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Tracing an Ethic of Care in the Policy and Practice of the Troubled Families Programme

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Introduction

There is a mounting recognition of the utility of an ethic of care approach in researching family policy and practice (See for example Barnes, 2012; Morris and Featherstone, 2010; Smart and Neale, 1999; Williams, 2004a and 2004b). To some extent this is a recognition of the centrality of caring practices to dominant understandings of family life, and therefore analysis of concepts of care offers an opportunity to evaluate the adequacy and distribution of care practices. A number of authors have also commented on the significance of moral judgements of care practices within families as constituting the ways in which individual identities are constructed, for example in the normative evaluations of what it means to be a 'good mother' (Finch and Mason, 1993; Hughes, 2002) or indeed a 'troubled family'. Hughes argues that, "Through the negotiations of giving and receiving care, reputations as a 'good' person are at stake. In these enactments of responsibility, therefore, people are constructed as moral beings" (Hughes, 2002: 119). In this sense, an evaluation of the social, political and moral dimensions of care provides a mechanism to challenge 'othering' discourses constructed around disadvantaged families (Lister, 2004; Parr and Nixon, 2008) where care practices may reflect the complex contexts in which they are organised, such as "when families are living in a situation of material disadvantage and in physical environments that make everyday survival a struggle" (Barnes, 2012:39).

In addition to this focus on care practices within families, reflecting upon care ethics also generates useful frameworks for evaluating the practices of those whose role is to support disadvantaged families. Conceptualising such work as 'care' offers a discursive challenge to the policy and rhetoric which has tended to surround such 'troubled' or 'anti-social' families, often characterised by the language of enforcement, control and responsabilisation (Levitas, 2012; Bond-Taylor, 2014a). Engaging with the concept of care has the potential to provide a unifying focus both for the identification of 'care' activities within families and family support services, and as an ethical, moral and political framework by which family policy and service provision can be evaluated.

This paper therefore engages with ongoing debates about care ethics in order to evaluate current policy and practice emerging out of the Troubled Families Unit. Firstly, it reflects upon the experiences of families and their key workers, and the value that they place on care ethics within family support services. Secondly, it questions the extent to which the family intervention model

advocated within the Troubled Families Programme encompasses an ethic of care and how this might be impacted by the managerialist tendencies of the Troubled Families Programme.

What is meant by an Ethic of Care?

The genealogy of the ethic of care can be traced to the work of Carol Gilligan in her 1982 text *In a Different Voice*, in which she challenged the dominant notions of morality pervading psychology and moral philosophy at that time, most notably from the work of her PhD supervisor Lawrence Kohlberg. Kohlberg's model of the stages of moral development emphasised Kantian principles of 'justice' as the key to superior moral decision making, through the application to any given situation of abstract and generalisable rules about 'right' or 'wrong'. Gilligan's research revealed a different moral voice which she argued was more common amongst female research participants, and which emphasised principles of 'care' rather than 'justice' and prioritised situational decision making over abstracted rules. She therefore highlighted the gendered nature of moral philosophy, with masculine moral concepts of rights, rules and objectivity seen as superior to feminine notions of morality enacted through care, relationships and harm prevention.

Gilligan's claim that men and women have fundamentally different ways of reasoning may be criticised for its biological essentialism, however rejecting such reductionism does not require a concomitant rejection of all arguments around gendered depictions of morality. The social construction of gender within the context of patriarchal capitalism has segregated the male (public) domains and the female (private) domains, and the ethical principles which are seen to govern these domains therefore become associated with the respective gender (Friedman, 1987). Furthermore, if gender is understood in terms of performance (Butler, 1990), adherence to the ascribed moral codes of 'masculinity' and 'femininity' become a central mechanism by which gender identities are constructed and maintained.

Gilligan's research argued that women are more likely than men to engage in situated and relational decision making styles, and we can reflect upon the ways in which the social construction of gender and the social organisation of gender roles (rather than a biological essentialism) might produce this outcome. Given that caring duties continue to be differentially distributed between the genders, there may also be gendered differences in the values expressed during decision making practices, since care givers may need to take into consideration their caring obligations and the impact of any decisions upon those for whom they provide care. Research into 'family' as a set of practices oriented around relationality and care must therefore consider whether gender in itself determines the deployment or otherwise of a care ethic, or whether it is the practice of engaging in traditionally 'feminine' caring activities. Fathers or other male relatives who are primarily responsible for the care needs of their families may therefore also deploy care ethics.

Gilligan (1998, cited in Hughes, 2002) has furthermore distinguished between a *feminine* ethic of care and a *feminist* ethic of care, which offers a useful means of evaluating the way in which the individual relates their caring identity to wider social values. A *feminine* care ethic, she argues, is an ethic of special obligations and interpersonal relationships based upon self-sacrifice and which is

oppositional to self-development. It accepts the patriarchal social order, including the primacy of rationality, autonomy and justice as higher order psychological states. By contrast, a *feminist* care ethic exposes this as evidence of patriarchal relations and thus offers a critique of the inequalities inherent within justice-oriented principles. From this perspective, because inter-relatedness is central to human life, then autonomy, rather than being the means of solving problems, becomes the problem itself – producing a disconnection from emotions and relationships which creates both psychological and political problems. A *feminist* analysis therefore demands a reconsideration of the political contexts and gendered distribution of acts of ‘care’. Evaluating the extent to which there is evidence of care ethics within the practices of families and within the operationalization of support services is therefore complicated by the need to determine also whether this ethic of care is *feminist* or merely *feminine* in values.

