Family Aide Services in Victoria

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Data has been gathered by the Family Aide Projects Association from family aide services throughout the State of Victoria to enable policy and program decision making within the family aide program to be better informed. The 52 member agencies were canvassed to generate information which gives a more comprehensive picture of the operation of services than previously available. This paper presents a summary of the survey process and outcome.[1]

INTRODUCTION

The aim of the program as defined by the Family Aide Program Review Steering Committee (1988)[2] is:

> *To enable and empower families with dependent children, lacking family management and parenting skills, to cope more effectively through the development of skills and strengths.*

Family aide services are based on non-professional helpers working under professional supervision to provide such support and can be described as multi-input support and development services centred around the family aide's dual input of —

- *personal emotional support and task oriented help; and*
- *Casework/family support and counselling.*

— provided via a *team approach* to family problems and stress.

It became apparent to the Executive in early 1988 that informed policy and program decisions could not be made without current information on the services being delivered; so it was decided that a survey should be carried out to compile a picture of the operation of family aide services of which 34 programs are located in Community Services Victoria metropolitan areas and 14 in CSV country areas.

METHOD

The survey instrument was a detailed 16 page questionnaire developed by the project officer in collaboration with the Executive Committee and refined through a workshop process at a Family Aide Projects Association general meeting.

The survey contained four different groups of questions seeking — basic information about programs, models of intervention, staff and case data; and each question was accompanied by an explanation as to why the information was required. All 52 agencies indicated willingness to participate and 48 agencies completed the survey. The information obtained was collated and stored in computer data bases under the confidential control of the project officer.

Several workers commented that the exercise of filling in the survey was, in itself, a useful review process. One program reported modifying the delivery of its service after reflecting on the referral sources of cases.

SURVEY RESULTS

Program Establishment

Figure 1 depicts from the survey, the year and number of family aide projects established. Concepts of family support increased, with the highlighting during the 1960s, of the inadequacies of a child welfare system. Frequently children were separated from their families, causing considerable distress to both child and family and often leaving the child psychologically scarred for life. This increase in theoretical knowledge of children's development occurred along with an enormous escalation in the costs of substitute care. The 1975 Federal Government initiative, the Alternative to Residential Care Projects Program, aimed to shift the focus of child welfare from substitute care to family support and provided an impetus for experimentation in family support services and hence the establishment of family aide programs. These programs aimed to maintain children within their families within the community in the hope that this would not only relieve distress but be cost effective as well.

Settings for Family Aide Programs

As there is often a vital link between the location, auspice, sponsorship and funding of family aide projects, services were divided into six types —

- Family Support Services
- Foster Care Services
- Permanent Care Services
- Residential Care Services
- Youth Services
- Specialist Services

— and agencies asked to identify those services provided alongside their family aide program. In all agencies except one, delivery is accompanied by other family support services.The exception is an incorporated service which is accountable to a committee of management, and sponsored by local government and the community who contribute towards funding costs.

Fourteen agencies combine family support services with those targeted towards youth. Practice experience finds that vulnerable families tend to have repeated crises at different stages of their development and require a different focus of assistance in each crisis. Thus the combination of family support and youth services fit well together and this advantage of continuation of services to families beyond a focus towards young children seems to have been recognised by auspice/sponsoring bodies.

Auspice/Sponsoring Organisations

The distribution depicted in *Figure 2* shows that a range of different types of auspice and/or sponsoring organisations for family aide programs have evolved since the inception of family aide services.

Thirteen family aide programs are directly sponsored by local government, some actually auspiced by local council community services departments. Church welfare agencies auspice twelve agencies delivering family aide programs. Some of these agencies operate under the direction of a local committee of management although ultimate accountability usually rests with the auspice agency. Seven agencies are independent or autonomous organisations. Five of the agencies are sponsored by independent church organisations. Three programs operate as part of a community health centre. Three programs are operated by CSV, two from regional offices — Goulburn and Barwon, and the third from St. Kilda Family Support Unit but accountable to the CSV office at St. Kilda. Two programs are part of agencies which are branches of a larger organisation. Two programs are auspiced by country hospitals. There is one program delivered by an agency managed by a separate body which is a non-government organisation. Twenty five programs are located at different addresses to their auspice or sponsoring organisation.

