¹³ www.family-action.org.uk

¹⁴ www.stmichaelsfellowship.org.uk

¹⁵ www.scie.org.uk

3. Policy review: the background to Think Family

This review was designed to provide a background to the Think Family proposals and the rationale for the research and give a general introduction to family policy (detailing developments from 1997 onwards). Think Family can be seen as part of a broader policy development in a number of different and interconnected areas:

- Promoting families and moving parenting into the public arena
- Protecting and investing in children and early intervention
- Multi-agency working and 'joined-up' services, including strengthening links between statutory and voluntary services
- Reaching the most socially excluded and preventing generational cycles of exclusion
- Tackling crime and anti-social behaviour

The place of family in policy has been looked at primarily in relation to social exclusion, the criminal justice system and mental health. The authors recognise this is not a comprehensive account but the subject will be revisited in phase three of the project.

Commentary on more recent developments since the Think Family agenda was first launched can be found at the end of the chapter.

3.1 Contextual background

Changing nature of family

The working definition of family was given in section 2.1. It should be clear however that the definition of what constitutes a family is fluid and can vary depending on an individual's circumstances and culture. The definition that Government gives to family for its different tasks might differ significantly from a service user's definition and experiences of 'family'. A practitioner might use a definition of family that attempts to be responsive to both Government and service users, and will also have their own personal views about what family means.

Regardless of the definition given to family and the diversity of forms this might take, both Williams (2004) and Doolan et al (2004) found that people's commitment to their family relationships remained constant over time. Readers looking for a more comprehensive review of family policy should refer to the work of these authors¹⁶.

Changing nature of practice

Professional practice in the last 10 to 15 years has, to a great extent, been characterised by a focus on individual service users, evidence-based assessments and practice, and performance monitoring and evaluation. This is in contrast to a more 'systems based' approach to working with service users that would have been a core part of professional practice prior to this period. It could be argued that the need for practitioners to measure the success or otherwise of work they carry out with their service users limits their capacity to work outside of their statutory remit (including working with the families of their service users) and curtails creative practice (Doolan et al, 2004).

The emphasis on individualised practice has grown alongside a statutory imperative for family work, however defined. Even though this family work has to a large extent focused on the protection and development of children, there has been a very real move for practitioners who traditionally work

¹⁶ In addition, a review of policy developments in social care can be found in Kearney et al (2000) and Rankin and Regan (2004).

with adult service users to consider the family. These potentially contradictory ways of working for adult practitioners is one of the main focus points of this study.

3.2 Think Family

“Think Family argues that excellent children’s services, and excellent adults’ services, are not enough in isolation. To transform life chances and break the cycle of disadvantage, services must go further... The goal is to extend the logic of integration behind Every Child Matters beyond children’s services to include adults’ services and promote collaboration and coordination around the needs of the family.”

Written Ministerial Statement, Edward Miliband, 10 Jan 08.

In June 2007 the Cabinet Office Social Exclusion Task Force (SETF) published the report, “Reaching out: Think Family”. The report described 2% of all families (approximately 140,000) as ‘families at risk’ – those experiencing multiple and complex problems, such as low income, poor housing conditions, physical and mental health problems, worklessness, and substance misuse. HM Treasury (2007) calculated that these families could cost the state between £55,000 and £115,000 a year if nothing about their current behaviour or needs changed. The report highlighted how statutory and voluntary organisations trying to meet these families’ needs often work in ‘silos’ and with family members individually. As a reaction to this individualised working, the report included best practice examples where parents and their children received an integrated service.

Involving families could mean giving family members a role in the service user’s care, addressing family member’s needs as individuals by signposting them to other services or working with them, or taking a whole family approach by carrying out a group intervention.

A follow up report published in January 2008, “Think Family: Improving the Life Chances of Families at Risk,” outlined the Government’s strategy for working with ‘families at risk’, promoting the need for multi-agency responses with integrated service planning, commissioning and delivery. Adults’ services, they argued, should work more closely with children’s services and consider service users’ needs as parents as well as individuals. Four main elements to this approach were highlighted:

- 1) There should be no “wrong door” to services. Any contact a family member has with a service is an opportunity to guide them into other services that they need.
- 2) Practitioners should actively think of the needs of the family as well as, and in relation to, the needs of the service user.
- 3) The focus should be on families’ strengths and should aim to develop the family’s capacity to look after their own needs.
- 4) Support given to families should be relative to their need: the greater the need the greater the support.

3.3 Early developments in family policy

Think Family draws together elements of earlier policy direction in relation to: promoting stable family life, joined-up services and focusing on the most socially excluded as a means of protecting and investing in children and tackling crime.

Labour’s 1997 manifesto focused on sustaining family life through better financial support, work-life balance and improved housing circumstances. It also highlighted support for the family as a way of tackling crime as the family was “the first defence against anti-social behaviour,” (Labour Party, 1997). The Social Exclusion Unit (SEU) was created soon after Labour’s appointment as an in-government think-tank whose role was to review the causes, impact and means of tackling social exclusion, and facilitate joined-up working across government departments.

Recommendations for family policy were fully explored following the 1998 Comprehensive Spending Review (CSR) (HM Treasury, 1998). In addition to the promises in the manifesto, it outlined strengthened support for marriage and stable adult relationships, improving services and support for parents (especially in children's early years) and targeted approaches to the most serious problems affecting some families, including domestic violence, juvenile offending and teenage pregnancy.

In 1998 two national, integrated programmes brought parenting to the fore of policy discussions. To ensure children had a better start in life, Sure Start local programmes were introduced, bringing together post-natal, health and childcare services, as well as preparing parents for their child's learning and schooling. The Crime and Disorder Act 1998 legislated for multi-agency Youth Offending Teams (YOTs) and created Parenting Orders. The court order made parental 'support' compulsory, instructing parents to attend classes if their child was subject to criminal and anti-social behaviour proceedings, a child safety order (not sufficiently supervised), or was truanting.

Families were given further consideration in relation to mental health services. "Modernising mental health services" (Department of Health (DoH), 1998) set out the Government's plans for reform - "working with patients, service users, their families and carers to build healthier communities," (p.6). It noted that overburdened families caring for patients were a failure of past care services. The National Service Framework for Mental Health (DoH, 1999) set national standards for promoting mental health and treating mental illness; standard six asserted that carers should receive an assessment of their own needs and have a written care plan created in discussion with them. Joined-up services were also prioritised as for the first time mental health was made a shared priority for health and social services in "Modernising health and social services" (DoH, 1999).

A range of measures was introduced to financially support parents and encourage them to return to work, for example the Family Support Grant (1999), Children's Fund (2000), the New Deal for Lone Parents (1998) and the Working Families Tax Credit (1999). A National Family and Parenting Institute was set up in 1999 (the 'National' was dropped in 2006) to be a centre of expertise on parenting by conducting research, influencing policy, and providing advice and information for parents and practitioners.

3.4 Public service reform and seamless services

The precursor for the method of service delivery within Think Family was introduced in Labour's proposals for the reform of public services in their 2001 manifesto, giving front-line staff the freedom to make improvements to services within a framework of national standards. Their vision was a flexible 'catch-all' web of public services.

"We have a new approach to improving the quality of mainstream services, preventing people falling between the cracks, and reintegrating them into society if things go wrong." (Labour Party, 2001)

Key problems affecting families and communities were to be targeted for study by the SEU: young people not in education, training or employment, truancy, school exclusion, teenage pregnancy, reducing re-offending, neighbourhood renewal and rough sleepers.

3.5 Every child matters: engaging parents and carers

In 2000 the need for joined up working and 'family thinking' in children's services was tragically highlighted by the murder of Victoria Climbié, who was known to four social services departments and seen by numerous practitioners before she died. A number of reasons were established for the failure of an adequate response in her case: lack of leadership and coordination, lack of clear accountability, not involving the right agencies, not prioritising resources, and insufficiently trained staff.

The “Every child matters” green paper (HM Treasury, 2003), published alongside the formal response to the inquiry (Laming 2003), proposed that children from all backgrounds have the right to be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic well-being.

The paper advocated an integrated approach to working with children at a local level. It put the onus on services to proactively engage parents and carers and highlighted that services should support families and carers as they have the greatest impact on children’s lives. It proposed that there should be a common assessment framework where information could be collected from multiple agencies and shared with them. The Children Act in 2004 made it a duty for any children’s services authority to promote co-operation between services for the benefit of children’s wellbeing, and legislated that, “a children’s services authority in England must have regard to the importance of parents and other persons caring for children in improving the well-being of children.”

Further policies encouraging parents to work were also put forward in, “Choice for parents, the best start for children: a ten year strategy for childcare,” (HM Treasury et al, 2004), again emphasising the importance of ensuring every child has the best possible start in life.

3.6 Adult services users and a move towards social inclusion

Social exclusion policy also began to apply elements of the Think Family approach to the needs of adult service users. The SEU report “Breaking the cycle: taking stock of progress and priorities for the future,” (2004) highlighted that certain groups consistently did not appear to benefit from social policies. These groups included people with physical or mental health problems, those who lack basic or formal skills or qualifications, and people from some ethnic minority groups. It noted services were often inaccessible to them, were perceived as inappropriate or could not meet their multiple needs. Their report “Mental health and social exclusion,” (SEU, 2004) identified parents with mental health problems as one of the four groups most likely to face barriers to getting their health and social care needs addressed.

The SEU advocated that hard-to-reach groups were to be engaged by: providing joined-up and one-stop shop services; tailoring support to the individual; making greater use of the skills and experience of the voluntary sector; involving service users in service development and ensuring policies were based on evidence of what works. The SEU was not the only government department to recognise the difficulties in working with vulnerable and socially excluded adults. The Neighbourhood Renewal agenda came to similar conclusions¹⁷.

In 2005, the green paper “Independence, well-being and choice,” was published by the DoH, outlining the Government’s vision for adult social care services. The importance of supporting family in caring for adult service users and service users’ role as parents were emphasised. Tony Blair also highlighted in the preface the need to learn from the experience and knowledge of front-line staff.

3.7 Preventing generational cycles of exclusion and tackling crime

The National Offender Management Service (NOMS) was created in January 2004 and made responsible for the management of offenders both in prison and out in the community. The “Reducing re-offending national action plan,” (Home Office, 2004) set out a number of pathways detailing the Government’s plans to reduce re-offending based on factors identified in the SEU report “Reducing re-offending by ex-prisoners,” (2002). One of the pathways was for children and families of offenders, recognising the importance of maintaining family ties and preventing generational cycles of social exclusion.

¹⁷ <http://www.neighbourhood.gov.uk/page.asp?id=1196>



In January 2006, the Respect Action Plan published by the newly established cross-governmental Respect Task Force, integrated most of the principles of Think Family, whilst framing them in the context of anti-social behaviour and ‘problem’ families. In contrast to previous responses to anti-social behaviour which emphasised a punitive response, the Respect Action Plan recognised the need for positive intervention and support for families with young people in, or at risk of entering, the criminal justice system.

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“We will roll out schemes which ‘grip’ problem households and the array of services involved with them and change their behaviour,”

p.21, Respect Task Force (2006)

The plan announced that from April 2006, a number of pathfinders – family intervention projects (FIPs) – would be funded to deliver integrated targeted support to parents of children and young people at risk and practical ways of intervening earlier, in order to reduce anti-social behaviour.

“Reaching out: an action plan on social exclusion,” launched by the SETF in September 2006, placed the ideas proposed in “Breaking the cycle,” (SEU, 2004) and the Respect Action Plan (Respect Task Force, 2006) within the context of public service reform. In a speech on social exclusion made prior to the release of the report, Tony Blair highlighted the need to give front-line staff the freedom to make changes:

“Agencies need incentives to co-operate. We need to liberate professionals to work ingeniously, strip away the rules, conventions and hierarchies that prevent them doing what is best in each individual case.”

Tony Blair, 4 September 2006

Women offenders and their families were given specific attention in the Corston report (Corston, 2007). Baroness Corston highlighted the disproportionate use of custodial sentences for female prisoners - many of whom had multiple needs and backgrounds of deprivation - and the impact the use of custody had on their children. The report emphasised a need to re-think the way that community services were designed for vulnerable women and more use of non-custodial penalties.

3.8 Thinking Family

In March 2007, “Every parent matters,” (DFES) was published, detailing the Government’s role in parenting as being to ensure parents were able to make confident and informed choices, were involved in shaping services that were responsive to their needs and could access additional support when needed.

In May 2007, the Cabinet Office released the policy review, “Building on progress: families,” focusing on children and families, rather than on family work with adult service users. Within ‘the next steps’ section, the authors combined all the proposals of previous reports: targeted and intensive support to socially excluded families, early intervention, appointing a lead professional, and increasing the accountability of individual practitioners. It also drew attention to increasing the skills and incentives of local commissioners to target and tailor support for the most disadvantaged families.

Following this in June 2007 the first Think Family report was released. Ten days later, the Prime Minister announced a restructure of government departments. The Department for Children, Schools and Families (DCSF) was established to bring together policy affecting children and young people. The DCSF were given the responsibility of taking forward the Think Family agenda.

The second Think Family report, published in January 2008, announced the Government’s commitment to providing £16 million to pilot 15 ‘family pathfinders’ and up to 6 ‘extended family pathfinders for Young Carers’, to test out the Think Family approach. At the time of writing, 15 local authorities had been successful in their bids for the funding to take forward the pathfinders¹⁸. Each of the pathfinders are designed to be exemplars of good practice and integrated multi-agency working.

The National Academy of Parenting Practitioners, promoted in the report, was launched in November 2008 as the official body for knowledge, training and good practice on working effectively with parents.

3.9 Summary

This section has provided a brief overview of policy developments moving towards the Think Family agenda. The agenda is an example of the Government’s more recent approach to integrated working and targeting the needs of vulnerable, socially excluded individuals and their families.

¹⁸ For further details visit www.everychildmatters.gov.uk/parents/pathfinders

Since the Think Family agenda was launched, debate on 'the family' has continued in British politics and the media. For example, the 'Good Childhood' report (Layard and Dunn, 2009), commissioned by The Children's Society, purported that excessive individualism in society was causing a range of problems for children including family break-up, poor teenage social relationships and acceptance of inequality. Extreme cases of children being at risk from their family (for example, Baby P) have further reiterated the importance of services working together and have also raised the issue that regardless of how integrated a service is, there still needs to be a named individual who is responsible for each case. Bad press over problems in public services and poor pay have been linked to difficulties in recruiting and retaining practitioners, putting further pressures on existing staff: Conservative figures obtained under the Freedom of Information Act suggest that the national vacancy rate for social workers is 14%, up 3% from 2005 (BBC News, 2009).

This research looks at how practitioners make sense of these policy messages – as well as other influences on their attitudes towards families from law, work culture, research and the media (Williams, 2004) – and how these all contribute to their practice with families. The literature review in the next section highlights findings from existing research on the practitioners' perspectives on working with families.



4. Literature review

The previous section provided a background to the Think Family proposals. The literature review focuses on practitioners' perspectives in relation to family work with adults with multiple needs.

The literary evidence has been presented under several themes and sub-themes, derived from the various reports and articles referenced. Post-analysis of the data for this project, the original themes were revisited and reorganised to mirror and inform the structure of the main findings.

The literature review summarises research that focused on different groups of practitioners, ranging from practitioners who have been trained in role to those holding a professional qualification. The findings have been presented as broad themes, however, where applicable the specific practitioner group involved in the research has been highlighted.

4.1. Practitioner values

Family work often involves working with a number of different people who might have conflicting views about what it means to be a good carer, family member or service user. The values of the practitioner, service user, family members, and organisation can be difficult to reconcile (Woodbridge and Fulford, 2004, Ipsos MORI, 2007c). Some practitioners relied on their own values to guide them instead of entering into a dialogue with the service user and/or the family about their concerns and their differences.

4.1.1 A 'good' parent/family member/partner

Bancroft et al (2002) found there was a tendency for practitioners to look at the role label assigned to individual family members and make assumptions about what that entailed rather than looking more closely at what they actually do within the family. Similarly, when practitioners thought about working with a parent that very often meant working with the mother.

Ipsos MORI (2007) found practitioners had very different views about whether parents were the experts on their own children and whether parents did all they could to protect children, which in turn affected their opinion on their organisation's safeguarding policy. Certain problems such as drug use could lead to different assumptions about the service user's ability to be a good parent, depending on the drug in use and its moral and social connotations (Bancroft et al 2002). These assumptions varied even between practitioners in the same type of service and could lead to different practice amongst practitioners and across services.

Doolan et al (2004) investigated how social workers would hesitate to use the avenue of care provided by relatives or friends of children at risk. The researchers found that practitioners were concerned about the potential for conflict between parents and relatives or friends over their role as care providers. They also felt that family or friends may lack the commitment of professional caregivers. For example, social workers were aware of the strict procedures in place to become professional caregivers and felt confident about the quality of the care that would be provided by them. This confidence was not necessarily felt towards relatives or friends who may be looking after a child.

Becher and Husain (2003) argued that practitioners' assumptions about service users' cultural values and boundaries, rather than a focus on actual behaviour and a discussion of values with service users, had led to the development of specialised services for minority ethnic service users, an over dependence on community networks and organisations, and had been a barrier to mainstream family support.

4.1.2 A 'good' service user

Practitioners also made judgements about how service users should behave: they should listen to and follow the practitioner's advice, turn up to their appointments and be courteous. Service users who were challenging and chaotic could then be perceived as unwilling to take up services, undeserving of the service or not worthy of pursuing because the treatment would be unsuccessful (Becher and Husain, 2003, Keene, 2001, Nixon et al, 2006, O'Shea et al, 2003, Rosengard et al, 2007, SETF, 2007). This could have serious consequences for these service users, for example, a reluctance to engage with social care could be perceived as a lack of commitment to children (Doolan et al, 2004) rather than reflective of the service users' negative experiences or perception of the service or their mental health (Rankin and Regan, 2004, Nixon et al, 2006, O'Shea et al, 2003).

Keene (2001) found practitioners and service users had differing expectations over what the service should provide, which could be frustrating for both parties.

4.1.3 Organisational values

Doolan et al (2004) and Kearney et al (2000) found that focusing on the child's needs as paramount could sometimes minimise the potential to work with the whole family. A considerable amount of joint training between child and adult social care focused on child protection, meaning that 'family work' could become synonymous with 'high risk, child protection work', to the detriment of working with adult service users and their families.

Some organisations had specific values relating to information sharing. For example, drug and alcohol services and mental health services were reluctant to share information, believing it infringed upon a service user's confidentiality (Rankin and Regan, 2004). The NHS in particular has strict rules around patient confidentiality, even when there are issues of public or child protection.

Practitioners questioned whether their role was to act on behalf of the service user or the family, and whether an intervention was in everyone's best interests (Bancroft et al, 2002, POPS 2008, Randall and Brown, 2001). Bancroft et al (2002) note that service evaluations tended to be based on the outcomes for the service user rather than the family, denoting an emphasis on putting the service user first.

Many practitioners recognised the stigma attached to parenting and targeted services, however Sure Start was viewed positively as it advocates a universal access point for families (Ipsos MORI, 2007c, Williams, 2004, Barrett, 2008). O'Shea et al (2003) and Barrett (2008) argued voluntary services may be better placed to work with families because service users engage with them voluntarily. Chaotic service users accessing these services are less likely to be reprimanded for non-attendance and can avoid a formal re-referral process.

Family self-help groups and support networks were identified as being able to counteract the affects of the blame attributed to the family (Bancroft et al, 2002, Williams, 2004). Recruiting staff that reflected the cultures and the community within which they work were noted as being a way to engage minority ethnic service users (Becher and Husain, 2003, Barrett, 2008).

4.2 Professional competence and dealing with emotions

Family work can be very emotionally challenging. Service users and family members often questioned or tested practitioners' personal or professional values, imbuing practitioners with uncertainty, frustration and discomfort. The evidence suggests that practitioners need support to manage these emotions. Family work requires a high level of skill and practitioners were often found to lack the training or support they needed to carry it out, leaving them questioning their professional capability.

Barrett (2008) noted that different staff experienced difficulties with particular types of service users but on the whole practitioners enjoyed working with people who made them feel good at their job and who appreciated what they were doing. Hence, practitioners could find it challenging to work with service users and families who are critical of them and who find it difficult to trust services, which is often true of adults with multiple needs.