From these early observations, Gilligan’s analysis of an ethic of care has been developed into a substantive framework which has extended far beyond its origins in feminist psychology (Barnes, 2012:11) and has application to a wide range of social policy concerns. However, the ethic of care perspective appears to have had very limited application in the field of criminology, with the exception of its cross over from social work to probation services (Gregory, 2010; 2011) and in the global field of international violence and human rights (Held, 2008; 2010). The challenge which an ethic of care poses to principles of ‘justice’ appears to present a valuable opportunity for critical criminological analysis, especially in the spaces where criminal justice policy and social policy collide, where we see the ‘criminalisation of social policy’ (Rodgers, 2008) or indeed the ‘socialisation of crime policy’ (Hughes et al, 2007). Barnes (2012) has argued that an ethic of care fits more comfortably with the concept of social justice than criminal justice, since it stands in opposition to legally oriented ‘justice’ principles. However, some of the binary oppositions evident within Gilligan’s work have been deconstructed in subsequent texts in an attempt to develop a more fully theorised account of care ethics (Friedman, 1987; Hughes, 2002; Barnes, 2012), and it is through those analyses which have integrated justice and care principles that an ethic of care approach might also usefully be extended to the state’s responses to criminal wrong-doing and broader aspects of ‘deviant’ or ‘anti-social’ behaviour.

Key Principles of Care Ethics

Tronto (1993) describes four principles necessary for the integrity of care: attentiveness, responsibility, competence and responsiveness. Each of these relates directly to one of four stages of caring: caring about, taking care of, care giving, care receiving. ‘Care’ practices which do not reflect these four principles of care are seen as ethically problematic and contrary to social justice objectives. These can be seen as deriving from a range of neglectful responses to the needs of others, including a lack of attentiveness to the circumstances of others which might reveal care needs, a failure to act upon the recognition of care needs, the incompetent and insufficient provision of care such that care needs might fail to be met in practice, and a lack of concern with the feelings of the care receiver which might fruitfully be used to improve care practices.

Barnes (2012) has suggested that to this typology we should also add Selma Sevenhuijsen's principle of *trust* as a fifth principle of care and Enger's principle of *respect* as a sixth principle, acknowledging that others are worthy of our responsiveness, and are not lesser beings because they cannot meet their own care needs. It is evident that not only would Tronto's four principles of care generate trust and respect between care giver and care receiver, but that trust and respect are also essential for those four principles to be adequately enacted. Being attentive to needs, for example is not easy where lack of trust means that the care receiver does not feel able to be open about their circumstances. Similarly the competent and responsive provision of support to meet care needs requires that the care receiver trusts the care giver to do so respectfully and accepts the care offered. Building relationships of trust and respect are therefore a central concern of an ethic of care perspective, and this highlights the relational character of care (Barnes, 2012). According to Barnes (2012: 25):

"Not only does care reflect the relational ontology of human life, and not only is it provided through relationships, it can generate dialogic processes that develop relational capacities among both care giver and care receiver. We develop our capacity to care through the practice of care with others."

To these 6 principles of care, I would also add three further principles described by Smart and Neale (1999) as necessary within an ethic of care approach to children and families: actuality, recognition of selfhood, and recognition of loss.

The principle of actuality advocates that decisions are made in relation to the reality of people's lives rather than highly abstracted or idealised notions of 'childhood' or 'family' and that it they should consider the practical contexts in which 'care' within families operates. This principle provides a clear contrast with the homogenising tendencies of neo-liberal policy and managerialist practice in which the complexity and uniqueness of the experiences of individuals and 'families' is reduced to a classification (as 'at risk', 'troubled', 'anti-social' etc) (Garrett, 2009), and where "...social values and moral issues are reduced to technical rationality, cut adrift from political debate involving interests and power, while social justice, material conditions and social inequalities are obscured from view" (Edwards et al, 2015).

The principle of recognition of selfhood demands that people are recognised as individuals capable of constructing their own identities, and that we consider the ways in which family and caring responsibilities can impinge upon the individual's capacity to maintain a sense of self. This reflects feminist care ethics in that it supports a critique of social structures and policies which disproportionately impose caring responsibilities on some citizens rather than others (traditionally women within the domestic sphere) without consideration of the potentially damaging impact of this burden on the individual.

The principle of recognition of loss acknowledges that interventions cannot always resolve disputes and return a situation to the way it was prior to that dispute. The basis of legalistic concepts of 'justice' is that law can be used to rebalance society and provide recompense when somebody is wronged. However, in the context of relationships, legal declarations that 'justice' has been achieved can have little relevance to those involved, who continue to feel aggrieved or hurt, and they can therefore serve to drive a wedge further between the parties to the dispute. An ethic of care therefore looks to prioritise attempts to sustain dialogue and rebuild relationships, looking to the future, rather than to promise instant, magical solutions to the problem.

Finally, if these principles are to be applied within a feminist ethic of care which challenges inequitable social relationships and pursues social justice goals, then they must be accompanied with a concern with the politicisation of 'care' in society. The body of work emerging on an ethic of care is increasingly challenging the distinction between the public and private and rejects the notion that care is a 'private' concern. The application of ethic of care theory to politics and social policy has drawn attention to the ways in which care is a political issue and that care ethics cannot reside within the private sphere alone, echoing feminist perspectives that emphasise the personal as political. Extending the ethic of care analysis from the private to the public therefore renders for analysis the actions of government, in the construction of social problems and their solutions, the distribution of funding for care, and the collective organisation of care practices. It offers therefore an opportunity to move up from practice to policy, and to challenge the discursive formations which construct social action in ways which prioritise 'justice' reasoning and neglect 'care' ethics. We can no longer understand relationships of care as personal or private:

“Care cannot be separated from other aspects of interpersonal relationships that embody gendered expectations, power relationships and the potential for abuse as well as nurturing. ***People’s capacity to do care well within families is affected by the extent to which care is valued and supported socially and practically***” (Barnes, 2012:38-39) [My emphasis].

These principles of care must therefore feature within policy formulations not just within grass-roots practice since the possibility of change through political action is dependent upon the appropriate vocabularies being in place, of being able to 'speak' care within policy contexts (MacKay, 2001: 216).

Family Experiences of 'Care' in Family Interventions

The voices of the families and project key workers included here have been drawn from a piece of research conducted on behalf of Lincolnshire County Council to evaluate their Families Working Together service (Bond-Taylor and Somerville, 2013) which pre-dates the Troubled Families Programme launched in December 2011. This service had been initiated in 2010 as one of the 16 community budget pilots for supporting families with complex needs established by the Department for Communities and Local Government to test the extent to which 'joined-up' multi-agency funding and governance structures could provide improved services to vulnerable people. Like the Troubled Families model, the project's family intervention approach was characterised by the allocation of a dedicated key worker to each family to offer a wraparound service, drawing up a plan of support including a range of incentives and disincentives for the family, and co-ordinating the services involved with the family to promote a more seamless delivery. However, the criteria for family inclusion in the service were significantly different, being: families which had at least one child or young person; had a minimum of three needs or challenges; had had involvement from at least four agencies; and where agencies have been working with the family for a minimum of twelve months.

Within this research, we interviewed all 14 key workers and their two practice supervisors, 12 families supported by the service, as well as 30 professionals from a range of partner organisations, including both management and operational staff. The interviews which we conducted with both

families and key workers within the Community Budget Pilot revealed the importance of relationships of care within work with families with complex needs. The ways in which they described the relationship between key worker and family suggested that successful family interventions operate within a care ethics framework, and that understanding the nature of this is of central importance to policy makers.

Some families already had a strong sense of themselves *as a family*, and expected the key worker to take that on board and work around *their* version of what family life was like; as one family member said in praise of their key worker: “She kind of gets us as a family” (young person). For other families, the key worker played an important role in working with them to explore what ‘family’ could mean, and the ways in which families can differ in their structures and relationships whilst still being an effective family unit which meets the care needs of each individual member.

“It’ll mean we’ll have to like... it’ll be a bit trickier but I think doing what [our key worker] told us to do we’ll become like a proper good family.” (young person)

Families were therefore clear that the key worker respected their own version of ‘doing family’, who ‘family’ might include and how ‘family life’ might look within this family uniquely. Moreover, it was of central importance to them that their key worker engaged with them on a personal level and did not treat them as just another family to deal with. Many of the families referred to their keyworker as a friend and saw them as part of the family.

“She takes the interest, not as a social worker but as a friend of the family.” (parent)

“To get into a family you’ve got to befriend a family, and the family’s got to treat them as a friend” (parent)

This was echoed in the key worker interviews, with one describing her role as being “a critical friend” (key worker) and another saying that “you almost live with the family” (key worker). The key worker was perceived by families as having a personal interest in the case, and caring about the outcomes for the family for more than just professional reasons:

“She’s not acting as a case worker or whatever it is you like to call her, she’s acting as a friend. She cared.” (parent)

“She puts her heart and her mind into it, and that is the thing that I’ve never had.” (parent)

This is in sharp contrast to families’ previous experiences of social work which was perceived as impersonal, arbitrary and unjust:

“With the social workers, because it says it, then that’s true, they don’t actually get to know the family.” (parent)

“We were a case and not a family” (young person)

Families identified the ways in which such depersonalised ways of intervening in family life were counter-productive because they threatened to further damage the fragile relationships within the family in that they act to divide and rule rather than to strengthen family capacity:

“[Social workers] were making suggestions to me about my behaviour bringing them up, how to bring them up, and I was trying to do it, and the result was the little bit of love that we had between the family, went out the window. There was a great big wall built up. ‘Oh Dad, you’re always listening to what the social services says. We don’t agree with that’.” (parent)

Indeed, a number of key workers commented on the need to distance themselves from social care from the outset in order to overcome family concerns about letting in “another do-gooder” (parent). As one key worker described:

“One of my first opening lines is that I’m not a social worker and they respond much better realising that you’re there to support.” (key worker)

Establishing trust and honesty were therefore central to the work of the key worker:

“It’s a case of the key worker getting to know the family, because the family have entrusted us, and they’ve allowed us into their lives, so it’s about us as individuals getting to know what it is they would like to see changed” (key worker)

“I generally find with families, ultimately, they want things to change, and it’s building up that trust and relationship with them, so that you can then say to them ‘The only way things are going to change is by you doing things differently’” (key worker)

“Some families, you’re probably the only person that goes in that’s non-judgemental, honest, and straight with the family about things, and encouraging them all the time, praising them when things have worked” (key worker)

Therefore, whilst the intervention of some statutory services is experienced by families as distant, frightening, confusing and unpredictable, families trusted their key worker to support them in engaging with these services, acting as a buffer or intermediary to advocate for the interests of the family as a whole, alongside the best interests of the child.

“Yeah, you know, like, when social services get involved you’re very nervous, you know, are they going to take the children away? All sorts of things run into your head, don’t they? But I find with my key worker I don’t have to worry about that because she’s there to support me and I know that my children are not going to get taken off me and she’s there to support me, and that I’m not there on my own, I don’t have to battle everything on my own.” (parent)

Knowing that you aren’t alone is clearly important and a problem shared may well be a problem halved. For many of the families, the most important feature of the support was just having someone to talk to about their problems, and importantly knowing that someone cared enough to listen to what they had to say, and respected their opinion on the matter. The impact of this on self-esteem was also notable and family members developed further strength and resilience because of this:

“I was happy every day because I loved helping myself. I found it really good that I was doing it, because it’s something that I never done before.” (young person)

“Being able to hold my head up and not down. I can look at people now and not like look away... now I can actually look up and smile.” (parent)

It is clear therefore, that within this service, family interventions reflect relational modes of working with families underpinned by care ethics. Key workers are attentive to the needs of the family, and take responsibility for either the direct provision of support or the co-ordination of other providers. They advocate for the needs of the families and thus also ensure the competent provision of support which meets their needs. They also demonstrate responsiveness to the ways in which families experience the support from their key worker and others and are careful to ensure that their self-esteem are not damaged by the interventions. Trust and respect are central to the relationships established between key worker and family and are also promoted between family members, whilst acknowledging that some relationships may not be capable of being rebuilt and are doing more harm than good (for example where there is a violent partner living in the home). Families appreciate key workers treating them as an individual family rather than as just one case in the case load, and the principle of actuality is clearly evident in the ways in which key workers provide holistic and family specific support within the context of the specific family practices of the household. However, alongside this, they work with individuals within the family to ensure that they also have the space to develop their self-identity. Families value support services delivered within a framework of situated care ethics and families with complex and multiple needs may particularly benefit from these relational strategies of support. Family intervention services certainly have the potential to incorporate care ethics into their modes of working with families in a way which is effective and which is appreciated by families.

Tracing an Ethic of Care in Troubled Families Policy Documents

It has been argued that principles of care are characteristic of the relationships and care practices which take place at the *micro-level*, but are less evident in the normative principles espoused in policy documents at the *macro-level* (Sevenhuijsen, 2003). Even where, on face value, care ethics appear within policy documents, Gilligan (1995) argues that it is also important to distinguish between the articulation of 'care' *within* a justice framework and care as a framework *in itself*, providing an alternative to the justice framework. Within a justice framework, care merely becomes "the mercy that tempers justice" (Gilligan, 1995:36) but leaves the basic justice framework intact. It allows for exceptions to the rule, rather than refining the rules themselves. Macro-level articulations of 'care' values within policy documents must therefore be critically evaluated for evidence of a wider consideration of care ethics, and for evidence of contradictory moral frameworks which will dilute care ethics or provide obstacles to their practical application.

Selma Sevenhuijsen, during research analysing a Dutch health care policy report, developed *Trace*, a methodological framework for policy analysis which "takes the feminist ethic of care as its main point of reference" and aims to "evaluate the normative frameworks of policy documents that deal in one way or another with care" (2004:13). There are a number of subsequent examples of the *Trace* method being successfully used within research projects focusing on an analysis of family and parenting policy. Fiona Williams (2004a) book *Rethinking Families* provides an account of the application of a *Trace* approach within the Care Values and the Future of Welfare (CAVA) research project, and she has also used *Trace* to critically evaluate the Every Child Matters Green Paper

(2004b). Murray and Barnes (2012) have utilised the *Trace* method to undertake an analysis of 'Whole Family' discourses emerging from the *Think Family* policy stream, enabling them to identify dichotomous representations of 'family' within policy documents and to reflect upon the ways in which these are reinterpreted by practitioners working with families.