Practitioners sometimes felt disempowered in their efforts to help service users and their families when faced with complex needs (Hinton et al, 2001, Nixon et al, 2008) and it could be difficult to retain clarity of purpose when families had a range of support needs (Nixon et al, 2006, SCMH, 2000). Training was particularly needed on withdrawing support and ending family work (Lemos and Durkacz, 2002, Nixon et al, 2008).

Practitioners often see family work as a specialist area and feel they lack the skills to complete this competently (Hinton et al, 2001, Kearney et al, 2003). Kearney et al (2002) point out that although practitioners may *feel* that they do not have the expertise to work with issues on mental health, drug or alcohol misuse, 50-90% of families they worked with had experienced these issues. Hence, the fear may be that of the unfamiliar rather than the unknown (Rankin and Regan, 2004). However, in some cases, there may be limits to practitioners' abilities which need to be recognised, for example, Lemos and Durkacz¹⁹ (2002) noted that some housing practitioners they worked with did not have the skills to explore deeper emotional and complex issues. Hence, their role in family work may appropriately be limited to signposting to other agencies.



¹⁹ Refer to Lemos and Durkacz (2002) for a practitioner toolkit for help in exploring family and friendships.

Box 4.1 summarises the good practice highlighted by the literature in relation to professional competence and managing emotions.

Box 4.1 Good practice: professional competence and dealing with emotions

- Good communication, interpersonal skills and reflective practice are essential for any practitioner involved in family work (Hinton et al, 2001, Barrett, 2008).
- Practitioners should reflect on their own attitudes and comforts/discomforts about family work before working with service users (Hinton et al, 2001).
- Practitioners should be up front with families about the purpose of their involvement and what their intentions are in order to resolve any issues that are concerning the family (Barrett, 2008)
- Family work requires understanding in working with all family members and acknowledgement that non-specialist knowledge about other agencies is needed. Practitioners need to be aware that knowledge can be gained from service users and their families as well as from their own personal experience (Kearney et al, 2000).
- Training can improve skills, reduce fears, encourage staff to think creatively about their work and reflect on their practice (Barrett, 2008).
- Regular supervision, both personal and professional, is vital (Barrett, 2008, O'Shea et al, 2003, Hinton et al, 2001). Supervision on important practice issues could be provided by senior professionals from either the same or a different agency (Kearney et al, 2000).
- Formal debate and negotiation could take place on risk assessment to agree definitions and functions across agencies (Kearney et al, 2000).
- Assigning families to teams rather than individuals can give practitioners more support and provide service users with more consistency (O'Shea et al, 2003). (NB: This does not preclude giving a named professional lead responsibility in the case).
- Practitioners who are new to family work can be encouraged to participate if it is identified as non-threatening and something that can be taken on by the whole team. Uptake of family work can be made easier by boosting practitioners' self-esteem and increasing team morale (Hinton et al, 2001).

4.3 The practical implications of family work

Family work with chaotic service users was repeatedly highlighted as time consuming and resource intensive (O'Shea et al, 2003, Humphreys et al, 2005, Atkinson et al, 2002, Kearney et al, 2000, McInnes, 2007, Noaks et al, 2004, Peck et al, 2001, SCMH, 2000, Barrett, 2008). Meeting the basic needs of service users and addressing the explicit core functions of the practitioner's post could take precedence over family work if it was not a direct remit of the organisation. Additionally, family and preventative work was likely to be cut back first when there were limited resources and high caseloads (Ipsos MORI 2007c, RDA 2003, SCMH, 2000, McInnes, 2007, Hinton et al, 2001, Kearney et al, 2000, Randall and Brown, 2001).

4.3.1 Practical demands

Koshinsky Clipsham (2006) noted a number of practical factors requiring additional time and resources, including difficulties in contacting the family, providing printed materials about the support on offer, visiting the family in their home, lack of access to transport and organising appointments to fit various schedules. Becher and Husain (2003) highlighted that, where relevant, a full range of interpreting services need to be made available to avoid an over-reliance on family members to translate.

4.3.2 Funding issues

Practitioners noted statutory services could be reluctant to spend money on family work if there was not an associated statutory obligation to do so (Ipsos MORI's research, 2007c). Similarly, services based on short-term funding are restricted in their ability to engage with families (Hinton et al, 2001, Nixon et al, 2008, Ipsos MORI, 2007b, McInnes, 2007, Barrett, 2008). Front-line voluntary sector managers agreed on the vital role played by outreach work but noted it was costly (Barrett, 2008). Doolan et al (2004) highlighted that front-line practitioners often did not have much control over resources available to families, which limited their ability to be creative and respond to need, and practitioners did not know how to access resources within their own organisation (Kearney et al, 2000).

4.3.3 Prioritising family work

Peck et al (2001), SCMH (2000) and Kearney et al (2000) found practitioners' job titles, for example 'mental health worker' or 'child care worker,' were important in giving practitioners an identity, status and a focus to their work. However, they could also be a barrier to taking on work perceived to be at the edges of their role. Embedding work with families and friends into the frameworks practitioners use - for example in assessments, support plans and job descriptions - was important in getting practitioners to prioritise family work (Lemos and Durkacz, 2002). Doolan et al (2004) argued that having professional structures and procedures that supported rather than curtailed flexible and creative work would encourage work with families.

Signposting to other agencies might be the most appropriate type of family work for some organisations (Barrett, 2008). Practitioners who saw their role primarily as management of cases over a short time period rather than prolonged care and support could find it difficult to dedicate time to families (Hinton et al, 2001, POPS et al, 2008). Hinton et al (2001) and Barrett (2008) also argued that practitioners who tried to promote independence in their service users often preferred to refer them on to other services rather than carry out longer-term intervention. Hinton et al (2001) outlined important questions for organisations considering developing new practice, highlighted in Box 4.2. These were developed in relation to health promotion work, but the questions could apply equally well to implementing Think Family.

Hinton et al (2001) point out that to implement new work practice, as with Think Family, time needs to be dedicated to ensuring it is incorporated into an organisation's agenda. Champions of the new practice should be identified and outcomes should be monitored (Barrett, 2008, Hinton et al, 2001).

Box 4.2 Good practice: questions for agencies taking Think Family forward (Hinton et al, 2001)

- What family work are practitioners currently involved in and what are the gaps?
- What family work has been done in the past and what were the successes and pitfalls?
- How long do service users stay with the service and how far do valuable relationships develop with practitioners? (to determine the nature of the work possible)
- What are service users' main concerns about their family and well being and how are these expressed?
- How can both practitioners and service users be involved in identifying their needs in order for these to inform the development of policy and strategy?
- What are the opportunities and barriers to promoting family work?
- Do practitioners have any training in family work? How interested or willing are they to engage with these issues and what are the training gaps?
- How can practitioners be identified who can have a key role in developing family work?
- Is there a budget for developing new initiatives?
- Are practitioners aware of local resources and do they use the support they could provide?

Refer also to Kearney et al (2003) for a guide to developing protocols for family-centred work.

4.3.4 Staff retention

Services who have difficulties in retaining staff find it difficult to provide consistent support to service users and their families (Ipsos MORI, 2007b, Kearney et al, 2000, McInnes, 2007, Noaks et al 2004, RDA, 2003).

4.4 Multi-agency work

Multi-agency work is essential to family work as no one organisation could meet every need a single family demonstrates (Barrett, 2008). In order to carry out the work effectively, practitioners need to have a number of skills, including a broad understanding of what services are available to service users and families and what they do, and be competent in networking and forming relationships with practitioners in other organisations. Interpersonal skills, management support, partnership agreements and protocols are key to deciding how work and responsibilities will be divided between organisations.

4.4.1 Positive aspects

Atkinson et al (2002) and Nixon et al (2008) noted a number of positive aspects of multi-agency work for practitioners, including having a broader perspective on the family's needs, reduced feelings of isolation and an increased sense that their practice was safer and risks were reduced.

4.4.2 Different priorities between agencies

While family work may be a high priority for one organisation, it may not be for another (Kearney et al, 2000, Keene, 2001). Practitioners commented on the high thresholds required to receive statutory support services (Ipsos MORI, 2007c, O'Shea et al, 2003, Barrett, 2008). Exclusion from one service could be used as a reason to exclude from another, for example Kearney et al (2000) found some mental health workers used inclusion criteria for clinical treatment as a threshold to their own service. Practitioners identified that targeted interventions sometimes narrowed their inclusion criteria to prioritise limited resources (Ipsos MORI, 2007a, Kearney et al, 2000).

Certain professions could act as a block to change (SCMH, 2000). GPs were a group particularly identified as hard to engage in multi-agency work (Ipsos MORI 2007b). This could be due to the need for longer consultations which the service does not provide (O'Shea et al, 2003), a lack of formal training on social issues, and/or perceived issues of patient confidentiality. Schools were identified as a potential key player in family work (Ipsos MORI, 2007c), however school engagement varied, and where some schools wanted to do more they lacked the necessary resources (Ipsos MORI, 2007b).

4.4.3 Different practice models and knowledge bases

Many reports identified a 'culture clash' between different agencies, with different practice models and knowledge bases and definitions of the 'problem' and what constitutes 'success' (Humphreys et al, 2005, Ipsos MORI, 2007b, Rankin and Regan, 2004). Keene (2001) found that practitioners tended to see 'their own' problem as the primary or causal problem, but noted that, despite this, agencies tended to use the same methods for dealing with that problem, for example, motivational strategies, cognitive and behavioural methods.

4.4.4 Statutory and voluntary agencies' differences

A number of differences and 'sticking points' for statutory and voluntary organisations working together were noted. Practitioners from voluntary organisations sometimes felt they were excluded from joint working or not treated as equals by the statutory sector (Ipsos MORI 2007b). More positively, they argued they had greater scope than statutory services to be entrepreneurial and flexible in responding to need (Rankin and Regan, 2004). Barrett (2008) noted that voluntary organisations did not always have the appropriate skills or time to carry out in depth evaluations of their services, or the human resources to carry out enhanced Criminal Record Bureau (CRB) checks, for example. Voluntary sector practitioners commented that they were providing information to statutory services but did not receive any information in return (Barrett, 2008).

Networking between statutory and voluntary sectors could be sparse as could the promotion of what voluntary agencies offered (Boswell and Wedge, 2005, RDA, 2003), perhaps due to a lack of resources. In particular, networking between statutory agencies and minority ethnic community groups was thought to be weak (Becher and Husain, 2003).

4.4.5 Knowledge of other agencies and information sharing

It could be difficult for practitioners to have an overview of external services and to keep up to date with information on the relevant contacts within an agency (RDA, 2003) or on what services were available (Ipsos MORI, 2007b, O'Shea et al, 2003). Similarly Lemos and Durkacz (2002) highlighted that there was not enough awareness of the gaps in service provision. Kearney et al (2000) found that even within one service area there were differences between the ways teams were structured, with few joint protocols and differing levels of guidance. Practitioners felt they lacked understanding about different care areas, for example, children and adult care (Ipsos MORI, 2007).

Good personal contacts are key to multi-agency work (RDA, 2003) and as such any organisational restructuring can upset existing working relationships (Kearney et al, 2000, Peck et al, 2001).

Practitioners demonstrated some misconceptions about how other agencies worked, believing that other practitioners had the freedom to work in ways that they could not within their own service. SCMH (2000) found that practitioners from both health and social services backgrounds believed other organisations to be more autonomous and flexible in their practice than their own. They also believed that their own staff were more tied to accountability issues and that management were in control of their caseload. When practitioners felt threatened or embarrassed about their work they became defensive.

Confidentiality was seen as a barrier to sharing information as well as to multi-agency working (RDA, 2003, Barrett, 2008), particularly in health services (Kearney et al, 2000). Some professionals were wary of alerting another statutory service to a service user's problem fearing that it might jeopardise the service user's situation (Rankin and Regan, 2004). Practitioners wanted more definitive guidance on when a patient's right to confidentiality was superseded by the need to remove a child from harm (Ipsos MORI, 2007).

4.4.6 Practical issues

Multi-agency work is time consuming and demanding of resources. Case conferencing for family work might be useful but organising a number of practitioners to attend who are already short of time would be very difficult (RDA, 2003). Whilst multi-agency work can take on many different forms - from multi-agency public protection panels to more general joint case management - box 4.3 highlights broad themes in relation to good practice in multi-agency family work.

4.5 Implementing changes in work practice

Kearney et al (2000) and SCMH (2000) noted the importance of involving staff in organisational changes and developments in reducing resistance to change and keeping staff enthused.

Regarding social care, local authority planners and senior managers said that substantial inter-organisation and intra-organisational planning and policy making was taking place (Kearney et al, 2000). However, practitioners wanted central government to be more realistic about the time it took for working practice to change and improve (Ipsos MORI, 2007c, Kearney et al, 2000).

4.6 Conclusion

This section has begun to demonstrate the breadth and complexity of issues involved in carrying out family work with adults with multiple needs. Family work requires excellent interpersonal skills, understanding of, and sensitivity to, the complexities of family relationships, and professional expertise and experience. Practitioners need to be supported emotionally and professionally to reflect on the difficulties of their work, and be given the practical resources and organisational structures to carry it out and manage it.

The next section details the findings from the practitioner focus groups where many of the issues within this section were discussed in relation to the case studies.

Box 4.3 Good practice: multi-agency work

Good communication

- Clear and open communication and opportunities for dialogue between agencies.
- Early appointment of a coordinator
- Developing links with community groups and places of worship

Professional development and integrity

- Training opportunities with other agencies that include child care, child development and family working within the child in need frameworks.
- Less conventional learning opportunities, for example, regular peer briefings
- Need for protected time for interagency work
- Comparable pay, terms and conditions

Senior practitioners' leadership and management skills

- Valuing staff learning and investing in nurturing and developing teams – viewing partnerships as a process and not a structure
- Development of professional identities focused on the skills of individuals in the team rather than their professional backgrounds
- Strong leadership and active commitment from management teams to partnership working
- Management level development and training.
- Willingness to pioneer new approaches
- Financial resources and dedicated, sustainable funding, and pooled budgets

Working protocols and partnership agreements

- Clearer common targets
- Agreed criteria for referrals, assessments, case allocation and information sharing
- Identifying key contacts within agencies who can be a point of call for queries
- Ownership and use by managers of protocols and the consequences of non-compliance spelled out
- Use of multi-agency referral panels
- Robust service level agreements
- Shared accountability models
- Need for joint commissioning and crossover posts

Governmental good practice

- Recognition from central Government on good practice and progress made
- Clear directions from the Government about the role of different agencies (and funded accordingly)
- Compulsory measures to work with other agencies

Noaks et al (2004), Becher and Husain (2003) McInnes (2007), SCMH (2000), Ipsos MORI (2007b), Rankin and Regan (2004), Ipsos MORI (2007c), Kearney et al (2000), Keene (2001), Kearney et al, (2003), RDA (2003) Barrett (2008), SETF, (2007).

5. Research findings

The results were derived from a series of focus groups held with practitioners from both statutory and voluntary services. These practitioners worked primarily with adult clients but some also worked with families (see section 2.6.1 for further details on the practitioners who took part).

The aim of the focus groups was to discuss the opportunities and barriers to working with the families of individual adult service users.

Each focus group centred on one of three case studies that provided an assessment of an adult with multiple needs.

The following topics were discussed in each focus group:

- The needs of the service user and their family and what agencies could support them
- The benefits and costs of carrying out work with families and how these are weighed up
- Practitioners' experiences of multi-agency work

The research identified several themes that illustrated many of the complexities of family work, and mirrored those outlined in the literature review. These themes are presented in section 5.3.

5.1 Context of findings

Practitioners who took part in this research covered a wide spectrum of training and professional experience. Only one practitioner had undergone academic professional training to work therapeutically with families (in adult mental health services).

The views that practitioners hold about family work and their support needs for practice will inevitably be influenced by their previous experience, training, professional knowledge and theoretical stance. A specific example can be seen in relation to an organisational imperative to involve carers which occurs in adult mental health services but not in drug and alcohol services. Family work means different things to different people, depending on their role and organisational remit.

Family work can take place at a number of different levels including:

- Engaging with family members in pursuit of the objectives of the work with the service user
- Helping the family actively engage with the service user, for example through home and joint visits
- Working with other agencies who have responsibility for other family members
- Referral and signposting
- Active 'therapeutic' work

Box 5.1 demonstrates the types of family work that research participants talked about taking part in. The themes identified within the following section clearly do not apply to all practitioners in all roles. Therefore, wherever possible, findings have been differentiated between the various professional levels, highlighting the varying needs of practitioners in relation to family work²⁰.

²⁰ The 'S' and 'V' which appear after participants' names refer to whether they are part of a statutory or voluntary organisation respectively.

Box 5.1 Family work and its benefits

All practitioners who took part in the research were carrying out some family work, regardless of whether or not their service was designed for families. The work ranged from minimal interaction on the telephone to long-term, whole family therapeutic intervention.

Several practitioners were passionate about the ability of family work to deal with the root of problems as opposed to simply tackling the presenting issues. Other benefits discussed include: being able to address family relationships in recognition that it might be the most important thing to the service user; the family could act as “allies” in helping the service user to engage with the intervention; they could remind the service user about appointments or taking their medication, monitor their behaviour, speak to other relatives in a language and manner they understood, and could be a source of support and encouragement.

By involving the family, the practitioner could become much more knowledgeable about the service user and the way that they needed to be supported.

“The more I speak to him [the husband of the service user] the more I realise that when she goes home, she’s got to face this rather hard man, who’s got his own problems in understanding and his own distress at seeing his wife change in front of him.” Rob, S

Another essential aspect was being a source of practical advice, information and support, particularly around finances and housing (which were big sources of worry) but also on what other services provide and how they operate:

“I think it’s who can help? What is available? What is practical at the time? Because a lot of the calls are instant crisis calls – the families that have just heard that their daughter’s come out of court, she wants to come home to the family home, hasn’t lived at home at nine years, what do I do?” Sophia, V

The key skills required for family work include facilitation/mediation and providing a safe space for the family to speak and work through their problems.

“We’re probably adept at allowing people to speak, reformulating words that are used by one party to prompt another party to respond, you know all the facilitating skills perhaps? And bringing down the temperature... Or focusing on what really seems to be being said as opposed to a lot of the chatter.” Rob, S

5.2 Case studies: an introduction

Three case studies were developed to take forward this research. The details were based on interviews with a number of adult service users and their families and were intended to provide a focus for the practitioner groups in order to draw out issues relating to practice as opposed to theoretical concerns. The individual strengths and concerns and family matters for each of the cases are summarised here. Full details can be found in appendix 2.

5.2.1 Sarah

Sarah has one young child and one teenage child who are both cared for by their maternal grandparents. Sarah is currently in prison and has a history of drug use.

Family members	Individual strengths	Individual concerns	Family matters
Sarah (32) – service user	<ul style="list-style-type: none"> • Good levels of literacy and numeracy • Good work skills • Good physical health 	<ul style="list-style-type: none"> • Recovering from drug use • Offending history • Low confidence in ability to change lifestyle • Copes poorly with stress and frustration 	<ul style="list-style-type: none"> • Would like relationship with daughters • Feels family wants her to fail
Debbie (13) - Sarah's child	<ul style="list-style-type: none"> • Supported by school counsellor and CAMHS • Good physical health 	<ul style="list-style-type: none"> • Low self-esteem • Being bullied • Lonely 	<ul style="list-style-type: none"> • Confusion and anger over relationship with mother • Frustration with family's mixed response to bullying • Mixed emotions about Jessie
Jessie (4) – Sarah's child	<ul style="list-style-type: none"> • Good physical health • Confident and happy 	<ul style="list-style-type: none"> • Notices Debbie is unhappy 	<ul style="list-style-type: none"> • Does not know Sarah is her mother
Steve (65) and Jenny (55) Grandparents	<ul style="list-style-type: none"> • Provide good care and boundaries for the children 	<ul style="list-style-type: none"> • Financial strain • Health problems • Jenny is socially isolated with few interests or activities outside the family 	<ul style="list-style-type: none"> • Differing attitudes on tackling Debbie's bullying and difficulty making friends • Mixed emotions about Sarah • Steve and Jenny's relationship under strain

5.2.2 Dan

Dan has two teenage children who live with his wife, from whom he is separated. He is a problem drinker and living in a hostel.