According to Sevenhuijsen, an ethic of care adds two dimensions to analyses of policy documents. Firstly, it acts as a lens, "a set of spectacles through which the normative frameworks in policy documents can be traced" (2004:16), providing the analyst with "a set of sensitizing questions and concepts that should assist in digging out the relevant elements in policy documents" (2004:16). Secondly, as a framework of moral values, it serves as a standard by which policy and practice can be assessed, and by which discussion of 'care' in everyday life can be illuminated. *Trace* therefore provides a mechanism by which these two objectives can be achieved, allowing an ethic of care to be developed as a methodological and epistemological strategy "in a situated way" (2004: 16) which is conscious of the power and value systems inherent in technologies of knowledge production.

Sevenhuijsen argues that policy documents act as "vehicles of normative paradigms" (2004:14-15) and thus *Trace* offers a method by which these can be identified, unpicked and subject to challenge. Through this, care is positioned as a political concept and as a "social and moral practice in notions of citizenship" (Sevenhuijsen, 2004:14). Normative paradigms configure 'knowledge' in ways which construct social problems as particular kinds of issues and concerns, in order to regulate social life. They thus act as 'modes of governance', and determine the power relationships between political authorities and their subjects, reflecting Foucauldian analyses of purposive discursive formations which constitute the subject (Foucault, 1972; see also Henry and Milovanovic, 2003).

"From this perspective normative paradigms are broader than value statements: they also contain modes of defining problems and recurrent ways of speaking and judging. By preferring certain narrative conventions and modes of communication, policy documents encapsulate power. They confer power upon certain speaking positions and vocabularies, and are therefore instrumental in producing hegemonic discourses, in including and excluding certain modes of speaking."
(Sevenhuijsen, 2004:15)

Sevenhuijsen's *Trace* method therefore provides a useful mechanism for the analysis of documents generated within the Troubled Families Programme. Most notably, DCLG has provided guidance for local authorities within the document, *Working with Troubled Families* which describes its objectives thus:

"...this report is an aid for that change. It is a tool to help local authorities and their partners, who have asked for guidance on how best to work with troubled families, and for the evidence about family intervention to be brought together in one place" (DCLG, 2012: 6)

Commentators have already pointed out that the depiction of this report as 'evidence-led policy making' is problematic (Levitas, 2012; Portes, 2012; Talbot, 2013; Hayden and Jenkins, 2014), particularly given the fact that it does not offer a full review of the literature and draws some of this evidence from the widely criticised report by Louise Casey, *Listening to Troubled Families*. These two reports are presented as operating as a pair, with reference to each report contained (explicitly or implicitly) within the other. Within the conclusion of *Listening to Troubled Families*, it is described how, "The next part of the challenge will be to understand more about how the success with families

is achieved, and then to seek to widen this approach to a far larger group of families across the country; to reshape, redesign and refocus services” (DCLG, 2012: 64). Then, in Casey’s foreword to *Working with Troubled Families* she indicates the report’s origins in the interviews conducted for *Listening to Troubled Families*: “I wanted to set out for the first time in one place what these families had told me about what it was about family intervention that had been different, in the context of the evidence about the family intervention approach” (DCLG, 2012: 4).

The family intervention approach advocated within *Working with Troubled Families* is grounded in family focused working and can be seen to reflect an ethic of care in a number of ways, illustrated by the statement:

“This work requires a single dedicated worker to walk in the shoes of these families every day. To look at the family from the inside out, to understand its dynamics as a whole, and to offer practical help and support” (DCLG, 2012: 4)

The notion of shifting perspective to assess families “from the inside out rather than the outside in” (DCLG, 2012: 26) is an acknowledgement of the importance of understanding the unique contexts of family life and to develop a deeper understanding of the ways in which individuals within families are interconnected rather than autonomous. It is argued within the report that families often see traditional services as failing to understand them because they don’t see the whole picture, and instead attempt to provide numerous individualised responses to problems which are isolated from each other. This reflects concerns by care ethicists that ‘justice’ oriented approaches fail to take into account the constraints on decision making which individuals face when they consider their caring and interpersonal obligations. For example, actions taken within a school to punish a young person for their non-attendance will have little impact if they are frequently absent in order to support a parent with physical or mental health needs. Moreover, understanding the specific dynamics of households and the family practices in which they engage enables the care ethics principle of actuality to be actioned, with family workers being attentive to the direct needs of each *individual* family rather than ‘troubled families’ as a whole. This can generate more appropriate ‘bespoke’ responses, particularly where “workers can identify strengths that the family may have and involve the family in coming up with solutions” (DCLG, 2012: 25).