Family members	Individual strengths	Individual concerns	Family matters
Dan (47) – service user	<ul style="list-style-type: none"> In recovery from problematic alcohol use Supported by housing service Successful career before alcohol use 	<ul style="list-style-type: none"> Health problems Low self-esteem Lonely and depressed Early history of being abused £12,000 debt 	<ul style="list-style-type: none"> Desire to rebuild relationships with children and ex-partner Feels shame and guilt about past behaviour Good relationship with younger brother
Rana (n/k) – Dan's ex partner	<ul style="list-style-type: none"> Caring and warm towards children and sets clear boundaries Taking English and Maths classes Part-time work 	<ul style="list-style-type: none"> £12,000 debt 	<ul style="list-style-type: none"> Arguing with Omar about school behaviour High emotions about Dan's alcohol use and past behaviour
Amina (19) – Dan's child	<ul style="list-style-type: none"> Two close friends Studying at university 	<ul style="list-style-type: none"> Lacks confidence and trust in people 	<ul style="list-style-type: none"> Desire to rebuild relationship with father but concerned about mother's feelings Angry with relatives who speak negatively about father
Omar (15) – Dan's child	<ul style="list-style-type: none"> Many friends Good at sports and creative activities 	<ul style="list-style-type: none"> Difficulties with his identity Low concentration at school Some pro-offending friends Previous exclusion from school 	<ul style="list-style-type: none"> Close to mother though frustrated by her non-communication with father Angry with father but wants to rebuild a relationship Angry with relatives who talk negatively about father

5.2.3 Karen

Karen has three young children and is living with them in temporary accommodation. Karen is experiencing depression.

Family members	Individual strengths	Individual concerns	Family matters
Karen (25) – service user	<ul style="list-style-type: none"> Good work history Meets children's basic needs Maintains boundaries, eg, stopping boyfriend coming to flat under influence of drugs 	<ul style="list-style-type: none"> Depression Housing problems Health problems Loses temper quickly No close friends Use of alcohol to relax Financial strain 	<ul style="list-style-type: none"> Concerned about boyfriend's drug use No financial support from Amy's father or her boyfriend Strain in relationship with boyfriend Anxious about how depression is affecting children
Amy (4) – Karen's child	<ul style="list-style-type: none"> Good relationship with brothers. Gets on well at nursery 	<ul style="list-style-type: none"> Health problems Missed nursery 5 times in last month 	<ul style="list-style-type: none"> Concerned about her mother's low mood Confused about relationship with father
Joshua (19mths) Charlie (3mths) - Karen's children	<ul style="list-style-type: none"> Good health Good relationship with sister 	<ul style="list-style-type: none"> Restless from staying in flat 	<ul style="list-style-type: none"> Unknown
Dave (26) - Karen's boyfriend and Joshua and Charlie's father	<ul style="list-style-type: none"> Frequently comes to the flat to see children and take them out 	<ul style="list-style-type: none"> Daily use of cannabis – other unknown drug use 	<ul style="list-style-type: none"> Relationship with Karen under strain Puts few boundaries on children's behaviour

5.3 Thematic analysis

The qualitative data derived from the focus groups was analysed using NVivo (a social science software package) in order to develop several broad themes. These were influenced by the priorities of practitioners in the focus groups and the evidence in the literature. A summary of the themes is given in box 5.2 below. The data to support the themes is presented within the following section and is also incorporated into the discussion in section 7. In addition to the themes, we have also presented potential solutions put forward by practitioners.

Box 5.2 Summary of the five main themes

1. Challenges and values

Practitioners were faced with a number of challenges in their family work, for example, how much information to share with family members and to what extent they should be guided by service users in their decisions. Practitioners would draw on their personal and professional values to resolve these challenges, and accordingly broaden or narrow their perspective on the issues involved.

2. Managing the unfamiliar

The behaviour of service users and family members could be unpredictable. Practitioners were concerned they could worsen the family situation if service users and families were not ready to address their issues and work towards a solution. If family work did not go as planned, it could be detrimental to the practitioner's relationship with the service user. In some cases where the practitioner was not sufficiently skilled or supported in their work, involving the family could increase the risk of harm to a service user and/or their family members.

3. Dealing with emotions

Practitioners could not help but be affected by the negative emotions expressed by some of the service users and their families, for example, feelings of anger, resentment and hopelessness. They found it difficult to remain professional, positive and solution-focused in the face of these emotions, particularly those who were working with both service users and their families.

4. The practical implications

All practitioners talked about the practical implications of working with families. Financial resources, for example, needed to be flexible to carry out work across different geographical areas. Family work required additional human resources as extra time was needed to meet with families, to co-ordinate multi-agency work and to take up training and learning opportunities.

5. Multi-agency work

Practitioners had varying levels of awareness of, and knowledge about other agencies and, for the most part, were more knowledgeable about organisations from their own sector. They identified a number of difficulties in carrying out multi-agency family work including problems caused by differing policies on information sharing and confidentiality, as well as service thresholds.

5.3.1 Theme one: challenges and values

Each of the focus groups demonstrated that practitioners were faced with a number of challenges in their work with service users and families, regardless of their training and professional experience. Day-to-day challenges included how much information to share with family members and to what extent they should be guided by service users in their decisions.

There were three key challenges that repeatedly arose in relation to family work. These are presented below.

5.3.1.1 Ensuring the family could make an informed decision on whether they wanted help or not

Practitioners were concerned that while service users were engaging with them voluntarily and choosing to share their information, this was not necessarily true of the family. Practitioners understood that families had a right to receive support if they wanted it and they also understood that families had a right to refuse support and maintain their privacy.

However practitioners were unsure whether service users and families were actually exercising their right to refuse support or whether they were refusing because they did not understand the support on offer, because they felt there was a stigma attached to the service or they had previously had bad experiences with services. Some practitioners pointed out that families did not always recognise that they needed support as the focus had always been on the service user. Self-referrals from family members brought relief to one practitioner because it was clear that they wanted help.

The challenge for practitioners lay in how to engage families when it was unclear whether or not they would welcome support. An example of this difficulty is given in Box 5.3.

Box 5.3

Sarah's relationship with her family is very poor and previous attempts at reconciliation have failed due to Sarah's continuing drug use. The children are cared for by Sarah's parents. One practitioner talked about the difficulties associated with approaching the family members of service users with substance use problems:

"It's very hard for families sometimes to understand that they do need help because the focus is so much on the person with the addiction that it becomes their addiction. So if you say to somebody like in the family like 'how about you?' it's like 'what do you mean me? I'm not the one. I don't take drugs.'" Sophia, V

Practitioners agreed that they should follow the service user's lead on whether or not to try to make contact with the family. However, some practitioners noted that there were difficulties in weighing up the family's right to privacy with the service user's desire for support. If the family member was unhappy about having their personal information shared it might backfire on the service user. An example is given in Box 5.4.

Box 5.4

Karen knows her boyfriend Dave uses cannabis and sometimes cocaine and amphetamines but she is not sure how frequently. She suspects his drug use has increased and is concerned. Practitioners discussed a possible consequence of speaking to Dave about this in any family work.

“Depending on the approach, Dave might feel betrayed and the consequences could be another risk factor [to Karen].” Carolynne, V

Alternatively, some practitioners mentioned that the service user’s right to privacy could clash with the family’s need for support. Speaking to family members could pose difficulties if there was a lack of trust between the service user and the family member.

“Most practitioners working purely in drug and alcohol feel they don’t have that much contact with families apart from when they get angry phone calls saying, ‘Has my son turned up for his appointment?’” Sophia, V

One practitioner felt that the supremacy of service user confidentiality in their organisation had been used to the detriment of family support, and felt that information sharing worked best if both sides understood the boundaries. For example, the practitioner could explain to the family member that they could not speak to them about the service user’s level of drug use but they could talk to them about how the family was coping with the service user’s behaviour.

Some practitioners did not see long periods of non communication between service users and families as a reason not to contact a family member. For example, families may not have been in contact for some time because they did not have the service user’s current phone number or address.

“If you don’t hear from somebody you think about them all the time, you worry, and if you’re not speaking to somebody there’s still some sort of communication going on so that’s the first step to find out what that silence is about.” Carl, S

Some practitioners felt that encouraging service users to resume relationships with family members before they were ready could risk the working relationship they had with their service user.

“If she’s going to be working with the family members she’s got to have a good relationship hasn’t she? You’re not going to want to involve somebody that she can’t stand the sight of anymore.” Chrissy, V

5.3.1.2 Finding a middle ground between the practitioner’s expertise and the family’s

There were mixed views on the extent to which practitioners should be led by service users and their families. Of the practitioners with professional backgrounds, some would prioritise their ability to facilitate whilst still allowing families to be active participants in decision-making, while other practitioners placed greater emphasis on the primacy of their professional expertise. Similarly, differences were found between practitioners who had not received professional training, with some championing service users and their families as experts while others relied on their own personal and practice experience. Some practitioners felt very uncomfortable about having the label of ‘expert’, as

demonstrated by the quote from Carl below. The quote from Chrissy illustrates the view that practitioners should take the lead from the service user:

“The problem sometimes with being an expert is that you just go along with your own strategy, you think you know everything [but] you don’t know the stories of this family.” Carl, S

“I like to support people to make their own decisions and that’s how I like to work rather than saying ‘oh you need this, you need that.’” Chrissy, V

Practitioners’ views about what could be seen as ‘traditional’ family roles (for example, mother as primary care giver, father as breadwinner) might affect firstly which family members they chose to involve, and any divergence from that role could also be used as a reason to challenge them:

Box 5.5

Karen has three children. Martin is the father of Amy (4) and Dave is the father of Joshua (19mths) and Charlie (3mths). Practitioners had different views on whether to involve the fathers in any family work and whether to involve Karen in this decision.

“I would need to question whether or not Martin is engaging or not. Once a month, it’s difficult. I think we would probably be minded to say he doesn’t engage because there’s no financial contribution [and] if he’s only seeing the child once a month there’s minimal if any emotional contribution there.” Julie, S

“Martin could be helped to see how this lack of support is affecting his child’s wellbeing.” Lidia, V

“Are we including Dave in this? I guess I was thinking actually is he a member of this family or not? In the sense that he seems to be but doesn’t live there and perhaps doesn’t offer very much support.” Chrissy, V

“There is a drifting relationship with David and Karen which could be strengthened.” Sam, S

Practitioners discussing Dan’s case study talked about offering support in a way that fitted in with service users’ and families’ cultural beliefs. They felt it was important to come to a shared understanding of the problems (see box 5.6). Some practitioners work with service users’ own definition of their problem. One practitioner said his service users sometimes describe their symptoms of depression in purely physical terms and when working with them he mirrors their terminology and is careful not to use the word ‘depression’ to avoid labels with which a service user is uncomfortable.

One practitioner mentioned the need to consider whether it was appropriate for them, as a male practitioner, to approach a female family member from a Muslim culture about their relationship with the service user. This raises an additional issue around the knowledge, training and support practitioners need to engage with people from diverse cultures and backgrounds.

Box 5.6

Dan is of Pakistani origin but was born in the UK. Practitioners focused a lot on the impact of Dan's cultural background on their approaches to offering support. They felt they needed to work in a way that was in tune with Dan and his family's beliefs about his alcohol use.

"We grew up in a culture whereby you go for a pint after work... He grew up in a culture [where] presumably although dad did it, in public it was abhorrent." Ian, S

"We may think that it might strengthen him to acknowledge it [his alcohol use] at some point in a more public setting but we need to go with his cultural shame." Rob, S.

"When this man is seeing professionals we don't want alcoholism thrust at him all the time as a defining concept for him." Rob, S

"Within non-individualistic societies the family, one member of the family has a problem, the family has a problem. And they're being left out, 'why is Dan getting all this attention when it's us as a family that have the problem? it's our problem.'" Ian, S

5.3.1.3 Ensuring that all parties are supported proportionately

Practitioners sometimes felt their values would pull them in a certain direction and result in them identifying more with the situation of the service user or with that of the family. This became particularly apparent in Sarah's case where two practitioners who both worked for drug and alcohol services took very different views on the root causes of family breakdown. Adam thought that a service user's alcohol use was exacerbated by problems with other family members, and Sophia believed that the alcohol use and not family members caused family breakdown.

"I did a presentation last week and I asked the workers 'Guys why do you think the problem is? Why do these guys drink so much?' I said they're drinking because their wives or their family brought them down, that's why they're drinking." Adam, V

"The reason that most relationships and marriages break up is because the person can't take it anymore, so they practice a tough love and they go, 'you know what, I've got to keep myself safe in this scenario.'" Sophia, V

It is important when involving a family that practitioners consider the potential benefits and costs to members of the family, as well as to the service user. This can prove difficult in practice as practitioners are not routinely privy to an assessment on the family and their likelihood of engaging with services before contacting them. This was discussed in relation to Dan's case in Box 5.7.

Box 5.7

Dan separated from his wife Rana three years ago and their relationship had been poor for a long time, partly as a result of Dan's drinking. He is in the early stages of recovery and would like to have contact with his children. Practitioners were unsure whether Rana would want to resume contact with Dan and talked about the ethics of encouraging Rana to engage:

"Look - we've been working with Dan for a while now and we're moving onto the issue of addressing this £12,000 worth of debt you're handling, you know we want to sort of help you out with that in whatever capacity we can, come on down." There's a carrot dangling there for them.
Ian, S

5.3.1.4 Solutions from practice: discussing challenges and values

Through their discussion of these challenges, practitioners highlighted a number of ways they were or could be supported to resolve them. **Supervision and the opportunity to talk to other colleagues** were repeatedly highlighted as important ways for practitioners to be able to reflect on their own values and practice.

"I work with a team so I've got three people... they'll come out if they have to and talk in front of the family and I've got someone who supervises me." Carl, S

"We do have to make assumptions at work, we do have to [make assumptions] this is going to be for your benefit mate because you're not in a fit state to make that informed decision yourself. But I would need support that I was not being racist in any of my, I was just making assumptions about his ethnicity." Ian, S (talking specifically about Dan's case)

This opportunity appeared to be particularly lacking for lone workers, that is, those people who work in satellite offices by themselves. Some of the practitioners believed that having different workers for the service user and the family avoided confusion around confidentiality, and practitioners would be less susceptible to identifying with the circumstances of one over the other.

Practitioners looking at Dan's case felt a **discussion around beliefs and values** was necessary when working with service users from a cultural background unfamiliar to the practitioner. This was believed helpful not only to address the practitioners' own concerns about how their beliefs may differ from the service users and families, but also to think creatively about practice and the relevance of taking a whole family approach.

Generally practitioners agreed on a **'no pressure' approach** towards involvement with both service users and families; making the offer and giving them the space to decide whether or not to take it up.

"But it has to come [from a feeling] that they're not pressurised. It's like trying to change a drug user, the minute they're feeling pressurised they might go 'yeah, alright, yeah, yeah, yeah' (backing away towards the door) 'oh I can't wait to get out of here.' And it's exactly the same for the family sometimes." Sophia, V

Some practitioners mentioned the importance of making **repeated offers of support** as circumstances within families changed, while others invited the family along to an initial appointment but did not continue to pursue it if they did not get a positive response.

Practitioners recognised that in addition to their effectiveness in engaging families, the **role of all front-line staff**, including reception and administrative staff, was to create a welcoming atmosphere for families.

“I’ve sent people along [to a drop-in service] and I’ve seen them and it’s just they go in and no-one jumps on them and they wander out again because it isn’t receptive enough.” Rob, S

“Not discourage [the family] with comments like ‘who are you?’ but be sensitive in how you ask.” Lidia, V

“A lot of my clients have walked into drop-ins and actually had to give more information than they gave the Home Office just in order to be accepted.” Ian, S

Practitioners had a **range of strategies to engage people** and make support readily accessible at any service point, using a variety of promotional methods. Services could be promoted through written materials, websites, outreach workers, and through practitioners in other agencies. Practitioners talked about using **both targeted and universal approaches**. A targeted approach might be suited to interventions at key crisis locations, such as courts or family visitor days in prisons. Universal approaches could mean putting information and outreach workers in neutral, universal locations like GP’s surgeries, schools and children’s centres, or having satellite workers – workers from one agency regularly making themselves available at another agency - for example, housing workers attending a children’s centre.

Practitioners mentioned a number of ways of counteracting the stigma attached to services, which underlay some of the confusion around whether service users and families wanted support or privacy. Universal approaches were felt to be more positive and less stigmatising.

“And it’s nice to see the families come in [to children’s centres] and you know they do, they do access other things. The job centre people come in and that’s really nice ‘cause it’s not that you go in there because you’re failing, it’s more of an uplifting experience rather than being sent to social services because you’re not doing a very good job.” Chrissy, V

Practitioners also mentioned the **benefits of being able to access family self-help/support groups** which offered families and service users the chance to meet people in a similar situation whose lives were improving.

One practitioner spoke about working with families in a way that was **positive and hopeful** and that challenged people’s perceptions of themselves and the stigma attached to substance use.

“They weren’t allowed to mention ‘I’m an addict’ or to address this in these therapies. They started to get used to a sense of themselves as being mothers, parents, brothers, and also a sense of themselves as things they had done prior to using alcohol or substances, things that they might have achieved in.” Carl, S

Many practitioners spoke to their service users about the nature of the support they would provide and why, and tried to maintain an attitude of **being open and willing to learn from the service user and their family**.

“I often make a point of saying to my client, ‘the best way for me to find out about you is to speak to a family member, do you mind if I do?’” Rob, S.

“When they’re [practitioners] actually going into that other culture and saying “hi, tell me what you know about you and I don’t know about you.” Ian, S

Some practitioners expressed concerns about service users and families becoming dependent on services to resolve their problems. A range of strategies were put forward to **ensure service users did not become dependent**: helping them come to their own decisions, enhancing their connections to community services, setting them tasks which would increase their self-efficacy, and building their self-confidence.

Two practitioners felt that a front-line **work force that better reflected the gender and ethnic make-up of their service user population** would lead to a more informed and creative approach to service delivery, and could improve take-up of services.

“Even in my team, I’m the only bloke on my course doing the psychotherapy course, and the year above there’s no men... in a four year course there’s five men in the whole place and two of those are porters. And the social work teams.” Carl, S.

“I just think we have to pay more attention in recruitment looking at the demographics of your area. Saying, look, 30% of the population here are from, you know an indo-european culture, or from a particular cultural background and your staff group needs to reflect that.” Ian, S



5.3.2 Theme two: managing the unfamiliar

The literature reviewed universally acknowledged that working with families is complex and challenging. This was endorsed by all the practitioners who took part in our research, regardless of their level of training or experience. Given this complexity, practitioners unsurprisingly demonstrated a range of concerns regarding family interventions.

Practitioners were concerned they could worsen the family situation by encouraging family involvement when service users and family members were not ready to address their issues and/or work together towards a solution.

“Working with the family can be a can of worms and you’ve got to be able to deal with the worms that you reveal, which is not something that can be predicted.” Rob, S

They were also concerned that family work that did not go as planned would be detrimental to their relationship with the service user and could be damaging to their professional reputation. In some cases where the practitioners were not sufficiently skilled or supported in their work, attempting to strengthen family ties could increase the risk of harm to service users or their family members, or allow abusive behaviour to go unchecked. As one of the participants commented,

“The road to hell is paved with good intentions” (Rob, S).

Different practitioners felt at ease with differing levels of family intervention, for example one might feel comfortable with phoning a colleague and making a referral to their organisation for family work, but may not feel competent to call the family him or herself to instigate a referral. Rob felt that although he was a very qualified practitioner and could work with partners in the context of them being carers, when they asked for help with their personal relationships he still felt uneasy:

“Even when I’m coming across some of the demands of couple counselling I feel de-skilled instantly.” Rob, S.

Most practitioners were sensitive to the possible deleterious consequences of family work, as demonstrated by Ian’s quote:

“One of the most disturbing themes of all forms of psychotherapy is that any literature you read on it tells you that intervention can be good or bad. It can be good or bad. It’s good to set limits, it’s bad to set limits. It’s good to set boundaries and use them as therapeutic tools, but boundaries can be taken this way and that way.” Ian, S

Practitioners in adult mental health services were particularly aware of the extent to which individuals could be affected by their family relationships and the skills needed to carry out work that involved the whole family. Box 5.8 highlights a discussion between two such practitioners about bringing Dan together with his family.

Box 5.8

Dan has not lived in the family home for three years and has had little contact with his children Amina (19) and Omar (15). Dan would like to reconnect with his family and make amends for his past behaviour towards them, which was fuelled by alcohol. Practitioners talked about the possible benefits and also the unintended negative consequences that could arise:

Ian, S: *“What interventions could be done that would most readily build up his self-esteem? I presume contact with his kids.”*

Rob, S: *“The self-esteem could be most quickly boosted, although most ruinously impacted on too if you’re not careful, contact with the kids.”*

Ian, S: *“Omar’s what 15? It’s dad time for him, I think Dan needs to be aware of that. Really just ‘it’s not all about you mate’ this kid’s 15 he really needs, or possibly really needs his father around.”*

Rob, S: *“Mind you, depending on how you sold that to him... it might just throw him into more self-punishing thoughts which probably preoccupy a lot of his mind anyway. Maybe he drinks to block that kind of stuff out.”*

Other practitioners were less aware of this complexity and were in danger of operating outside their area of competence. This was particularly true when considering the risk of causing emotional and/or physical harm to family members or causing damage by breaching a confidence. The details of Karen’s case raised concerns about child protection and showed practitioners’ confusion about how to address this issue (see box 5.9). Julie, however, was clear that she did *not* have the expertise to provide parenting support:

“The responsibility would fall down to that agency [social services to provide parenting support] because the needs of the child are most important. I don’t [have] the knowledge, the expertise or the authority to go down that road.” Julie, S.

Box 5.9

Karen knows her boyfriend Dave uses cannabis daily and sometimes cocaine and amphetamines. She suspects Dave’s drug use has increased over the last six months. Dave is the father of their two children Joshua (19 mths) and Charlie (3 mths). Practitioners in one focus group discussed the safeguarding risks for Karen’s children if they involved Dave in an intervention.

“He might be leaving paraphernalia around, kids can get hold of it.” Julie, S.

“She’s aware of class A use which is a concern.” Julie, S.

“But actually bringing him into this situation at the moment could turn this family down to a child protection situation rather than a struggling single parent so what’s best?” Chrissy, V

“You wouldn’t want to encourage a risk but at the same time, if he is addressing his drug use and he can crack that then he could be a good support for the family.” Chrissy, V

Practitioners did not only focus on current (potential) harm to children but were also concerned about past harm. This was particularly foregrounded when a practitioner did not believe they had the skills to deal with such information.

“There could be abuse issues from the past especially if you’re working with women, the amount of women who’ve been to prison who’ve got past abuse issues and they might not necessarily have disclosed that.” Yvonne, V

Collecting information on a family to assess the potential risks of family involvement could be difficult as it was not always possible to get accurate information from the service user, for example an account of their past behaviour towards their child (or a family member’s behaviour towards them), let alone information from other family members or agencies.

Organisational capacity was another issue:

“We’d have to get proper [criminal record bureau] checks done if we were to invite the extended family so the time involved in running those checks is not viable. ‘Cause at the end of the day we’re taking on a responsibility for that time period for the people in our care.” Julie, S

Where the family are involved in supporting the service user, practitioners noted it was important to thoroughly assess each family member’s ability to cope. Jan highlighted that too much responsibility could have negative consequences for both the carer and the service user.

“Expectations may be too high and responsibilities too great. In the past I have overestimated carers’ ability to cope, with (nearly) tragic consequences.” Jan, S.

When involving families, practitioners highlighted there was a greater danger of unintentionally disclosing information. Breaching confidentiality when involving the family could be damaging to the relationship between the practitioner, the service user and the family, and ultimately impact on the success of the support offered. Two practitioners noted that greater care was needed when involving children, as Ian notes below. They felt this was something to bear in mind, however, rather than a reason not to carry out the work.

“With that one individual who’s a grown man, he can take much more responsibility for what’s going on. Whereas with the family I think you have [to] really take responsibility of the fact that you’re engaging kids in a complicated process that can be very damaging.” Ian, S

5.3.2.1 Solutions from practice: managing the unfamiliar, complexity and risk

As mentioned, family work encompasses a broad spectrum of practice from making referrals to other agencies to working with the whole family. Regardless of their level of experience of working with families, each practitioner stressed the importance of adequate **professional supervision**, as the quotes below highlight.

“When you go in you’d better have damn good support so you can explore with other professionals what worms, if that can be used, that word, or issues you have inadvertently aroused in the family.” Rob, S

“Supervision is an ongoing issue... in childcare it needs to address a number of components, personal and the professional.” Carl, S

Practitioners recognised that many workers were not formally trained in family work and offered some solutions to how such workers could be supported to deliver it at some level. One

practitioner suggested that workers should have **a clearly set out framework for working with families with limitations for individual practitioners**. One practitioner highlighted that there were specific areas where practitioners particularly needed to have clear guidance and training, for example, on domestic violence. Another suggested workers without formal training in family work could receive **supervision from formally trained family practitioners**.

“I think there would need to be people within the teams who were there as consultants, not in a doctor/hierarchical sense of the word, but in the sense of people to run to and go ‘oh I don’t know what’s happening!’” Ian, S



5.3.3 Theme three: dealing with emotions

Many practitioners talked about the impact of listening to and working with families' negative emotions, which often included anger, resentment and hopelessness. Practitioners could not help but be affected by these emotions and found it difficult to remain professional, positive and solution-focused. This was particularly true for those practitioners whose role involved working with the whole family.

As mentioned in section 5.3.1, practitioners sometimes had pre-defined views about the roles of certain family members, for example, 'mothers' and 'fathers', and service users and their families may have similarly strong beliefs. When someone in the family was not fulfilling their 'role' or had 'foregone' it but subsequently wished to return to it, this could elicit resentment, anger and guilt.

"[The family are] going to be angry, they're going to like 'oh here she comes, miss queen bee, back into the children's life' 'oh right, I'm mummy now today ok, I'm going to take the kids to school,' 'Are you going to pick them up or are you going to go and use? Because I'm a bit worried because you've left them at the school gate.'" Sophia, V

Given this high level of feeling, it was easy for practitioners to take on the emotions of service users and families themselves, regardless of how experienced they were:

"One of the things that I try and watch myself is getting pulled down to this despair all the time." Carl, S

If practitioners became enmeshed in the emotions of *either* the service user *or* the family about their personal circumstances, it could be difficult to listen and maintain a neutral stance. For example, when a female service user in prison was dismissive about the impact of her actions on her family, with whom the practitioner also worked and knew to be struggling, the practitioner could not help but feel angry. As she was not able to express this anger to the service user, and was a lone worker, she was not able to offload her emotions at all and had to contain them.

"There is an expectation when I'm working with people like 'well my mum can look after my children, my mum can do this, and I'm having my fourth baby now'" Sophia, V

Similarly, Sophia described how she felt vulnerable to being manipulated:

"I said [to the service user] remove yourself from that situation if you are able to, to go for a walk round the block or to do something rather than go into attack reaction. And then a couple of weeks later the mum spoke to me and said 'she told me that you'd said to her right that if I drove her mad,' and this is the words, 'if I drove her mad, then really she's just got to get out.'... But they get twisted, they get blurred, they get fed back different ways and that is quite scary. It can be quite scary." Sophia, V

The face to face focus group for Sarah's case described how negative media portrayals of the hopelessness of individuals and families affected by substance use influenced the way that service users and families saw themselves and their situation. This was something that practitioners worked hard to counteract:

"In society as a whole and front page news and media coverage and highlights, [it] isn't about people in recovery... it's about people who are not in recovery. So this seeps through all of us." Sophia, V



5.3.3.1 Solutions from practice: managing emotions

Practitioners had to be able to **manage their own emotions around family work**, as well as those of the service users and their families, which could be exhausting and difficult. Some practitioners were not receiving enough support from their managers and colleagues for the family work undertaken.

Practitioners had to be able to **manage their own emotions around family work**, as well as those of the service users and their families, which could be exhausting and difficult. Some practitioners were not receiving enough support from their managers and colleagues for the family work undertaken.

Practitioners said they needed **regular personal supervision** where they would have an opportunity to talk about their feelings in relation to their work. This supervision session could also be used to discuss the difficulty of the work, the amount of effort that they put in and provide a space where good work could be acknowledged.

“Just getting positive feedback, because, again, I see people predominantly in the prison. I don’t see the ones in recovery that haven’t come back.” Sophia, V.

Those who were not formally trained, for example in mental health, social work, or health, and/or were lone workers, in particular needed **regular supervision to help them to manage emotionally complex scenarios**.

5.3.4 Theme four: the practical implications

Practitioners noted that family structures varied greatly. They spoke about individuals having children with different partners, less people getting married now, greater numbers of working parents, more elderly people being looked after in care homes rather than by families and more single parent families. Adults with multiple needs that include mental health and periods of imprisonment are likely to have even more complex family relationships, which can include multiple ex-partners living in different areas and children from different relationships.

Practitioners discussed practical challenges to carrying out effective family work, which included assessing how many family members a service could realistically support and the extent of the support that could be managed. Chrissy highlighted the difficulty in carrying out family work when there is a very real geographical distance between family members.

“Can we go back to family support? Extended family support? I don’t know. I’d like to think that you can but I don’t really know whether it’s possible. We haven’t all got the grandma round the corner do we?” Chrissy, V

5.3.4.1 Financial resources

Borough/county specific funding to work with families does not often reflect the reality of geographic dispersal of family members. Working with a service user in one county but actively engaging with the family and practitioners in another can cause problems when commissioning services.

Working with families may pose difficulties with funding if an agency is funded on the basis of working with a particular service user group and not for working with families. Collaboration between boroughs for funding could be challenging and time consuming.

Some practitioners spoke of competing funding priorities. For example, the level of funds spent on offender drug treatment in comparison to offender family support was felt to demonstrate the government’s prioritising of individuals over families. Similarly, the attention and funding given to children’s services was felt to be far greater than to adult services. A number of practitioners talked about existing funding constraints in adult services and wondered whether including families and partners would simply add further pressure (see Julie’s point below). Even where specific funding is available, it is often time limited.

“I guess do each of these agencies have the sort of funding required to give as much support as we’d like. Because you could rattle off a whole list of agencies that would be beneficial to them but would they take it on?” Julie, V

Practitioners also highlighted, however, that longer term savings could in fact be made by involving families. Early intervention could prevent overuse of crisis services and help families to care for people who the state would otherwise have to care for.

5.3.4.2 Human resources

Those practitioners who provided a service primarily for individual service users found involving families took extra time and resources.

When discussing Karen’s case, Julie highlighted the practical implications of involving Karen’s ex-boyfriend Martin, who was the father of her oldest child.

“This is a severe drain on the practitioners, how many members of the extended family should we look into?... That’s a lot of time and resources required to do that isn’t it? He might have an alternative family that he also needs to support, it’s exponential. The list could just go on and on. We tend to focus on the immediate family really.” Julie, S.

Working with chaotic service users and their families could increase the likelihood of non-attendance or unscheduled attendance, thus making work planning even more difficult.

If services are expected to work with family members who will be an addition to practitioners’ caseloads, then the full workload – that is both service users *and* family members – should be accounted for when looking at resourcing and managing the service.

“Carers do not count towards our caseload numbers but some need significant support so it is difficult to balance priorities.” Anne, S

One practitioner pointed out that working directly with the family requires a suitably large and child friendly space in an agency’s building. This may not be possible for adult agencies that have not previously worked with families or children, and could contravene relevant procedures, for example, having vulnerable children in the same waiting room as potentially high risk individuals would clearly not be acceptable. Family work can of course take place at the family home but this requires additional time and is only suitable for certain types of family work. Working with minority ethnic families may require interpreting services to be available.

5.3.4.3 Solutions from practice: practical implications

One practitioner pointed out the potential **cost savings of co-location**, which could also mean that service users and practitioners both have access to a range of professionals on the same site. They also felt strongly that **investing in existing staff** would be more effective in terms of delivering a high quality service that was widely available, more rewarding for practitioners, and more cost effective than employing new specialists. **Specialist resources could then be deployed in a supervisory capacity.**

5.3.5 Theme five: multi-agency work

Welfare and support organisations are predominantly structured to focus on ‘one problem, one service’. Very few organisations have a remit to work holistically and/or have the skills or resources to deal with all of a service user’s needs. One agency is unlikely to be able to meet the needs of every family member and family work will nearly always mean multi-agency work. Practitioners worked with other agencies in a variety of different ways and settings.

Practitioners spoke about a number of difficulties in multi-agency work. They had varying levels of awareness of other agencies and for the most part, were more knowledgeable about organisations from their own sector. Identified problems included differing policies on information sharing and confidentiality, and on thresholds for services. Other issues included the specialisation of services and the need for co-ordination in multi-agency work.

5.3.5.1. Knowledge of other agencies

The ways in which practitioners accessed other professionals depended on a number of factors: their personal contacts, the initiative they took in researching other organisations, the culture of the organisation towards multi-agency work, the availability of services in their area, working models within teams and local multi-agency agreements. One practitioner described how their organisation fostered good working relationships with other agencies and was also keen to investigate new schemes that may help their service users:

“There’s always been a tradition of very active, pro-active [community] services [in the area I work]. The statutes are going to be aware of it by that fact.” Rob, S

“You might find a research project that’s getting off, or actually starting to treat people and you’ve got referral rights because you happen to be a mile down the road. Accident of geography.” Rob, S

Lack of knowledge was another barrier to multi agency work. Management could play a key role in feeding back information about other services. Box 5.10 illustrates a discussion about the confusion around the availability of services in Sarah’s case and the restrictions around each agency’s support.



Box 5.10

Sarah needs support with her drug use and offending behaviour. Her children Debbie (13) and Jessie (4) need emotional support. The children's grandparents Jenny and Steve, who are also their full-time carers, need help with their finances and health. They all need help with their family relationships.

Practitioners in the online focus group discussed which agency should start the ball rolling.

Anne, S: "Not very obvious to me... maybe drug agency or after prison service?"

Judy, S: "Too often no-one and status quo prevails because the prison would be looking after Sarah, social services would be looking out for the children and the grandparents would be left struggling on their own... Grandparents would be helped if it looked like the placement was in jeopardy."

Anne, S: "Maybe GP would pick up issues [with the family]?"

Judy, S: "Only if they were affecting health of Jenny and/or Steve... Children need help from CAMHS and school to deal with their situation and bullying."

Anne, S: "I don't think [Sarah] would really come to mental health services – she has the DIP team to support her drug recovery."

Judy, S: "Not really working though is it?... She could get CBT in primary care."

Anne, S: "Maybe there is a homeless issue coming out of prison which affects allocation of GP then access to service."

Judy, S: "What do prison family liaison do?"

Anne, S: "Don't have any experience of them."

5.3.5.2 Sharing information and confidentiality

Information sharing remained a problem for all practitioners due to the myriad of agency specific policies and practice around confidentiality. Practitioners recognised that some agencies were gatekeepers to other services and therefore the decision to make a referral was very important.

One practitioner felt that the nature of the relationship between the voluntary sector agencies and service users could potentially be jeopardised by sharing information as some service users were more willing to engage with voluntary agencies because they thought the information was not going to be shared (the views of the service users' focus group on this point can be found in section 6).

"I think people want to know where that information is going and who's got it and ... where it's likely to be shared, that's sometimes difficult to say 'cause once it's out there it can get passed on, people don't know where it goes... A lot of people are against identity cards aren't they, the thought that a lot of people would have an assessment on them which might be shared among other agencies is perhaps a bit of a hot potato." Chrissy, V

They also noted the balance of information sharing between agencies varied, with voluntary agencies having less access to historical information about service users than statutory services.

“I think information can be difficult in the voluntary sector, you don’t have a right. There’s still this thing about confidentiality and what agencies have the right to see.” Chrissy, V.

5.3.5.3 The impact of the specialisation of services

The growing trend to ‘specialise’ in one type of practice and to deal with one type of problem and/or service user was seen as having a detrimental impact on public services. One practitioner commented that such a trend had made it more difficult for service users to access the type of help they need. One practitioner (Carl) thought that workers had adopted a culture of only being able to see service users in terms of their individual problems rather than working towards a holistic solution. This has particularly negative implications for adults with multiple needs who are likely to need support from more than one service. Rob spoke about whether an agency that was not specifically designed to address alcohol use would be able to effectively deal with this issue.

“Maybe I’m being rather prejudicial. If a service doesn’t have a specialist stamped on it, I question it’s ability to sort of be the best to follow it through.” Rob, S

Ian was of the opinion that this trend for specialising practice did not recognise that the underlying problems of service users were the same, regardless of which access point they used to enter the system:

“There’s low self-esteem, there’s the physical addiction, there’s the psychological addiction... There’s rejection, there’s all these other issues that are familiar to any other problem.” Ian, S

Practitioners spoke about the lack of universal family services. In terms of statutory provision, practitioners spoke mostly in terms of children’s services but because of the high thresholds for being accepted into those services, practitioners felt that the families were likely to be stigmatised as ‘problem families’:

“You should be able to ring social services - I guess that is the idea - and say, I need some support, but because you tend not to get it, [it] tends to be the families who are really in crisis therefore it’s got the stigma.” Chrissy, V

One practitioner talked in particular about how the specialisation of work with the whole family - located in the world of psychotherapy - had led to a belief that it could not be carried out successfully by other workers. This view was reinforced by a lack of training opportunities for family work in mainstream services. Ian makes the point that attitudes towards family work do not have to come from an ‘all or nothing’ approach.

“There’s a lot of science behind it [family therapy] and an evidence base behind it but unfortunately we do have to work with families and that’s it. And it’s a bit like a engineer saying to a mechanic “Don’t go near that car until you’ve [qualified],” “I’m sorry I have to go near the car, and I know how to fix that bit and I know how to fix that bit and that’s what I’m going to do.” Ian, S

5.3.5.4 Service thresholds and policies

Expectations in relation to a particular service will vary depending on whether you are the service user, the family member or the practitioner. Regardless of expectations, an organisation has to uphold their own individual service thresholds and policies. Box 5.11 illustrates the point that, despite practitioners’ personal views, they had to work within the threshold policies of other agencies:

Box 5.11

Karen's children Amy (4) and Joshua (19 mths) share a bedroom. As Karen is finding it difficult to take the children out of the flat Joshua is quite restless. He finds it difficult to sleep which disturbs Amy. Karen's boyfriend Dave is using drugs but not inside the flat.

Two practitioners talked about housing and children's services' policies in relation to supporting the family's concerns.

Chrissy, V: *"I did also wonder about the children sharing a bedroom as well, I don't know what the age is where..."*

Julie, S: *"Well our policy, if they're different sex and one is over ten then..."*

Chrissy, V: *"Over ten then she's still got a way to go."*

* * *

Chrissy, V: *"The threshold isn't high enough really for them to have a service."*

Julie, S: *"They'd need to be confirmed drug users using in front of the child."*

The particularly high threshold for children's services was discussed by many of the practitioners, regardless of their background. They expressed confusion about the role of children's services in family work. They also felt that they were too crisis-oriented and did not focus enough on supporting the whole family. Some practitioners who were or had been social workers felt that this was contrary to the approach they had been taught some years ago.

"I think my manager she qualified about 30 years [ago] as a social worker, she was a generic social worker her caseload had adults, all sorts of dogs, people everything and she would have worked with all parts of this family. The problem is that the services are split even with adult and children's services." Carl, S

"When I was doing children's work (30 years ago!) we would have done all the work required for any family member, including Sarah." Judy, S

Notwithstanding what they knew about children's services, they continued to make referrals because of a perceived lack of alternatives.



5.3.5.5 Perceived and actual differences between agencies

The perceived differences between agencies could be devious. For example, some practitioners assigned particular characteristics to the 'other' agency and treated individuals working within that environment as if they were all the same. This was in contrast to their perceptions of their own team as comprising skilled individuals with different outlooks that benefited their organisation as a whole. Within the focus groups, one statutory practitioner identified their own preconceptions of voluntary workers as being untrained and possibly having their own moral agenda. Similarly, a voluntary practitioner referred to statutory professionals as 'textbook junkies' – having all the training but none of the personal experience. One practitioner experienced this in-group/out-group mentality within his own agency, between adult and children's services.