Understanding families and their complex biographies is described as demanding considerable empathy from the dedicated family intervention workers who are seen to be “standing alongside the families, their difficulties and the process being put in place” (DCLG, 2012: 18). This empathy is essential in trying to understand how things *feel* for the family (DCLG, 2012: 25) and thus provides an anti-dote to neo-liberal perspectives which focus on measurable outcomes rather than more subjective evaluations. However, empathy is also seen within this report as a strategy for making families more receptive to behaviour modification interventions since “The skill needed on the part of the key worker is the ability to deliver tough messages with empathy, and based in a real understanding of the families’ situation” (DCLG, 2012: 24). What is different about family interventions in comparison to family experiences of other services is that the family worker does not merely provide the tough message about what needs to change, but that they are also active in supporting the family to make these changes and to understand how to do so.

The provision of practical help and support is therefore also an important feature of family intervention work from a care ethics perspective. The care ethics principles of responsibility and

competence demand that key workers provide adequate support for families and do not merely issue ultimatums about what needs to change. They must engage with families to provide practical solutions to help families overcome the specific obstacles to change which they face. The provision of practical help, of literally donning a pair of rubber gloves and working with families on cleaning and clearing jobs within the home is also seen as an important way of building trust, a key principle of care ethics. Honest and productive relationships of trust are seen within the report as integral to the family intervention approach and practical support can initiate this since they “signal to families that the worker intends to keep their promises and is there to help” (DCLG, 2012: 21) thus setting out how this service differs from others experienced by families in the past. This again is seen in the report as enabling more coercive messages to be given to families about their situation “including absolute clarity about what needs to change, how it can change and the consequences of not doing so” (DCLG, 2012: 24).

The report also recognises to a lesser extent the impact on the emotional well-being of the family members of the provision of family support grounded in empathy and trust. This is illustrated within the report through a quote from one of the Listening to Troubled Families interviews:

“L [the worker] were the first person to ask me that. And I think, maybe because I talked through all my personal stuff, that I felt I could trust her...She asked me things, though, that no-one else ever asked me...She wanted to know...and it was just nice to know that she actually gave a stuff about helping me rather than just getting what she needed done, done.” (DCLG, 2012:17)

This statement echoes an ethic of care in that the interviewee clearly values the fact that the key worker actually cared about her as an individual, that she ‘gave a stuff’. Not only does this illustrate the importance of attentiveness to need, and principle of actuality with the interviewee treated as an individual, but it also depicts the importance of the recognition of selfhood, of being able to share biographical experiences and present ones ‘self’ as worthy of support. This is echoed elsewhere in the report:

“Families can feel that the relationship with a case worker is very different to other agencies. They are clear that they want to feel that they are treated as a human being, that they are listened to, and that their individual circumstances are being taken into account.” (DCLG, 2012:20)

Building these relationships equally enable families to see their support workers as human beings, as “just normal people” (DCLG, 2012: 19) rather than as representatives of an agency (eg social work, the council etc). The report describes how families tend to talk about their key worker by name and see that it is they as an individual, rather than the service in which they are located, that has helped them improve their lives (DCLG, 2012:19). This relationship enables the key worker to support families who often have lengthy histories of unsuccessful service referrals, characterised by poor communication and depersonalised interventions. Through advocacy and service co-ordination they can begin “re-opening communication with these agencies” (DCLG, 2012:17).

However, in order to do so, the importance of trust and relationship building is extended to the multi-agency partnerships in which key workers operate, and the report acknowledges that they need to be “invested with the trust and the support to oversee what the family really needs in order to change” (DCLG, 2012:28). This further illustrates a point frequently made by care ethicists, that

individuals are rarely either care providers or care receivers, and that those providing care also need care to support their own needs in that process.

Challenges to Care Ethics within Troubled Families Policy Documents

Alongside these depictions of the family intervention model as characterised by care ethics, there exists extensive legalistic language which perhaps reflects an ethic of justice rather than an ethic of care. In particular, the notion of contractual arrangements for support is a significant feature of the Working with Troubled Families model, based in the strategy developed within the original Dundee Families Project model which saw “families signing up to a contract that offered a mix of support and challenge to them with a new threat of sanction if families refused help” (DCLG, 2012:11) and which elsewhere in the report is described as “a written contract that the family and agencies sign” (DCLG, 2012:23). This language of ‘contractual governance’ (Crawford, 2003) is founded in the liberal notion of two free and equal parties making a fair exchange of terms for mutual benefit. Yet in the context of family interventions, this raises questions about the relative power of the ‘parties’ to the contract to determine the conditions and the penalties for non-adherence, echoing Crawford’s critique that such contractual governance is ‘inauthentic’ and facilitates ‘regulated self-regulation’ (Crawford, 2003: 488). Whilst some examples are given of the benefits for the family members, such as redecorating childrens’ bedrooms in return for their attendance at school, elsewhere this is unclear and the benefits appear to be simply the avoidance of sanctions, such as eviction for non-maintenance of property as in the following case study in the report:

“Lisa challenged the family about the state of the property and put in a contract with the family which required them to meet certain conditions – for example keeping it clean.” (DCLG, 2012:7)

Indeed the threat of sanctions is depicted as essential for the success of the family intervention model since “the threat of sanctions such as loss of tenancy ‘concentrates the mind’ of families and is a key mechanism for bringing about change” (DCLG, 2012:28). This understanding of human behaviour in terms of the autonomous, rational calculation of risk and reward certainly reflects a model of justice ethics which stands in sharp contrast to the relational understandings of families depicted elsewhere in the report.

Moreover, the need for sanctions and ‘tough consequences’ as a strategy to secure engagement depicts ‘troubled families’ as devious and evasive, and this is echoed in the repeated use of language to describe the family intervention service engagement with families. Here we see that “Families and their problems are gripped”(DCLG, 2012:27), that “Cases are not allowed to drift” (DCLG, 2012: 27) and that doing too much for families is “allowing them off the hook” (DCLG, 2012: 22). Key workers are thus described as “persistent, tenacious and assertive” (DCLG, 2012: 23), as “relentless” (DCLG, 2012b: 24), and as “authoritative and challenging” (DCLG, 2012: 27) and that this is necessary to prompt a “wake up moment” (DCLG, 2012: 27) for families. It is therefore illuminating that at times within the report, families are described passively as having being “worked with” (DCLG, 2012: 11, 14) rather than as active and equal participants in generating solutions and moving the family forward. There are therefore some clear tensions between the depictions of care-full engagement

with the feelings and experiences of families and the practice of engaging families through threat of sanctions.

In addition to these tensions within the Working with Troubled Families report, the depiction of a holistic family intervention model based in care ethics within this report stands in even more marked contrast to the stereotypical and stigmatising depiction of families in the Listening to Troubled Families document (Casey, 2012). Here, families (or at least some family members) are held responsible for the problems which they face with seemingly little attempt to take into account wider contexts:

“...it was clear that the reasons for that behaviour had come from the household itself – the poor parenting skills, the constant changes in the home, family and partners, and the ongoing verbal and physical violence” (Casey, 2012: 59)

The use of rhetorical devices such as ‘it was clear’ (Casey, 2012: 51, 54, 59), “Unsurprisingly...” (Casey, 2012: 50) or “Understandably...” (Casey, 2012: 50) appear throughout the report to demonstrate the strength of the position Casey is taking. In this way, Casey’s perspective is positioned as absolute whilst families’ perspectives are frequently denied/undermined, for example:

“Many of the families complained about professionals or agencies involved with them, and in particular, social services. However it would not be fair to always lay blame there when looked at dispassionately.” (Casey, 2012: 51)

By contrast, the report consistently apportions blame to families without corroborative evidence, in spite of the fact that they have also reported being failed by services. Families are portrayed as non-cooperative, with claims that they lied to professionals, blagged, refused help, refused to cooperate, deflected inquiries etc (Casey, 2012: 51). Yet suggestions by families that professionals may have also done these things are deflected.

Whilst Casey claims that “No judgements are made on individual families” (Casey, 2012: 2) the judgment made on ‘troubled families’ as a whole is that they are entirely “dysfunctional” and this dysfunction is positioned in opposition to “normal” families:

“The impression of families’ isolation from more ‘normal’ or positive friends or networks came across strongly...They tended to stick with a network of other dysfunctional peers.” (Casey, 2012: 50)

Families struggling to cope with the complex circumstances in which they find themselves are therefore further undermined by this unhelpful creation of stigmatising discourses in which the language of ‘troubled families’ is used to present the families as ‘other’ rather than to understand families “from the inside out” and develop empathy and care-full systems of support. Thus whilst these two reports are presented as a pair which work together, with one informing the other, the depictions of ‘family’ and the support which they deserve are quite different. It is much more difficult to see care ethics influencing the Listening to Troubled Families report than it is to see it within the Working with Troubled Families report.

Within this purported exercise of “listening to troubled families” it is also important to reflect upon what is omitted from the report as well as what is included. The report features a list of the

characteristics of ‘troubled families’ which emerged from Casey’s interviews, including: intergenerational transmission, large families and shifting family make up, dysfunctional relationships, anti-social family and friends networks, abuse, institutional care, teenage mothers, violence, early signs of poor behaviour, school, anti-social behaviour, mental health problems and drug/alcohol abuse (Casey, 2012). From other research with similar families (Bond-Taylor and Somerville, 2013; Davies, 2011; Mitchell and Campbell, 2011; Morris, 2012), it could reasonably be expected that this list would have also included poverty, inadequate housing, disability and physical ill health, yet these are conspicuously absent here. It also seems incongruent that worklessness is not identified as a concern in spite of the fact that it then forms one of the key criteria for payments by results under the new Troubled Families Programme.

Similarly, the issue of gendered power relations is not identified within either report, in spite of the fact that gender fundamentally shapes the nature of ‘family’, the relationships within families, and the biographies of harm and abuse experienced by family members. The gender neutral language of ‘parent’ and ‘parenting’ is used extensively, in spite of the value judgements that are made on a gendered basis (eg in the references to teenage *mothers*) and the fact that these forms of intensive family support, and the sanctions attached to them, tend to be levied at families headed by a lone female (Parr, 2011). Engaging with a *feminist* ethic of care would require issues of gender to be rendered more visible and for support to families to consider underlying assumptions around the gendered distribution of ‘caring’ responsibilities and the subsequent impact upon women’s social and economic independence. Projects promoting the ‘empowerment’ of the family often serve only to strengthen existing power relations within the family, and between family (and especially mothers) and local authority services (Bond-Taylor, 2014b). Interventions within families which fail to address such concerns or to prioritise the rights of women to make lifestyle choices have the potential to reproduce patriarchal relations and to subject women to additional social control (Dominelli, 2002).