"People that work with adults think children workers are up their own selves meaning that... basically working with children is this 'save the children' it's got that mentality. Whereas if you work with adults it's some people perceive it as 'oh you can't really cut it because children's work is really hard.'" Carl, S

Any *actual* differences between practitioners were more the result of the way they approached their work and articulated what they did, which was linked to their training and support structures. The most noticeable difference was that those from mental health or social care backgrounds tended to speak about cases in a more reflective way – repeatedly putting forward ideas then commenting on their possible effectiveness. The benefit of professional training in enabling this approach can be clearly seen. This discussion between Rob and Ian provides an example of their reflections on Dan's feelings about the abuse he experienced as a child.

Rob, S: "If you found out your sibling took the same punishment or received the same treatment as you got, it would mean you feel less lonely in your memories with it, wouldn't it."

Ian, S: "Possibly."

Rob, S: "Possibly."

Ian, S: "As an older brother he might feel a wee bit guilty."

Rob, S: "Yeah."

Ian, S: "Certainly it would take the focus away from you."

The differences were also apparent in the lexicon used by individual practitioners. The four practitioners from adult mental health services in particular used language and concepts specific to their profession, for example in referring to therapeutic aims, articulating emotions and roles within the family succinctly (for example, Rob's quote below), and noted the importance of the therapeutic relationship between them and the service user, as highlighted by Ian.

"And the sexual abuse by the uncle could be reflecting upon a rather arm-length parenting, or does it reflect on an uncle who was a complete and utter bastard who was very manipulative?" Rob, S

"The therapeutic relationship you'd have with that service user can be so much more meaningful when you're not engaged with the family." Ian, S

5.3.5.6 Co-ordinating multi-agency work

Coordination was deemed essential to multi-agency work. Practitioners identified that it minimised the potential for duplication and ensured that one person retained the whole picture and was ultimately responsible.

“Some agencies provide more and some agencies provide less, such as mental health services versus police etc. It’s not a balanced process. There still have to be a blame taker or an individual party that is charged with the responsibility of creating the multi-agency atmosphere as adversed to all just accepting it’s the culture and norm.” Ian, S

One practitioner mentioned the common assessment framework and was asked how they felt the approach was working. They felt that the initial assessment meeting and assignment of work to different agencies worked well but review meetings were less well organised and attended – a fundamental aspect that would need to be improved upon if multi-agency working was to have the anticipated effect for service users and their families.

Practitioners from both statutory and voluntary organisations noted the implications in taking on the role of co-ordination, especially when they also had a full case load to deal with.

“Which agency or groups of agencies is going to take what is effectively a life long responsibility for monitoring their progress? Because there’s always going to be some problem, no family is problem free, so who can monitor that on a long-term basis, it’s quite difficult to actually ascertain.” Julie, S

5.3.5.7 Solutions from practice: multi-agency family work

One practitioner highlighted the importance of every borough or council having **local multi-agency agreements** that would clarify the roles and expectations of the individual agencies involved. Another practitioner suggested appointing lead practitioners for family work in different services, and suggested commissioners should be involved in monitoring the family work that agencies carry out.

Two practitioners spoke enthusiastically about the potential for **informal opportunities to access knowledge** from practitioners from other agencies.

“When you’ve actually got a one stop shop and everyone’s together officially you’ve got access to these different bodies of knowledge, unofficially you’ve got a huge amount of access to a huge amount of knowledge just through getting to know Jimmy that works downstairs that’s a housing officer and bloody good at his job...” Ian, S

Knowledge could be gained in a variety of ways, for example, basic information on the benefits system could be obtained informally over the telephone. However one practitioner emphasised the importance of **ensuring practitioners do not misadvise people and to refer on if they are unsure**.

One practitioner felt it was important that key groups of people, such as GPs, were encouraged to participate in multi-agency work. A number of practitioners talked about schools being an important venue for bringing children and adults together which could play a vital role in providing a universal, non-stigmatising space for family work (highlighted by Ian below). Organisations could make better use of existing community based resources when taking forward multi-agency work with families.

“A school counsellor to call in the parents would be perhaps more appropriate because that’s taking the alcohol side and putting that aside and saying that doesn’t matter, what’s going on here, is Omar’s failing at school, Omar’s suffering, you’ve got your issues, you’ve got your issues, what are we going to do here that...” Ian, S

“There are some good community schools in [place] that do encourage the community in, perhaps it is about communities and families having somewhere to go and using the schools.” Chrissy, V

5.4 Conclusion

The themes identified demonstrate both the complexity of family relationships *and* the complexity of working with families. Asking practitioners who have traditionally worked with individual adults to start ‘thinking’ and working with families is not equivalent to asking them to do an additional administrative task. It is instead asking them to participate in a potentially huge cultural shift and to do something that will not only take up a considerable proportion of their time but will also require a significant amount of skill, sensitivity and reflection. The consequences of effective family work can be extremely beneficial and can prevent family and social problems from escalating and continuing into the next generation. However, the consequences of poorly carried out family work can at best have a neutral impact and at worst be very damaging to service users, their families and to practitioners’ feelings of self-efficacy.

It is essential that practitioners receive thorough and appropriate guidance from their supervisors, their organisation, and from government on the kind of family work they are qualified to carry out, and that they continue to receive practice based support.

The next section describes service users’ views on the research findings and the discussion (section 7) provides more detail on the nature of the guidance and support practitioners need in order to effectively undertake family work.



6. Service user focus group

The views and involvement of service users is fundamental to the work of Revolving Doors. In order to test the findings and as the first step in securing the opinion of people who might be affected by any developments that arise from this research, a feedback and comment session was arranged. The attendees were drawn from two groups: a) the interviewees from the case study development stage (both service users and family members) and b) representatives from the RDA service user forum. Six service users and one family member²¹ participated and a discussion took place on three specific aspects of the findings: supervision and training, information sharing and confidentiality, and ways of approaching family involvement.

6.1 Supervision and training

The practitioners had highlighted the importance of receiving regular supervision to support their learning and practice, to provide emotional support and to give them guidance on the extent to which they could extend their usual work remit to include family members.

Service users felt there was an important distinction between what was a problem for the practitioner (for example, feeling uncertain, deskilled or not wanting to take on difficult work) and what was a problem due to the complexity or difficulty of a service user's issues. The group noted that service users can try to control their relationships with practitioners and with other family members and practitioners need to learn how to manage that. This highlighted a need for both emotional support and professional supervision. They felt there that there was generally a lack of quality supervision for practitioners. One group member noted that if a practitioner was supported well, they could utilise the techniques learned in supervision in their own work with service users and their families.

Service users did not want practitioners to be afraid of their responses. They wanted them to be willing to listen and have a discussion with them. They felt practitioners needed to fully understand child protection and duty of care policies and explain to service users what those policies meant. They wanted practitioners to be clear about these procedures, to adhere to them and to not be afraid of doing so. They felt practitioners needed to be more open and talk to service users about the boundaries to their role. If someone who experiences poor mental health was not well, the practitioner may have to make a decision on their behalf and, if possible, they should try to plan for this scenario when they were well. They wanted practitioners to realise that any support they gave would often be better than no support at all, even if the service user did not make this apparent at the time.

The group thought training - particularly multi-disciplinary training - was important for all those providing services. They felt GPs, in particular, needed more training in addressing social problems. However, practitioners generally needed time to reflect with their supervisors on how that training had subsequently been put into practice. The group felt practitioners needed to feel supported by their organisation if the boundaries around their work were to become more flexible.

6.2 Information sharing and confidentiality

Practitioners were unclear about when it was appropriate to share information about the service user – whether with family members or other agencies. Some practitioners made *assumptions* that service users would not want their information shared under any circumstances.

²¹ For the sake of convenience, the family member is grouped with service users in this section.

Members of the group were frustrated by this assumption. Many had experienced times when they had asked for their details to be passed on to another agency with little success, and it had been at best frustrating and, at worst, had had a detrimental impact on the family (see boxes 6.1 and 6.2). Confidentiality belongs to the service user, not the practitioner. The group highlighted that, without sufficient information, any risk assessment would be inadequate.

One person suggested that practitioners should spend one or more sessions with a service user just talking about information sharing and confidentiality. They could discuss what information the person is happy to share straight away, what information they would like from the practitioner (for example, clarification of what work another agency has been doing for them) and what information it might be important to share in the future. All this can go into the service user's care plan. As their relationship develops, they could return to the discussion and approach more difficult topics. Practitioners should always seek permission from the service user unless there are concerns about a child's protection. They might also need to explain the consequences of not sharing their information. Practitioners should reassure service users and explain to them why the information needs to be shared and the role of the people they want to share it with.

Box 6.1 Katie and her son Paul

Katie and her teenage son Paul wanted to receive support together. Katie is recovering from drug and mental health problems and Paul had special educational needs. They needed support to rebuild their relationship as Katie had not had a chance to form a good relationship with Paul during his teenage years. Katie was directed to carers' support.

Katie and Paul's practitioners had difficulties with information sharing. Paul's consultant was adamantly against joint sessions, portraying Katie as unwell and unadjusted. Paul's front-line practitioners wanted joint sessions and asked Katie to challenge the senior doctor's decision, which she thought absurd. In the end, both Katie and Paul were offered separate appointments at Paul's school to try to help re-build their relationship.



Box 6.2 Amanda and her children

Amanda was recovering from drug use. The drug service sent a nurse to carry out key working sessions at Amanda's home, which Amanda really appreciated. She felt her children needed support and education around having a drug using parent. However, although the nurse got on well with the children, she felt that she did not have the skills and training to work with them. Once home sessions had finished, it was not appropriate for the children to go to the service's building, where prescribing took place and other more unstable service users attended.

Amanda asked the drug service to refer her children to family services and gave them permission to share information about her treatment. The drug service did not pass her information on and Amanda was portrayed by family services as chaotic and unstable. The children were stressed and angry because they felt their mum was trying her best to care for them. They said they did not want to use the service anymore.

The family wanted to be seen by one service but it was not made available to them. Although Amanda's psychiatrist eventually got them into a family service, it was not in their borough. In the end, the children went to Ala-teen.

6.3 Approaching family involvement

Practitioners sometimes felt uncomfortable about approaching family members because they might not want to be involved. This could be because of the stigma attached to a service or because they might not understand what the service offered, or they might have had bad experiences with services in the past, among other reasons.

The group felt practitioners should ask them who they would like to be contacted by and the level of intervention they would be happy with. They felt that if family members cared about a service user they would be happy to meet with the practitioner or speak with them over the telephone, to be involved in the intervention or just to receive updates on key stages of the service user's progress. One service user felt that children should always be involved or kept informed. The group wanted appointments to be available out of office hours for families.

Depending on the relationship between the service user and a particular family member, the practitioner could either contact the latter directly to organise a joint meeting with the service user, or they could organise a separate meeting with the family member first to discuss their involvement. If the service user was concerned that their relationship with their family was poor and was uncertain about involving them, the practitioner could consider whether the potentially positive impact outweighed their concerns. Again, the practitioner could invite the family member to a separate meeting first to discuss these issues and explore the potential for further involvement.

Family members and partners could be asked about their own needs and about their expectations of the service. Family members and partners would need reassurance and advice about what to do if the service user's behaviour deteriorated. Practitioners should try to look at people's strengths as individuals rather than their diagnosis or family role. Service users agreed that their family would not necessarily look for support themselves because of the stigma attached to services. They highlighted the benefits of self-help groups where families facing similar difficulties could meet. One person suggested that every service, be it housing, mental health, substance use and so on, should have a part of their service dedicated to family work.

Service users voiced the need for culturally appropriate services and said that senior managers needed to be proactive about making links with community leaders from all cultural and religious backgrounds.

6.4 Conclusion

The views of the service users have contributed to many of the discussion points in the next section in considering the expertise and support practitioners need to carry out effective family work.



7. Discussion

This research was predicated on an attempt to look at how the principles of the Think Family initiative might work in practice to enhance and support the family relationships of adults with multiple needs. The research addressed three specific issues:

- to establish what practitioners see as the barriers and opportunities of the Think Family approach
- to establish best practice examples and ideas to take forward this work
- to establish the views of service users in relation to the principles of Think Family

Through exploring practitioners' attitudes towards, and experiences of, family work, the research aimed to inform developmental responses to improving practice in order to better support service users and their families.

By drawing together the findings from the practitioner focus groups, service user focus group and existing literature, this section considers what practical support practitioners need to deliver services to families and how agencies could start to build on their existing best practice in relation to family work.

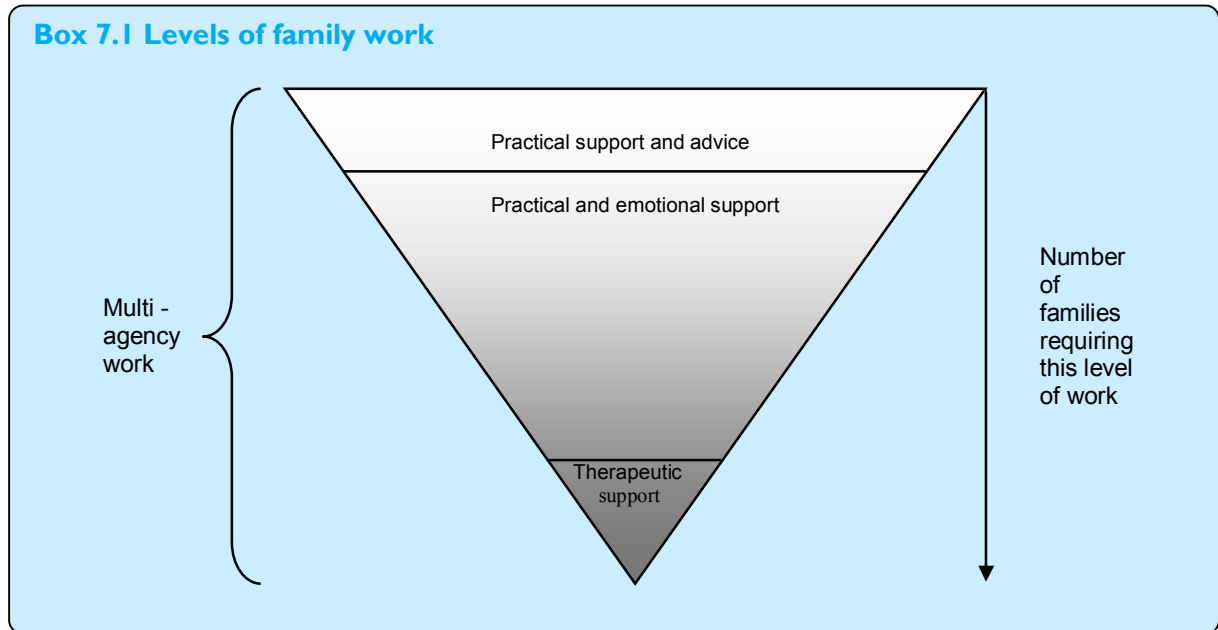
7.1 Starting and building on family work

The findings from this research demonstrate both the complexity of family relationships *and* the complexities of carrying out family work. Practitioners who are experienced in working with individual adult service users cannot simply add 'family work' to their list of tasks and carry it out accordingly. Family work requires particular skills, sensitivity, reflective thinking, and experience.

Family work takes place at a number of levels depending on the individual needs and circumstances of the service user and their family. It can be thought of as a continuum from short-term practical intervention that might be needed by many families (for example, referring the family to an appropriate support group) to longer-term and more therapeutic support required by fewer families but with much greater need. These differing levels are modelled in Box 7.1. The middle section represents the varying degrees of both practical and emotional support. The more intensive family work becomes, the greater the level of skill, training and experience with families required to take this work forward successfully. Wherever work with the family falls on this spectrum, however, it will require multi-agency working in one form or another.

Before embarking on any kind of family work, practitioners need to be able to assess what level of support the service user and their family need. They then need to decide what individual or agency, or which combination of agencies, are most appropriate to carry out the work. If practitioners are uncertain about whether they have the ability to carry out a particular type of family work, they should have the opportunity to discuss their concerns with a supervisor. At the very least, *all* practitioners have the ability to signpost family members and partners to other sources of support (always assuming that practitioners have the knowledge and/or the means to ascertain what is available in their area (see section 5.3.5).

Box 7.1 Levels of family work



In order to develop services that ‘think family’, organisations should start by thinking about the nature of the family work they already carry out and how this could be improved. Organisations should involve service users, their family members, and practitioners in a consultation process which asks:

- Which family members are the organisation involving?
- Where does family work sit within the model in box 7.1?
- What types of family work have been carried out successfully?
- Over what period of time do service users engage with the service and develop relationships with practitioners?
- What support would practitioners need to develop their existing practice?
- Are there any issues that are important to service users that are not being addressed and could be?

Readers can refer to the more comprehensive list of questions put forward by Hinton et al (2001) (see section 4.3).

Think Family proposes that *all* practitioners should consider the family situation of service users. It advocates a cultural shift in public services rather than the creation of more specialist family services, whilst recognising that these are undoubtedly needed for families with more severe, complex and enduring needs. Following the consultation process, organisations should consider the extent to which they can meet gaps in services for families within their own agency, by developing the skills of their staff and their organisational capacity. However, agencies must be *realistic* about what they can provide, as family work that is poorly carried out can be worse than no family work at all.

7.2 Implications for adults with multiple needs

Many adults with multiple needs will have experienced disrupted lives, which may have included - amongst other things - family breakdown, childhood adversity and educational disadvantage. Their current needs are likely to stem from both mental health and substance use issues and possibly housing instability or homelessness. Many will be fearful or distrustful of services, often based on previous negative experiences, and some will exhibit challenging behaviour.

This mistrust of services can lead to a reluctance to engage with support by some, whilst challenging behaviour may act as a barrier to access for others. Commonly, people who fall within this group have a breadth of need that means they do not meet the criteria for access to specialist statutory services. A large number will be or have been in contact with the criminal justice system.

Many are likely to receive support from voluntary agencies working in housing, substance use or mental health services. Given this, many of these agencies will have built up considerable expertise in engaging and working with adults with multiple needs. In a consultation process undertaken prior to this research, some of these organisations reported limited resources to undertake family work.

Building the capacity of voluntary organisations who work with this group to ‘think family’ is critical to ensuring the social inclusion of adults with multiple needs and their families.

Developing family work with adults with multiple needs should therefore focus:

- strengthening voluntary organisations’ links with statutory services
- ensuring practitioners have the appropriate level of knowledge:
 - to assess service users’ and family members’ needs
 - to assess which agencies could best meet those needs, including their own
- ensuring practitioners have access to other supervisory professionals with experience and expertise in family work
- training practitioners who demonstrate the competencies (see section 7.3.1) needed to carry out low to medium level family support work
- ensuring that organisational structures support multi-agency work and the level of family work provided.

Strengthening family relationships is important and valuable work but adapting practice in order to undertake it can be challenging, and unfamiliar work can make practitioners uneasy (see section 5.3.2.1). Practitioners who are given further training as proposed above could actively champion family work within their organisation and be a source of guidance for other practitioners who may be less knowledgeable and/or experienced.

The next section details the necessary characteristics required by practitioners and the organisational structures and support needed to start working with families in ways which go beyond offering practical support and effective signposting.

7.3 Delivering services to families

The key to successful family work which includes both practical and emotional support can be broadly divided into three areas, summarised in box 7.2.

Box 7.2 Delivering successful family work

Individual

- Positive approach to family work
- Good communication and interpersonal skills
- Willingness to work flexibly and undertake training where required
- Willingness to engage with other agencies

Organisational

- Clear organisational statement of commitment to family work developed in consultation with service users
- Clear policies on information exchange and management, confidentiality, service thresholds, diversity and inclusion
- Training commensurate with practitioners' roles and organisational expectations
- Regular supervision that encourages reflective practice
- Clarity of expectations of front-line practitioners
- Strong relationships with other agencies at managerial as well as practitioner level

Systemic

- Frameworks that promote inter-agency work
- Flexible funding and adequate resources

The following points in this section are derived from the different sources of evidence used in this research – the literature, the practitioner focus groups and the service user focus group – and are referenced accordingly.

7.3.1 Individual

This section details the individual competencies our research suggests are required by practitioners to carry out effective family work.

7.3.1.1 Positive about family work

Practitioners had to believe in the value of family work in order to help build positive relationships between service users and their families (see section 5.3.1.4). In some cases this involved infusing them with the hope and belief that their relationships could be strengthened and were worth the effort. In order for practitioners to start 'thinking family' within organisations there is also a need for individuals who will *champion* such work (supported by Hinton et al, 2001).

7.3.1.2 Good communication and interpersonal skills

Excellent communication and interpersonal skills were found to be essential for family work and multi-agency work (see sections 5.3.1.4 and 5.3.5.1), findings supported by many pieces of literature including Hinton et al (2001), Barrett (2008), RDA (2003) and SCMh (2000). In particular, facilitation/mediation was seen as a key part of family work (see Box 5.1, section 5.1) and both practitioners and service users highlighted the importance of communication with each other, particularly over differing views on confidentiality, values and expectations (also see Keene, 2001). Practitioners also needed to be able to communicate their own concerns and feelings about the work (see section 5.3.3.3).

While training can develop these skills, more successful workers will naturally possess these qualities (supported by Lemos and Durkacz, 2002) meaning that some practitioners will be more suited to family work than others.

7.3.1.3 Willingness to work flexibly and undertake training where required

Family work could be unpredictable and practitioners needed to be able to respond to situations that arose which they could not plan for, and in times of crisis (see section 5.3.2.1). Practitioners needed to be willing to follow the service user's lead on whether to engage family members, and to involve service users in decisions about their care (see section 5.3.1.2). This requires flexibility.

More practically, service users and family members with chaotic lives might often need to change their appointments with little notice. Family work can also involve seeing people in different locations and can require practitioners to work unsociable hours. Working with other agencies will involve coordinating busy schedules (see section 5.3.4.2).

Training may be required to develop practice around family work (see section 7.3.2.3). Practitioners must be willing to undergo training that is commensurate with the family work they are expected to carry out.

7.3.1.4 Willingness to engage with other agencies

In order to work with families successfully, practitioners need to develop a knowledge base of other agencies, including their roles and remits (section 5.3.5.1). The findings and the literature indicated that practitioners lacked awareness of some agencies and had misconceptions about the work of others (see section 5.3.5.5 and SCMh, 2000). It could lead practitioners to not share information or to not make referrals because they did not know whether the work fell within the remit of another agency, or alternatively to take on work which they were not skilled or well-resourced enough to deliver successfully (see section 5.3.5.3). Some practitioners were nervous about alerting other agencies for fear of it jeopardising a service user's situation (Rankin and Regan, 2004).

While some knowledge could be gained through training, each practitioner has a responsibility to find out what local services are available for families. The findings suggest multi-agency work requires ongoing effort and attention, as relationships with other organisations take time to develop and are vulnerable to frequent staff changes and turnover (also highlighted by RDA, 2003 and Ipsos MORI 2007b).

7.3.2 Organisational

The following section describes how organisations can best support practitioners to carry out successful family work.

7.3.2.1 Clear organisational statement of commitment to family work, developed in consultation with service users

If practitioners in adult services are to start giving family work a higher priority than it has at present, they need to receive a clear message that their agency is committed to this work and why it is important to the agency's aims. Consultation with service users is crucial in constructing such a statement because they are the impetus for the organisation's mission and can articulate how strengthening their family relationships could support them beyond their time with the service.

Organisational frameworks such as assessment forms, job descriptions, and support plans need to reflect this commitment by explicitly referring to families (Lemos and Durkacz, 2002).

7.3.2.2 Clear policies about information exchange and management, confidentiality, service thresholds, diversity and inclusion

Sharing and receiving information from other agencies remained a problem for all practitioners due to their confusion over different policies and practice relating to confidentiality (see section 5.3.4.2). Practitioners were also unclear about other services' thresholds. Organisations need clear policies on information exchange and management, confidentiality and service thresholds and, importantly, must ensure that their staff understand them.

Policies on diversity and inclusion are fundamental to family work as culture underpins many of our family values, relationships and behaviour. Agencies need to ensure that the family work offered is appropriate to its service users' needs and that practitioners are adequately supported to deliver culturally sensitive family work. Practitioners suggested that organisations should consider and prioritise the ethnic make up of the local population when recruiting staff, as practitioners drawn from similar backgrounds could make important contributions to discussions on appropriate practice (section 5.3.1.4, Becher and Husain, 2003, and Barrett, 2008).

7.3.2.3 Training commensurate with practitioners' roles and organisational expectations

Practitioners needed varying degrees of training in family work in order to provide practical and emotional support to service users and their families. The training should be commensurate with the training practitioners have already undertaken and the level of family support they would provide as part of their role (see section 5.2.2.3). Involving service users in training could inspire practitioners to think differently about the impact that their work can have.

Appropriate training could be offered to practitioners in the following areas:

Knowledge

- An understanding of child protection policies and procedures and their agency's responsibilities in relation to these
- The role and function of children's services
- The role and function of local children's and families' agencies in the voluntary sector
- Working with cultural differences
- An understanding of child and adolescent development appropriate to the role
- An understanding of the different theoretical models used in family work

Skills

- Managing disclosures of current, recent or past abuse
- Managing risk in the context of work with families
- Managing family dynamics

- Good communication and listening skills
- Setting boundaries to interventions
- Assessing need in the context of family work and making appropriate referrals

One practitioner felt investing in practitioners through making professional training available and accessible was more worthwhile and offered better value for money than employing new specialists (see section 5.5.3). Professional development opportunities in family work could stimulate practitioners, give them time to reflect on their work and build links with other services, all of which would benefit their practice. For example, front-line practitioners could be offered subsidised training courses in child development or counselling. Practitioners who demonstrate good practice and a commitment to service users and families, and show a desire to learn and to improve, should be given opportunities within their organisation to progress (being offered the role of lead family officer for their organisation for example).

Multi-agency training would also provide a useful opportunity for practitioners to network and could stimulate interesting and necessary discussion about the role and responsibilities of different statutory agencies and their thresholds. Training developed more specifically for family work would need to include detailed information about the role of children's services (see section 5.3.5.4 and supported by Ipsos MORI, 2007). Training on information sharing should include sessions on involving service users in the decision to share information, and on sharing information for the purposes of child protection (see section 5.3.5.2).

7.3.2.4 Regular supervision that encourages reflective practice

The need for supervision which supports practitioners emotionally and professionally was repeatedly highlighted as essential to effective family work (see sections 5.3.1.4, 5.3.2.3, 5.3.3.3, and 6.1, also see Barrett 2008, O'Shea et al, 2003, Hinton et al, 2001, for examples). Practitioners suggested that workers could receive supervision either from trained professionals within their own agency or from a different organisation (see section 5.3.2.3, also suggested by Kearney et al, 2000).

Regular supervision was seen as vital to helping practitioners reflect on challenges they found difficult to resolve (see section 5.3.1.3). Practitioners also needed support to think about the evidence underpinning perceived risks and their fears about dealing with unfamiliar situations (section 5.3.2.3, also supported by Doolan et al, 2004 and Kearney et al, 2000). They also needed a space to reflect on any assumptions they were making, including cultural assumptions, which could affect their practice (section 5.3.1.2 and supported by Bancroft et al, 2002). Supervision should also help practitioners to reflect on how they have used their training in practice (section 6.1) and how to apply the skills they have demonstrated in other areas of their work to less familiar situations (supported by Kearney et al, 2002).

Practitioners said they appreciated positive acknowledgment of the good work they were doing, especially as family work could be very demanding and slow to show change. Unsupported practitioners may find it more difficult to be positive with service users about their progress (Barrett, 2008) or decide to leave their post, making it very difficult for services to provide consistent support to families (for example, Kearney et al, 2000, Noaks et al, 2004).

Opportunities to talk with their supervisors and/or team about how their own organisation was approaching family work (section 5.3.3.2) could help practitioners to stay motivated about developing their own practice (Kearney et al, 2000, and SCMH, 2000).

7.3.2.5 Clarity of expectations of front-line practitioners

Practitioners need clarity from their organisation about what is expected of them in relation to family work. In addition to an organisational statement of commitment (see section 7.3.2.1), consistent messages about expectations should be given in supervision and training. These could apply to the parameters of the work (for example, practitioners should *always* ask about a service user's parental role during assessments) and could also apply to the way practitioners interact with family members (for example, being friendly, open and clear about what they are able to assist them with). Practitioners highlighted the fact that expectations made of them needed to be extended to other front-line staff, including those working on reception or in administrative roles (5.3.1.4).

Multi-agency work needs to be advanced as a core part of a practitioner's role (supported by Kearney et al, 2000). Time dedicated to gaining knowledge of other agencies needed to be supported by practitioners' organisations, for example, through encouraging staff to take-up opportunities to network. Managers could give recognition to team members who made significant contributions to building links with other agencies.

7.3.2.6 Strong relationships with other agencies at managerial as well as practitioner level

Managers have a vital role to play in building links with other agencies (see section 7.3.3.1) and in ensuring that knowledge of multi-agency agreements and important changes and developments in multi-agency work are passed down to front-line practitioners (see section 5.3.5.1). Equally, difficulties in multi-agency work arising at ground level need to be passed on to senior managers so that they can collaborate with and, if necessary, challenge other agencies about their responsibilities. Front-line practitioners could have a key role in feeding back to managers where they have identified service gaps. Managers should have access to training in skills for senior level multi-agency work when needed (identified through 360° appraisals).

A lack of networking between statutory and voluntary agencies in particular was highlighted (see section 5.3.5.5 and Barrett, 2008, Ipsos MORI, 2007b, Boswell and Wedge, 2005, Becher and Husain, 2003). More opportunities for communicating and networking between sectors are needed (see section 5.3.5.1). Voluntary organisations could be invited to multi-agency training events and to consult on aspects of multi-agency agreements, for example on information sharing policies and gaps that may exist in support.

Managers could also promote new opportunities for multi-agency work by promoting informal learning opportunities (section 5.3.5.7) such as work shadowing or short briefing sessions between organisations, or through establishing satellite work arrangements.

7.3.3 Systemic

This section highlights frameworks that organisations need to help them **work together** to deliver services that support families.

7.3.3.1 Frameworks that promote inter-agency work

Practitioners and the existing literature highlighted the need for multi-agency agreements that supported family work (see section 5.3.5.7 and, for example, Noaks et al, 2004 and Becher and Husain, 2003). These agreements could build on or link in with existing partnership agreements, for example around outcomes for children, and Crime and Disorder Reduction Partnerships (CDRPs). Partnership agreements could include what family support agencies would provide, referral criteria, policies on information sharing, joint training and professional development, processes for review and evaluation, and the designation of key contacts within agencies for family work. Multi-agency

partnerships could also play an important role in identifying gaps in service provision (Lemos and Durkacz, 2002).

7.3.3.2 Flexible funding and adequate resources

Some practitioners highlighted the fact that more financial and human resources were needed to support existing family services, and that there was also a need for more family services (see section 5.3.5.4 and supported by Ipsos MORI, 2007c). Practitioners noted the length of time it could take for families with multiple needs to show progress. They also noted that family work could take longer in a practical sense because it incurred a heavier administration load (see section 5.3.4.2 and supported by RDA, 2003, and Koshinski Clipsham, 2006). The literature highlighted a need for longer term funds for family work (for example, Nixon et al, 2008, and McInnes, 2007). Collaboration between boroughs on funding, use of pooled budgets, and joint commissioning of services could also support family work. In order to push forward the Think Family agenda successfully there needs to be a **sustained commitment** to funding the development of practice in family work.

Financial and human resources are also needed to promote services for families to service users, families and other practitioners. Services should be advertised through both written material and in person, in different settings and in a variety of relevant languages. GP's surgeries, courts, schools, children's and family centres, Citizen's Advice Bureaux and job centres might all be useful places to ensure family services are advertised.

7.4 Conclusion

This report has examined the potential for implementing the principles of Think Family with adults with multiple needs. This work could be carried out successfully with these service users if providers give family work due consideration as a significant addition to their existing model of working. Given the profile of this group, it is acknowledged that the bulk of this work is likely to be carried out by voluntary organisations in partnership with statutory agencies. Planning for the introduction of such work would necessitate organisations to carry out an audit of their existing family practice – both in terms of 'official' family services and informal support – and how this fits with service provision more widely in their local area.

It is clear that family work is complex and challenging for all involved but if carried out effectively by well motivated, trained and supervised staff, the positive outcomes for service users and their families could have a very important and valuable impact in both the short and longer-term. It could also be rewarding for practitioners and allow them to develop their skills and expertise to provide a more lasting avenue of support for their service users.

Recommendations for further development based on the findings within this report can be found in the next section.

8. Recommendations

A focus on the following areas could help practitioners to work effectively with families and simultaneously improve both services to adults with multiple needs and outcomes for their children and families. These recommendations will form the basis for further examination of potential developmental responses.

1. Building organisational capacity

Think Family acknowledges the crucial role of adult services in determining outcomes for children and families. In practice, adult services provide a range of responses to families related to their primary organisational aim, role and available resources. This research shows that practitioners are often unclear of their remit in working with the families of their service users, and of organisational boundaries to that work.

There is scope for a developmental response which works with an interested agency and its users to analyse current practice and then build capacity for working with families.

2. Building links with children's and family services

Think Family notes that adult services need to join up better with children's services in order to provide support around the needs of the whole family.

The research demonstrated both confusion about the role of children's services and frustration with the thresholds for intervention. There was also a marked absence of discussion - or apparent knowledge about - the range of statutory and voluntary preventative and early intervention services that exist to work with families.

Conversely many agencies who work with adults with multiple problems have developed a body of expertise in engaging with this group which may be valued by children's and family services. There is scope for a developmental response which builds links between these agencies to improve their individual and collective responses to families with multiple problems.

3. Developing multi-agency work

Joined up services are at the heart of the Think Family approach. This was also recognised by practitioners participating in the research who understood very well the necessity of multi-agency work. They also described its limitations and frustrations.

There is scope for work which develops opportunities and protocols for effective multi-agency work with families and in particular looks at and adapts promising models of work from other areas.

4. Developing competence

Think Family identifies the crucial role of adult services. Our research identified an overwhelming need for training and support for practitioners working with adults to enable them to take up this role with competence and confidence.

Areas for training have been highlighted in the discussion. These can inform a more precise analysis of training and developmental need, which was outside the scope of this research. It may be interesting to explore opportunities for reciprocity in training and support with agencies who are expert in working with families.

5. Developing culturally sensitive responses to families

Practitioners who took part in the research demonstrated an awareness of the challenges they face in working with cultural difference. They were also aware of the need for organisations to develop more culturally sensitive services.

There is scope for a developmental project which makes links between these services and community groups so as to improve services to families.



Appendix I: Literature review - website search

- **Action for Prisoners Families (APF)** www.prisonersfamilies.org.uk
- **Addaction** www.addaction.org.uk
- **Adfam** www.adfam.org.uk
- **Affect** www.affect.org.uk
- **After Adoption** www.afteradoption.org.uk
- **Alone in London** www.als.org.uk
- **Apex Trust** www.apextrust.com
- **Barnados** www.barnados.org.uk
- **Borderline UK** www.borderlineuk.co.uk
- **Cabinet Office Social Exclusion Task Force (SETF)**
www.cabinetoffice.gov.uk/social_exclusion_task_force/families_at_risk.aspx
- **Communities and Local Government**
<http://www.communities.gov.uk/housing/publications/all>
- **Clinks** www.clinks.org
- **Crisis** www.crisis.org.uk
- **Early Break** www.earlybreak.co.uk
- **Families do matter** www.familiesdomatter.co.uk
- **Family Action** www.family-action.org.uk
- **Family and Parenting Institute** www.familyandparenting.org
- **Family Rights Group** www.frg.org.uk
- **HM Prison Service North East** <http://neprisons.org.uk>
- **Mind** www.mind.org.uk
- **NACRO** www.nacro.org.uk
- **Ormiston** www.ormiston.org/home.html
- **P3** www.p3charity.com
- **Partners of Prisoners (POPS)** www.partnersofprisoners.org.uk
- **Prisoner Advice and Care Trust (PACT)** www.prisonadvice.org.uk
- **Prisoners' Families and Friends Services** www.prisonersfamiliesandfriends.org.uk
- **Rainer** www.raineronline.org
- **Relate** www.relate.org.uk
- **Rethink** www.rethink.org
- **Revolving Doors Agency (RDA)** www.revolving-doors.org.uk
- **Sainsbury Centre for Mental Health (SCMH)** www.scmh.org.uk

- **Social Care Institute for Excellence (SCIE)** www.scie.org.uk
- **St Mungo's** www.mungos.org
- **Sharp** www.s-h-a-r-p.org.uk
- **Shelter** <http://england.shelter.org.uk>
- **Thamesreach** www.thamesreach.org.uk
- **Thames Valley Partnership** www.thamesvalleypartnership.org
- **Together** www.together-uk.org

Appendix 2: Case studies

Assessment Form

Identifying details

Name	Sarah Maynard	AKA/previous names	n/a
Gender	Female	Date of birth	23/5/76
Address	HMP Bronzefield Woodthorpe Road Ashford Middlesex	Contact no.	
Post code	TW15 3JZ	Religion	None
		Ethnicity	White British

Assessment information

People interviewed for assessment	Sarah Maynard, Stephen Kirby (Sarah's step-father) and Jennifer Maynard (Sarah's mother). Deborah and Jessica Maynard, Sarah's two children, were present during the interview. Deborah did not wish to contribute.
Date assessment completed	16.10.08
What has led to this family being assessed?	Sarah is serving a 9 month sentence for theft and is due to be released from prison on 15 th January 2009 and return to the family home. Sarah has detoxed from heroin whilst in prison and taken part in some group counselling sessions organised by CARAT. Sarah is currently on a methadone script and has been referred to the DIP for drug support work on release. A support plan is needed to ensure Sarah returns to the community successfully and does not re-offend.

Details of children/dependants

Name	Deborah Maynard	Name	Jessica Maynard
Date of birth	3/2/95	Date of birth	10/8/04
Address	32 Upland Gardens Birchington-on-Sea Kent	Address	32 Upland Gardens Birchington-on-Sea Kent
Ethnicity	White British	Ethnicity	Mixed – White/Black Caribbean
Name		Name	
Date of birth		Date of birth	

Address	<input type="text"/>	Address	<input type="text"/>
Ethnicity	<input type="text"/>	Ethnicity	<input type="text"/>

Current family and home situation

Deborah 'Debbie' Maynard (13) and Jessica 'Jessie' Maynard (4) are the daughters of Sarah Maynard (32) and currently reside with Sarah's mother Jenny Kirby (55) and her partner Steve Kirby (65) in Kent. Jenny and Steve have a Residency Order for the children. They took over care of Debbie after she was born as Debbie was being left unfed and unwashed and Sarah appeared preoccupied by her drug use. Jenny and Steve do not receive financial support for Debbie.

Jenny and Steve were unaware that Sarah was pregnant with Jessie. Jessie initially went into emergency foster care and social services then asked Jenny and Steve if they would take over care of Jessie and they agreed. Nine months later, after family assessments with social care and CRB checks, they became full-time carers for Jessie and receive financial support for her.

When Sarah went into prison to serve her current sentence, the family had not heard from her in over 3 years.

Debbie had short periods of contact with her mother up to the age of 8 but in the last 5 years has only seen her mother on two occasions. Jessie is not fully aware that Sarah is her mother. Jenny and Steve have been together for just over 20 years; Sarah has not had contact with her birth father in 15 years.

Sarah's brother Carl (30) is in close contact with the family. Debbie and Jessie have different fathers and neither of them has contact with their father; Sarah has contact with Jessie's father from time to time.