Finally, the model of family intervention described within the Working with Troubled Families document appears to be also threatened by the processes put in place to roll out ‘troubled families’ interventions across England. The examples of good practice in the report, which appear to reflect care ethics and upon which the ‘troubled families’ model is constructed, are not taken from work within the Troubled Families Programme but from other pre-existing family interventions programmes developed under New Labour, such as FIPS and family pathfinders. Therefore, even if the model of working which is advocated demonstrates some potential for success, questions must be raised about whether such good practice could continue within the new framework. The Troubled Families programme with its payments by results process developed a much narrower set of criteria for inclusion, and with it the potential to direct interventions with families towards those specific criteria for which payments could be claimed, ie crime and anti-social behaviour, worklessness, and school exclusions and absences (Bond-Taylor, 2014a; Bond-Taylor and Somerville, 2013). Whilst more recently, additional criteria have been developed for identifying families for support, including domestic violence, ‘children who need help’ and ‘parents and children with a range of health problems’, tackling these issues does not qualify for payments, and the focus remains upon addressing a narrow range of problems experienced by these families with little weight given to the role of ‘softer’ outcomes in improving family well-being (Batty, 2013).

Furthermore, the Troubled Families Programme advocates the development of cheaper 'light' and 'superlight' versions of the model where families are smaller or are seen as having fewer problems (DCLG, 2012: 31). This will be reflected in the key worker case load with, for example, 'family intervention light' seeing case loads of 5-15 families per worker (in comparison to 5 or fewer in the standard family intervention model). The impact of carrying this considerably larger case load must be to reduce the time available to spend with families and thus build constructive relationships with them. This therefore has the potential to water down productive family focused activity and to effectively prevent the incorporation an ethic of care into family support. It is important to remember that "Such a project cannot be chopped up into short-term, time-limited, discrete 'interventions' delivered by disembodied experts" (Featherstone et al, 2013:1745) and thus the shift to family intervention 'light' and 'superlight' versions should be avoided in order to give the time and space to develop meaningful relationships of 'care' and support.

Conclusions

Families who have experienced support from a dedicated family intervention service describe the support which they have received in terms of care ethics. They judge the value of the interventions in terms of the quality of the relationships built between their family members and between the family and their key worker. Strengthening relationships provides an important underpinning for the improvement of family outcomes across a wide range of issues. Care-full support for families provides the opportunity to uncover the complexity of disadvantage and need within a household, to understand the family practices which are integral to maintaining the sense of family identity and thus to generate resilience in the face of adversity by establishing contextualised solutions. Moreover, the positioning of the key worker as advocate between families and other statutory services provides a buffer which enables families who have become labelled as 'troubled' or 'troublesome' to challenge this depiction and to hold services to account in meeting their needs. There is considerable evidence therefore of the value of care ethics within the construction of services designed to support disadvantaged families.

Sevenhuijsen's (2004) *Trace* method provides a useful framework to trace the normative paradigms within Troubled Families policy documents and to evaluate the role of care ethics within the policy. Whilst *Listening to Troubled Families* and *Working With Troubled Families* are presented as a pair of reports in which the former uncovers the problems faced by so called 'troubled families' and their alleged causes, and the latter offers a solution, they are actually quite different in tone and in their portrayal of families. There is also a considerable difference in the extent to which these reports demonstrate an ethic of care. *Working with Troubled Families* offers a model for family intervention which clearly draws on care ethics principles of trust and empathy, holistic approaches to identifying need and determining how to meet such needs, alongside a collaborative and relational focus to delivering interventions. By contrast, *Listening To Troubled Families*, in spite of its title and the implication in Casey's foreword that she wants to uncover families' stories, tends to undermine the

families' accounts, presents 'troubled families' in a stereotypical format as a homogenous group with a fixed set of problems (rather than each as unique), portrays them as evasive and/or passive in the face of engagement with services, and blames mothers in particular for their predicament. The importance given to the use of sanctions as a means to secure engagement and to promote change reflects an ethic of justice which attributes considerable autonomy to family members.

The body of work which has been generated on 'care' as a moral framework is of considerable value to any analysis of the Troubled Families Programme, its various predecessors or any future iterations which successive governments might bring. The work of 'doing family' requires 'care', but so does the work of supporting families. The challenge is therefore in creating systems of support which generate the spaces for key workers to build relationships of trust with families, to develop relational understandings of their needs and to explore specific and contextualised solutions and strategies of support. Questions about the caseloads allocated to the key workers, the time they can spend with families rather than on paperwork, and the pressures that they might be under to evidence measurable results for the financial sustainability of the service demonstrate the importance of viewing 'care' as a political issue and not merely a private, domestic practice.

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