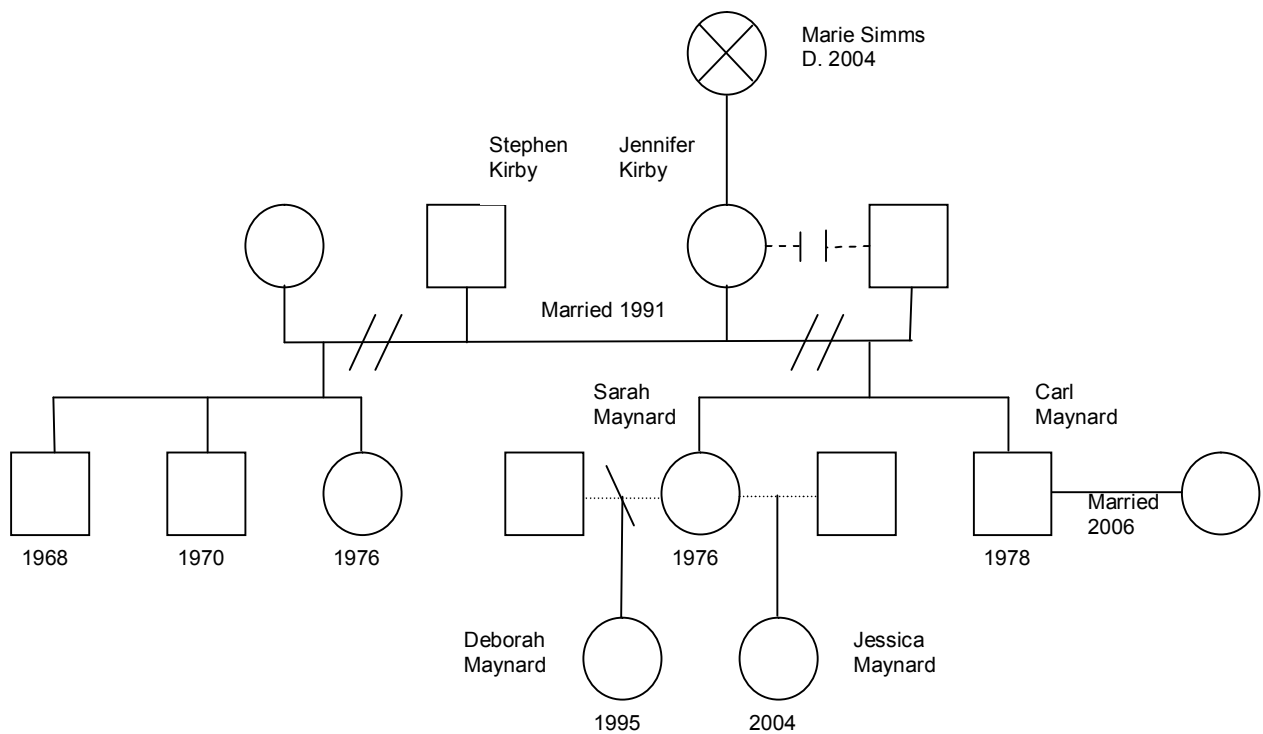
Services working with this family

GP	<input type="text"/>	Details	Dr Hilary, Hill View Surgery Hill View Rd, Birchington-on-Sea, Kent
Early years or education/ training provision	<input type="text"/>	Details	Birchington Day Nursery Station Approach, Birchington, Kent. CT7 9DJ. The Ramsgate School Stirling Way, Ramsgate, Kent CT12 6NB
Service	DIP	Details	Mill Lane House, Mill Lane, Margate Kent
Service	CAMHS	Details	Georges Turle House 54, London Road Canterbury CT2 8JY
Service	Prisoner Family Liaison Service	Details	HMP Bronzfield

Service	Children's social services	Details	Ramsgate, Kent
Assessment summary: strengths and needs			
Consider each of the elements to the extent they are appropriate in the circumstances. You do not need to comment on every element. Wherever possible, base comments on evidence, not just opinion, and indicate what your evidence is. However, if there are any major differences of view, these should be recorded too.			
1. Adult client	Sarah Maynard		
General health	Sarah is generally in good physical health. She is currently prescribed methadone. Whilst in prison, she has seen the dentist on two occasions for gum disease. She was under weight on arrival but has returned to a healthy weight since.		
Emotional health and development	Sarah finds it very difficult to cope with stress, becomes frustrated very quickly and can be aggressive if she cannot remove herself immediately from a stressful situation. Despite doing well on skills courses in prison, she has low confidence in her abilities. She also has low confidence in her ability to change her lifestyle.		
Behavioural development	For the past 11 years, Sarah has been using heroin and crack cocaine, which has dominated her lifestyle. Her friends and associates are all offenders and drug users. She has one offence for common assault in 2002 and one for actual bodily harm in 1997. The rest of her offences are related to her drug use – repeated thefts, and dealing and carrying drugs. The thefts undertaken in the last 3 years have shown a high degree of planning and organisation.		
Family and social relationships	Sarah has had infrequent contact with her family outside of prison and would like to see her daughters. She feels that her family is expecting her to fail and there is no way that she could please them. Sarah does not appear to understand the impact her actions have had on her family and at times has blamed her choice of lifestyle on her parents' separation.		
Participation in learning, education and employment	Sarah has good levels of literacy and numeracy, although she left school with no qualifications. Sarah has attended courses in catering and office skills in prison.		
2. Children/ dependants	Debbie Maynard and Jessica Maynard		
General health	Both children are currently in good health and have a registered GP and dentist. Jessie was withdrawing from heroin when she was born and Steve commented that she appears to have a very high pain threshold. Although Sarah will not confirm whether she was taking drugs when she was pregnant with Debbie, Jenny believe that Debbie's problems in childhood, with her gums and difficulties going to the toilet, may have been related to this.		
Emotional health and development	Debbie was described by the school counselor as being isolated and lonely and was referred to CAMHS, where she attended an initial appointment. Jenny and Steve describe Debbie as introverted and say she spends a lot of time alone in her room. Jenny and Steve believe Debbie feels confused and angry about her mother's neglectful behaviour. Debbie struggles to understand why her mother had Jessie and continues to find it difficult to adjust to Jessie as the new member of		

	<p>the family.</p> <p>Jessie is an extrovert and appears confident and happy. She looks up to her older sister. She picks up on tension in the house but it does not appear to have any significant impact on her own feelings and behaviour.</p>	
Behavioural development	<p>Jenny says that Debbie does not have any friends and is unable to build friendships because of the bullying she has experienced.</p> <p>Jessie appears to have no problems socialising and finds making friends easy.</p>	
Family and social relationships	<p>See section on emotional health. Debbie would like to build a relationship with her mother. Debbie also appears frustrated by her family's differing attitudes to her difficulty in making friends and discussions about 'the right thing to do' often lead to arguments.</p> <p>Jessie appears to have positive relationships with both Jenny and Steve.</p>	
Participation in learning, education and employment	<p>Debbie began secondary school in Birchington but her grandparents moved her to a school in Ramsgate after Debbie retaliated to bullying related to her mother. Unfortunately, Debbie continues to be bullied at her new school, although her school marks are fine. Jenny is considering removing Debbie from school and giving her home tutoring but Steve is completely against this.</p> <p>Jessie is due to begin infant school soon.</p>	
3. Parents and carers		
Basic care, ensuring safety and protection	<p>Jenny and Steve Kirby (carers)</p> <p>Jenny and Steve are attentive to the children's basic care and safety. The house is well furnished and clean.</p>	
Emotional warmth and stability	<p>The family moved to Kent from London in 2003. However, after experiencing continual anti-social behaviour by their neighbours, they moved into rented housing. Since then they have moved twice.</p> <p>Jenny and Steve seek to provide a stable and warm environment for the children. However, stress relating to finances, health, Sarah, and more recently Debbie's school problems has meant that arguments arise frequently over the best course of action. Jenny and Steve find it difficult to know how to respond to Debbie's social isolation. They are also worried about how other children will respond to Jessie's dual heritage when she starts attending school and how both they and Jessie will cope with it.</p>	
Guidance, boundaries and stimulation	<p>Jenny and Steve provide firm boundaries for the children and appropriate discipline. Disputes occur in the household over Steve being unwilling to engage with modern technology like the internet or what he considers to be too much TV.</p>	
4. Family and environmental		
Family history, functioning and wellbeing	<p>Jenny and Sarah's relationship appeared to break down in Sarah's teenage years and Sarah left the family home at 16. Jenny and Steve say they want nothing more than for Sarah to build a relationship with her daughters but find it difficult to see a way forward given Sarah's lifestyle.</p> <p>Neither Jenny or Steve have any criminal history.</p> <p>In the past year, Jenny and Steve have come close to separating as a result of financial strain, difficulties in managing their own stress, and differing attitudes towards resolving problems with the children.</p>	
Wider family	<p>They receive support from Jenny's son Carl, who lives in a neighbouring town; he sees them most days.</p> <p>Jenny's relatives live in Essex and she sees them about twice a year.</p>	

	<p>Steve sees his own children about twice a year. Most of his relatives live in Scotland.</p> <p>Jenny's mother Marie lived with the family from 2000 and had Parkinson's disease. She passed away in July 2004. Debbie was very close to Marie.</p>
Housing, employment and financial considerations	<p>Both Jenny and Steve are retired. Steve has had two strokes and Jenny had an operation on her knee this year due to arthritis, and needs a walking stick outside the house.</p> <p>This year Jenny and Steve began legal proceedings to receive payment from the local authority for Debbie. They already receive financial support for Jessie.</p> <p>The family lives in rented accommodation. They are finding it difficult to manage rising fuel and water costs.</p>
Social and community elements and resources, including education	<p>Steve has a number of friends in the local area and takes part in social sports activities. Jenny has one close friend in the local area but spends the majority of her time at home with the children.</p> <p>Birchington is a seaside village, popular for retirement. Transport links are good</p>



Assessment Form

Identifying details

Name	Daniel 'Dan' Parwani	AKA/previous names	Dhananjay Parwani
Gender	Male	Date of birth	26/6/61
Address	Direct Access Hostel Tower Hamlets London	Contact no.	
Post code		Religion	Muslim
		Ethnicity	Pakistani

Assessment information

People interviewed for assessment	Dan Parwani, Amina and Omar Parwani (his two children).
Date assessment completed	16.10.08
What has led to this family being assessed?	Dan is living in a direct access hostel and is starting to engage with a worker from a homelessness charity. He is a problem drinker and is waiting for a place at a residential detox unit. He would like to rebuild a relationship with his family.

Details of children/dependants

Name	Amina Parwani	Name	Omar Parwani
Date of birth	12/5/89	Date of birth	4/9/93
Address	Whitechapel London	Address	Whitechapel London
Ethnicity	Muslim	Ethnicity	Muslim
Name		Name	
Date of birth		Date of birth	
Address		Address	
Ethnicity		Ethnicity	

Current family and home situation

Dan has been living in a direct access hostel since September 2008. A worker from a homelessness charity referred him to the hostel after they met at a crisis centre following a drug overdose in August. The worker is trying to get him a place in a residential detox centre; Dan is not considered to be appropriate for home detox due to his risk of self harm and living in temporary accommodation.

Dan agreed to move out of the family home in 2005 and since then he has been mainly sleeping rough and in squats. He lived in a hostel for 4 months in 2006 but left after he was attacked by another resident.

Dan married Rana in 1980. They separated in 2005 but are not divorced. Amina and Omar live with their mother in a three bedroom flat in Whitechapel.

Services working with this family

GP		Details	Registered with his family's GP, Kingsway Surgery Tower Hamlets
Early years or education/ training provision		Details	Omar attends King William secondary school Berryfield Park Road
Service	Homelessness charity	Details	Tower Hamlets London
Service	Community Safety Team	Details	Metropolitan Police

Assessment summary: strengths and needs

Consider each of the elements to the extent they are appropriate in the circumstances. You do not need to comment on every element. Wherever possible, base comments on evidence, not just opinion, and indicate what your evidence is. However, if there are any major differences of view, these should be recorded too.

1. Adult client

Dan Parwani

General health

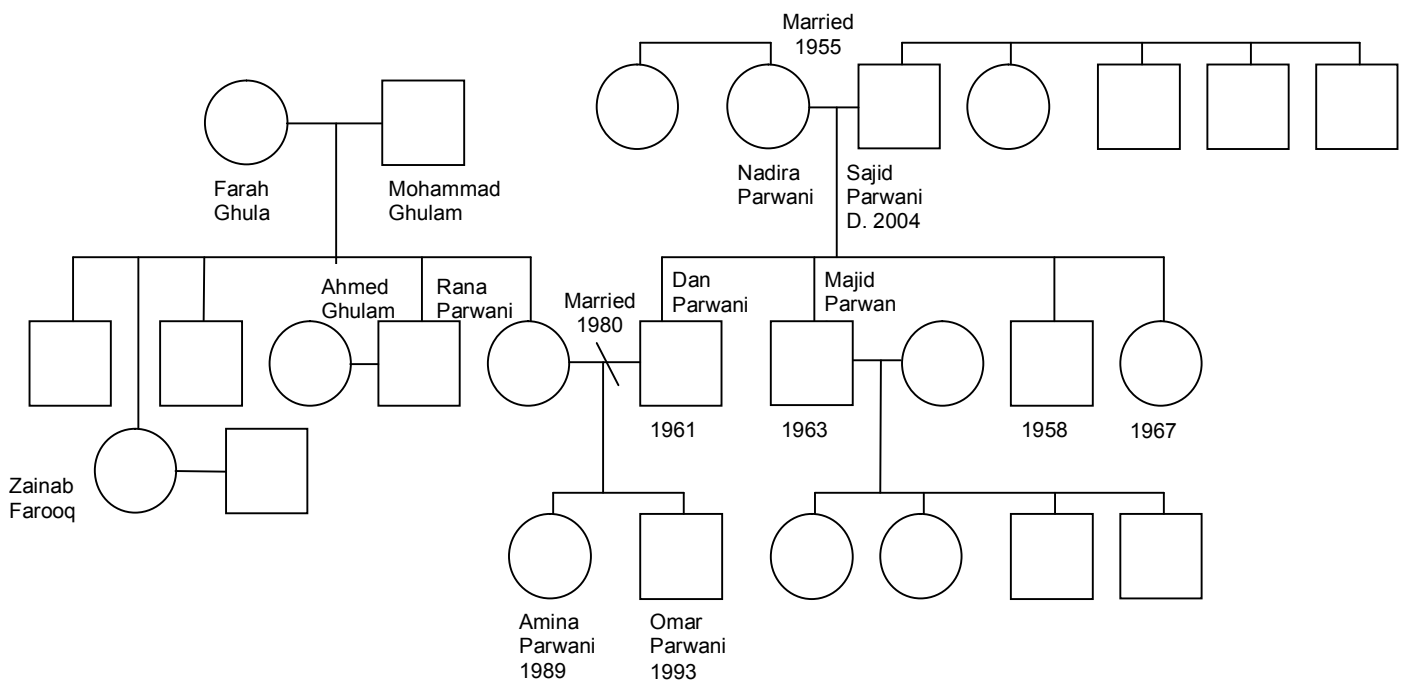
Dan has been to A & E on 6 occasions in the last two years – one after being assaulted by another street drinker, one due to being knocked down by a car, twice for alcohol withdrawal seizures, one from a black out, and the last following his suicide attempt. On his last visit Dan was diagnosed with cirrhosis of the liver. The hostel has arranged for Dan to see a visiting GP for monitoring.

After the birth of his second child Dan went to see his GP, who wrote a referral to the community drug and alcohol service. He had an assessment with an alcohol worker who wanted him to take part in a group programme before arranging a detox, to test his commitment to change. Dan attended the first session but felt very uncomfortable about sharing his personal experiences with the group, who were all white. He did not attend any more sessions and was discharged from the service. He made another attempt to attend a drop-in after he was asked to leave home. However the clinic was very busy that day and after waiting three hours he left, planning to return the following week, but he never did.

<p>Emotional health and development</p>	<p>In August Dan attempted suicide. He was visiting a woman at whose home street drinkers often congregated and took a couple of handfuls of painkillers from her medicine cabinet.</p> <p>Dan has very low self esteem and describes himself as a 'waste of space.' He feels depressed and lonely and unwanted. When not drinking he feels anxious about being 'overwhelmed' by depression. He is devastated about separating from his children, the upset he has caused his wife, and losing his career. He says drinking helps him to block out these feelings.</p> <p>Dan tells me he was sexually abused by an uncle when he was a young boy and this continues to cause him distress. Dan also suffered a lot of racial abuse both in and out of school in his teens and early twenties.</p>	
<p>Behavioural development</p>	<p>Dan has been drinking heavily for the past 20 years, for 15 of which he tried to conceal it from his wife or would deny it. He would binge drink after leaving work with his colleagues or by himself. After he left work he began drinking 5-6 cans of strong lager most days of the week, mainly outside his home or in pubs. He would drink continually at any social events (outside of the family) where alcohol was available. Over the last three years, Dan would generally drink whenever any alcohol was available or he had any money. He usually drinks about 7-9 cans of strong lager or sometimes cider 3-4 days a week, and tends to drink with other people as he finds he feels too depressed alone. Dan describes himself as like "jeckyll and hyde" – he is a kind and loving person but abusive when he has been drinking.</p> <p>After leaving the family home in 2005, Dan returned on a number of occasions when he was drunk and was verbally abusive to his wife. He received a caution and fine for this behaviour in 2005-6. Dan has been asked to move on numerous times by police in the past two years for street begging and drinking in public places.</p>	
<p>Family and social relationships</p>	<p>Dan loves his children very much and feels shame and guilt about how his behaviour has affected them. He calls them about once a month on the phone and speaks only very briefly to his wife. He has also met with the children twice in the last year in a park without his wife's knowledge. He would like to be able to see them at the hostel but is not comfortable about bringing them there and does not think his wife would agree.</p> <p>Dan's parents moved to the UK in 1953. Dan was very close to his father Sajid who died in 2004. Dan remembers secretly observing his father drinking by himself on many occasions. Dan feels his mother Nadira is cold and has always felt rejected by her; his mother appears much closer to his other siblings. Dan told his mother about the sexual abuse he suffered but she said to forget it and did nothing about it. Dan used to be very close to his younger brother Majid, who recently visited him in the crisis centre, but they have spoken on only a few occasions over the last three years.</p> <p>Dan's marriage to Rana was arranged by his mother and his aunt. Rana was born and living in Pakistan with her parents and sister. Dan was born in the UK and was ambivalent about his arranged marriage, however he did not want to let his family down. When Dan met Rana he was shocked by the cultural differences between them and was frustrated that Rana mainly wanted to associate only with the Pakistani community. Rana would sometimes leave passages from Qur'an relating to alcohol around the house. Once he had admitted to it, Rana would "preach" at him daily. Dan would leave early for work and come home very late.</p> <p>From 2003-4, Dan had an affair with a woman at work. Dan admitted the affair to his wife which was the final straw in the breakdown of their relationship.</p>	

Participation in learning, education and employment	Dan trained and worked as a chef after leaving school at 16. At school he was good at sports and continued to play cricket and football for local teams into his twenties. At 23 he became head chef of a local restaurant and at 25 became head chef at a restaurant in central London. He was asked to resign after being found drunk at work.
2. Children/ dependants	Amina and Omar Parwani
General health	Amina and Omar are registered with a GP and a dentist and are in good health.
Emotional health and development	Amina lacks confidence and finds it difficult to trust people; it takes her a while to build friendships. She has only two close friends both of whom are from the Pakistani community. Both children were upset and angry when they learned about their father's suicide attempt. Amina visited him in the crisis centre with Majid but did not stay long as she found it distressing. Omar in the end decided not to go. Omar is struggling with his identity – he feels torn between obeying and respecting his religion and his mother's rules and fitting in socially with his peers. Omar says he has lots of friends at school, one of whom he is very close to who is also of Pakistani background. In the last two years before his father left home Omar found it very difficult to concentrate at school. Omar does not tell his friends at school about his home life. See also Family and Social relationships.
Behavioural development	Amina is a cautious person and does not like to socialise in unfamiliar situations. Omar is an extrovert. He can be reckless and lose his temper very quickly. He has often got into fights with other children. His teachers say he hangs around with a group of rowdy boys in school, some of whom are pro-offending, and has been excluded from school on two occasions in the last year. Rana is concerned that Omar may be hanging out with the wrong crowd and blames his peers for the problems in school.
Family and social relationships	Both children are close to their mother, although Omar says he feels frustrated with her when she refuses to talk about their father. They feel a huge amount of anger towards their father for his behaviour. Omar can describe vividly occasions when he was embarrassed by his father at family or public events, and occasions when his father was verbally abusive towards him. However, he can also recall times when he had fun with his father – when they used to go to the park and play sports on the weekend. Omar wishes deeply that his father would stop drinking. Amina would also like to have a relationship with her father if he could stop drinking but worries about how this will affect her mother.
Participation in learning, education and employment	Amina gained 2 B's and a C at A-level and is now studying at the University of East London. She does not socialise with other students. Omar is good at sports and creative activities in school but finds studying difficult.

3. Parents and carers	Dan and Rana Parwani
Basic care, ensuring safety and protection	No concerns.
Emotional warmth and stability	Rana is caring and warm to her children. She finds it easier to praise Amina than Omar at the moment and has been fighting with Omar about school. When Dan was living at home he was often absent. When at home, his behaviour was unpredictable. Sometimes he would be quite needy and demand the children spent time with him. The children were angry and frustrated when he would talk often about what a close family they were during these times. At other times he would be irritable, dismissive and mean.
Guidance, boundaries and stimulation	Rana sets clear boundaries for the children and cares a great deal about their education.
4. Family and environmental	
Family history, functioning and wellbeing	See Section 1.
Wider family	The children often see their cousins around the neighbourhood and at family and religious events. They get on particularly well with Majid's children. However, they often feel angry when relatives talk about their father negatively and think that some relatives look down upon them because of their father. The distance between Dan and his family has grown considerably over the last eight years as his drinking has increased. Dan feels his wider family is happy for him to fail. Most of Rana's family live in Sheikhpura and Lahore in Pakistan. Rana speaks to her parents two or three times a week. Her parents have a very low opinion of Dan. Rana's brother Ahmed and her sister Zainab live in Upton Park with their respective partners.
Housing, employment and financial considerations	Dan has £12,000 worth of debt. Rana receives income support and has been taking English and Maths classes in the evening. She hopes to get a job soon. She often spends two or three days a week helping with alterations in a local dress shop for cash in hand, which helps pay off Dan's debt. Rana's older brother helps with housing costs while Dan's mother and aunt have helped to pay for other items for the children including books for Amina's university studies.
Social and community elements and resources, including education	Rana's social activities revolve around the family and religious activities. Dan feels his faith has disappeared but would like to be able to reconnect with it.



Assessment Form

Identifying details

Name	<input type="text" value="Karen Wilmot"/>	AKA/previous names	<input type="text" value="n/a"/>
Gender	<input type="text" value="Female"/>	Date of birth	<input type="text" value="16/4/83"/>
Address	<input type="text" value="12 Freymans Grove
Barking
London"/>	Contact no.	<input type="text"/>
Post code	<input type="text"/>	Religion	<input type="text" value="Christian – Church of England"/>
		Ethnicity	<input type="text" value="White British"/>

Assessment information

People interviewed for assessment	<input type="text" value="Karen Wilmot. Joshua and Charlie (two of her children) present at interview."/>
Date assessment completed	<input type="text" value="16.10.08"/>
What has led to this family being assessed?	<input type="text" value="Karen experiences depression, which worsened after the birth of her third child. Her back problems were also aggravated by this pregnancy. She is currently living in temporary accommodation in a second floor flat in Barking with no lift. The flat has a damp problem which is affecting both Karen and her eldest child's asthma. Karen has not paid her last two utility bills and suspects her boyfriend has been taking money from her to pay for drugs. Karen has a history of being verbally aggressive."/>

Details of children/dependants

Name	<input type="text" value="Amy Wilmot"/>	Name	<input type="text" value="Joshua Wilmot"/>
Date of birth	<input type="text" value="3/3/04"/>	Date of birth	<input type="text" value="11/02/07"/>
Address	<input type="text" value="12 Freymans Grove
Barking
London"/>	Address	<input type="text" value="12 Freymans Grove
Barking
London"/>
Ethnicity	<input type="text" value="White British"/>	Ethnicity	<input type="text" value="White British"/>
Name	<input type="text" value="Charlie Wilmot"/>	Name	<input type="text"/>
Date of birth	<input type="text" value="25/06/08"/>	Date of birth	<input type="text"/>
Address	<input type="text" value="12 Freymans Grove
Barking
London"/>	Address	<input type="text"/>
Ethnicity	<input type="text" value="White British"/>	Ethnicity	<input type="text"/>

Current family and home situation

Karen (25) describes herself as a single parent. She lives with her three children Amy (4), Joshua (19 months) and Charlie (3 months) in a two bed flat in Barking. The family moved there about two years ago.

Karen has an informal agreement with Amy's father, Martin Cuthbert (28), that he will look after Amy for two weekends each month but for the last six months Martin has taken Amy about once a month. He has not paid any money towards her care for the last three months.

Karen is currently in a relationship with Joshua and Charlie's father, David (Dave) Finch (26). Dave lives in Plaistow with his mother, Linda, and works as a labourer. He comes to the flat about 3-5 times a week or at weekends, depending on his work shifts and locations, and takes the children out. Dave's financial contributions to the household became more irregular about six months ago. Karen suspects his drug use has increased because his behaviour has become more unpredictable – he is either lazy, full of energy or short tempered. She has asked him to go home twice when he arrived at the flat 'high', and once he was sent home from work after using cannabis during a break. She has also noticed money disappearing from her wallet.

Services working with this family

GP	Dr Franklin	Details	Thatcher and Hale Surgery Barking London
Early years or education/training provision	Gillian White	Details	Little Cubs Nursery
Service	Housing worker	Details	Julie Stevens Homelessness project
Service	Health visitor	Details	Sylvia Gregory
Service	Housing officer	Details	Name unknown Havering council

Assessment summary: strengths and needs

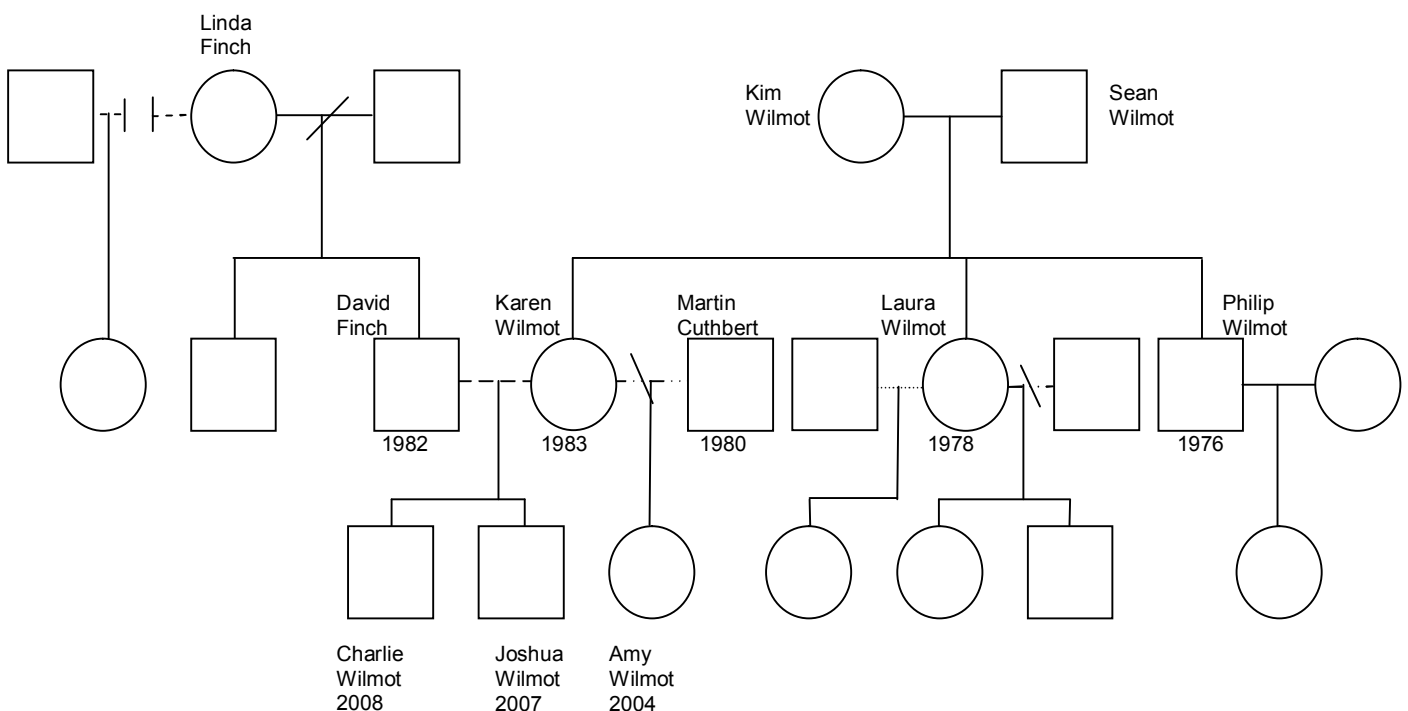
Consider each of the elements to the extent they are appropriate in the circumstances. You do not need to comment on every element. Wherever possible, base comments on evidence, not just opinion, and indicate what your evidence is. However, if there are any major differences of view, these should be recorded too.

1. Adult client	Karen Wilmot
General health	<p>Karen continues to suffer from problems with her back, which began during her last pregnancy and for which she has been prescribed painkillers. She is due to see a specialist on 21st November 2008. Picking up the children aggravates her back pain. Karen also found it difficult to keep food down during her last pregnancy and says she still lacks appetite due to stress, however her body mass index is in the normal range.</p> <p>Karen thinks her GP "couldn't give a **** about her". He recently offered her anti-depressants but Karen did not want to take more medication, as she is already on painkillers. Her GP did not offer her any other form of support.</p> <p>Karen suffers from bad asthma, which is aggravated by the dampness in</p>

	<p>the flat. Karen describes herself as a social smoker but says due to stress she is now smoking about five cigarettes a day, which is also contributing to her asthma.</p>	
<p>Emotional health and development</p>	<p>When Karen is stressed or frustrated she finds it difficult to cope and quickly loses her temper. She recently shouted at nursery staff on the phone when they warned her that Amy could be taken off their list due to repeated absence – there have been five occasions during the last month when Karen has not taken Amy to nursery. Seven months ago she was escorted out of the homeless persons' unit for being verbally abusive to staff.</p> <p>Karen is finding it hard to get out of bed in the morning. She is having difficulty coping with the demands of her two younger children, the condition of the flat, managing her finances, and the problems in her relationship with Dave. Her low mood means she finds it difficult to take the children out of the house, particularly since she has to carry the buggy down two flights of stairs, aggravating the pain in her back.</p> <p>Karen is reluctant to ask her family for extra help as she feels the children are her responsibility. Her parents do not get on well with Dave and she does not want to tell them about her concerns regarding Dave's drug use as she is worried they will cause more problems.</p> <p>Karen and Dave are having difficulty communicating as Dave is reluctant to speak about his drug use and denies taking money from Karen. Karen fears his drug use will escalate.</p> <p>Karen does not have any close friends and says she does not wish to make new friends due to problems she has had in the past where her friends turned against her.</p>	
<p>Behavioural development</p>	<p>Currently, Karen does not take any illegal drugs. She is drinking a 'few vodkas' or about half a bottle of wine 2/3 nights a week to help her relax. She says she does not want her children to see her drinking.</p> <p>Before Karen became pregnant with Amy she regularly smoked cannabis at the weekend and took cocaine and ecstasy on two to three weekends a month.</p> <p>She received a caution for being verbally abusive to a police officer in 2002 and a fine in 2003 for being drunk and disorderly. She has a spent conviction for common assault as a teenager.</p>	
<p>Family and social relationships</p>	<p>Karen's sister Laura lives in West Ham, London, with her three children. Her parents, Kim and Sean, moved to Kent just before Karen became pregnant with Amy. Her older brother Philip also lives in Kent with his partner and child. She sees them about once every two months and on the children's birthdays and holidays. Karen said she does not often ask Laura for support with child care as previously Laura has made excuses and Karen says 'she has her own problems.' Karen's parents have bought clothes and toys for the children but Karen is embarrassed to tell them about the problems she is having paying the bills, and says they are always critical of everything she does.</p> <p>Dave's mother Linda has also helped with buying things for the children and furniture for the flat. However, Linda is in poor health and Karen does not want to burden her by asking for more support.</p>	
<p>Participation in learning, education and employment</p>	<p>Karen gained 5 GCSEs and worked continuously for a number of years after leaving school at 16. She worked in a number of temporary office posts and as a bar maid until the age of 19 and then took up a permanent administrative post. She returned to work after having Amy but found the cost of child care outweighed the benefit of going to work. Karen would like to return to work if she could afford to.</p>	

2. Children/dependants	Amy, Joshua and Charlie Wilmot
General health	<p>All children are registered with a doctor and a dentist. Amy suffers from asthma which is aggravated by the damp in their flat. Over the past two years she has been admitted twice for an overnight stay in hospital following severe asthma attacks.</p> <p>A month after Joshua was born he was admitted to hospital with bronchitis. He currently appears to be in good health.</p> <p>Charlie is in good health. Karen tried breast feeding him for the first month but says she did not have the energy to continue and now bottle feeds him.</p> <p>Karen says she often does not have the energy to spend time shopping and cooking and gives Joshua and Amy a lot of ready meals or food from the freezer.</p>
Emotional health and development	<p>Joshua is a very active child and Karen says he is often frustrated when he cannot leave the flat and does not understand that she does not have the energy to take him out. Karen finds herself losing her temper quickly with Joshua at the moment.</p> <p>Karen is anxious about how her depression is affecting Amy. She says although she tries not to show it to her, Amy can sense when she's down and responds by giving her a kiss and cuddle. Karen feels that Amy helps her by playing with Joshua.</p>
Behavioural development	<p>See above.</p> <p>Amy's development appears normal, although she appears to find it difficult to relax. The nursery says she can be quite domineering when playing with other children; she also cries or gets very angry if she is frustrated or being told off.</p> <p>Joshua finds it difficult to concentrate and is often restless and prone to tantrums; however this may be due to being stuck in the flat.</p> <p>Amy and Joshua share a room in the flat. Joshua is quite a restless sleeper and disturbs Amy's sleep.</p>
Family and social relationships	<p>Joshua and Amy get on well. The children all look forward to seeing Dave and he is attentive with them when he sees them. They are often upset when he goes, particularly Joshua.</p>
Participation in learning, education and employment	<p>Workers at the nursery believe Amy to be a good learner.</p>
3. Parents and carers	
	Karen Wilmot, David Finch
Basic care, ensuring safety and protection	<p>Karen meets Charlie's basic needs and changes and feeds him regularly. Karen says she feels exhausted most of the time and feels a bit like 'a machine' responding to Charlie.</p> <p>Karen believes that Dave will never bring drugs to the flat or use them around the children, though she knows that on occasion he has used cannabis before arriving at the flat.</p>
Emotional warmth and stability	<p>Karen feels guilty for not being as affectionate towards her children as she ought to be, and finds that she wants to spend more and more time alone. Karen says that on days when she is feeling better she makes a special effort to do things with the children.</p> <p>Karen says Dave is a good father to the children – always playing with them and taking them out - and he makes an effort to come round and see them.</p>
Guidance, boundaries and stimulation	<p>Karen's low mood and tiredness mean that she has not got the energy to maintain firm boundaries and discipline with the children, though she tries her best. Karen finds it helpful when Dave is there because it gives her time to rest.</p> <p>Dave tends to try and distract the children rather than discipline them because he says he does not want to ruin their time together.</p>

4. Family and environmental	
Family history, functioning and wellbeing	Karen and Dave's personal relationship is under pressure. Karen says they rarely spend any time together without the children and have not slept together since she became pregnant with Charlie. Dave has spent convictions for cannabis and common assault from his teenage years. Karen knows that he uses cannabis daily, and sometimes cocaine and amphetamines, but is not sure what else or how often.
Wider family	See section 1.
Housing, employment and financial considerations	Karen became homeless when her relationship with Martin broke down and they could not afford their bedsit on only one salary after Amy was born. In February 2004 Karen moved in with her sister Laura for two months, and she then made a homelessness application. In April 2005 Karen was placed initially in a bedsit above a take away where she lived for 8 months. Young people often congregated outside the flat, creating a lot of noise particularly on the weekends. Amy could not play outside because of the rubbish. With help from Julie Stevens, a worker at a homelessness project, Karen moved into her current accommodation. Karen has made numerous complaints to the council and the letting agency about the condition of her accommodation but to no avail. She does not know who her current housing officer is. The neighbours do not like children playing outside the flat. Karen is struggling financially and is concerned that she will not be able to pay the arrears on her utility bills, but does not know what to do about it. Dave has suggested tampering with the meter and Karen is thinking about doing this.
Social and community elements and resources, including education	Currently, Karen does not participate in any social or community activities outside of the family. Before Joshua was born, Karen sometimes volunteered at the community centre where Amy took part in play activities. The nearest park is a 15 minute walk away. Transport links are good; buses go to the local supermarket and shopping centre every 15 minutes.



Appendix 3: Interview guide for service users and family members

Thank you for agreeing to take part in this research.

We would like your help in putting together a case study – a made-up story – about (as appropriate):

- a woman in prison whose children are being looked after by their grandparents
- a person who is homeless with children

I will be asking you about *your* experiences of this situation. The information from this interview and from interviews with other people in a similar situation to yourself will be used to make up the case study.

The final case study will not be based on any single person. No one will be able to recognise you from the case study and your name will not be kept on any documents for the research. We will then be discussing the case study with professionals from different services to see how they could better support individuals and their families.

There are no right or wrong answers. If you feel you cannot answer a question or do not wish to answer a question just let me know and I will move on. If at any time you wish to stop the session, let me know and I will stop. I will arrange the payment for the session when it is completed.

This session will last about an hour and a half. Would you mind if I tape-recorded the interview?

Do you have any further questions before we begin?

1. Introduction

1.1 How many children/grandchildren do you have?

- What are their names?
- What ages are they?

1.2 Would you mind telling me your age?

2. Living arrangements

2.1 How long have you been living here/in your current accommodation?

2.2 For housing case study only:

- Condition of the accommodation
- Suitability of the accommodation for children
- How does this compare to other places you have lived in?
- How long are you likely to remain here?
- Were there any other choices about where you could live?

2.3 For grandparent case study only:

- Length of time children living with grandparents
- Where children living before then
- Suitability of the accommodation for children
- Who decided where the children would live?
- Where might the children have lived if grandparents had not agreed to care for them?

3. Family and relationships

- 3.1 Which members of your family are you in contact with?
- 3.2 (For each person mentioned) Can you describe your relationship with them?
- 3.3 For any service users interviewed, what is your relationship like with the mother/father(s) of your children?
- 3.4 For grandparents interviewed, what is your relationship like with the mother/father(s) of your grandchildren?
- 3.5 How have the children coped with the changes in their parents' lives?
- Any changes in their behaviour?
 - Any other issues?
- 3.6 Are there any other important people your life?
- Relationships?
 - Close friends?

4. Finances and employment

- 4.1 Are you working at the moment?
- 4.2 How are you managing financially?
- 4.3 Have you received any advice or support about finances from any organisation or services?

5. Support services

- 5.1 For housing case study, at the point when you began to have difficulties with housing, did you receive support from any services?
- 5.2 For grandparent case study, have you/grandparents received any support from services in looking after the children?
- 5.3 What support services have you used?
- Health
 - Emotional or mental health
 - Relationships
 - School
 - Social services
 - Prison services
 - Leisure activities
 - Voluntary
 - Any gaps?
- 5.4 Do you receive any help from other family members or friends?
- Who?
 - What kind?
 - How often?

- If infrequent, on what basis?

Thank you again for taking part.

Is there anything else that you would like to add that you feel is important that we have not spoken about?

Appendix 4: interview guide for practitioner focus groups

1. Introduction

Introduction to research and Think Family
 Each person to introduce themselves. Name, type of service/organisation, main role
 What kind of contact do agencies have at the moment with family members and adult’s partners (FMP)?

2. Case study

- 2.1 In what ways does this family need support?
- 2.2 Who, if anyone, would be best placed to provide support?
- 2.3. How would this support come about?

3. Benefits and costs of working with FMP (using case study)

Use case study to complete the grid below – then expand to more general points.

<i>Benefits of working with FMP</i>	<i>Costs of working with FMP</i>
Practitioner	Practitioner
E.g. Able to get a full assessment.	E.g. Takes a lot of time and effort.
<i>Benefits of not working with FMP</i>	<i>Costs of not working with FMP</i>
Practitioner	Practitioner
E.g. Don’t have to take responsibility for another person.	E.g. Less successful work with client.

4. Benefits and costs continued

4.1 What are the most significant issues identified in determining whether or not you work with FMP?

Explore.

5. Multi-agency working

- 5.1 What are the key difficulties in multi-agency working?
- 5.2. What could be done to improve multi-agency work?

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