Funding

The Family Aide Program is a sub program of Community Services of Victoria Family Health and Support Branch, Family Support Program. However funding of programs is complex and the research aimed to ascertain the percentage of funds obtained by agencies for running their family aide programs from each source as distinct from the total agency running costs.

The findings from the data showed that in the majority of cases continued operation is dependent on funds from two or more sources and all programs depend on continuing support from Family Health and Support, including the special case of a demonstration project funded till the end of 1988 which will then require CSV funds to continue operation. Although seven programs receive 100% of the cost of running the program from the one source it is not certain that administration and oncosts were included in the calculation. Many programs incur peripheral costs such as those for —

- materials for group activities and outings
- educational speakers for user groups and staff
- holiday camps for parents and children
- toys and equipment for developmental child care groups
- stocking material aid resources for specialist consultants

— which are further complicating factors for budgeting. Programs are often reduced to scrounging for funds to cover these sorts of expenditure.

The relative size of programs was estimated using survey data on the numbers of hours worked in each program by co-ordinators and family aides (paid and unpaid). These estimates were used with the survey data on funding sources to generate the information on the relative importance of the various funding sources as graphed in *Figure 3.* It is, at best, an approximation as the survey did not obtain details on hours which counsellors, other professional and administrative staff devote to family aide programs. A further difficulty arises in that in some programs family aides are paid whilst in others all are unpaid; 14% of the total family aide hours worked in the State fall into the latter category. These unpaid hours have been included in the calculation of funding distribution as a separate source of funds. If they are excluded the share attributable to Family Health and Support would rise from the 45.7% shown in the pie chart to 52.1%.

With no clear policy for the funding of programs, funding patterns appear to have been ad hoc with agencies seeking funds wherever they could. Thus it might be concluded that the extent of family aide services provided is more a measure of good luck in attracting funds than a measure of meeting local needs.

Needs based funding might change this pattern by more rationally directing family aide resources to agencies and locations with the highest needs. Needs analysis is complicated by the fact that family aide services are provided both at the primary prevention level and at secondary/tertiary level of family support service provision. Whilst avoidance of institutional care was the original focus of service provision the advent of funding from other sources (such as the Victorian Government Family Life/Family Strengthening Program, family and community service grants, mental health division of the Health Department and Local Government) has led some services to move towards the primary prevention role.

Some family support funding which originated in the Commonwealth as special purpose direct grants to agencies have now been transferred into the base of the Family Health and Support Program for the State to manage. Therefore, in summary, 36 programs are funded through Family Health and Support. However, in only five cases was 100% of costs indicated, with uncertainty as to inclusion of hidden costs such as accommodation. Six cases are covered for between 90-95% of costs, 24 for between 50-89% and one at 36.5%, two instances where 100% and 50% of funding comes from the Commonwealth Office of Child Care and two similar cases for the same amounts from other CSV funds were collapsed under Family Health and Support.

Other funding sources included Local Government, family and community support grants, extended family care, home and community care (50% of one program's funds), Health Department, agency auspice, other agency funds/sources, and outside agency sources. The percentage of these funding sources contribution to program costs ranged from 4.93%-100%.

Funds for Special Target Groups

Funding for special target groups occurs in ten programs although others commented that whilst they were not specifically funded to work with particular target groups they were working with families with psychiatric and intellectual disabilities. Four programs receive funds from the Office of Psychiatric Services to employ a family aide to work specifically with families where there is a psychiatric problem.

One program had been funded for one family aide for one year through the Office of Intellectual Disability Services to work with one particular family. One program operates as part of a residential facility for single parent families with preschool age children; another provides family aides from an agency which assists pregnant women and families with at least one child under two years. Three other programs listed special target groups as:

'Families in distress, children at risk'
'Multi deficit/excluded families'
'Low income, disadvantaged families'.

One program gets 5% of its funding from the Department of Sport, Youth & Recreation to work with isolated women.

The definition of 'special needs' requires clarification in terms of funding issues of services to families with such needs. Children's special needs can arise either from parental role limitations or a disability of a child. Children often need the increased developmental opportunities which are being created through the Family Aide Program. The question could be raised as to how family aide services fit into the future arrangements of specialist child and family services.

FAMILY AIDE PROGRAM STAFF

The survey showed that 270 people were doing family aide work, 209 as family aides and 61 as family aide volunteers; the majority in both categories work part time with the total number of hours per week worked by family aides employed by projects equalling 3709 hours per week.

If a 38 hour week is assumed an estimate of 97 effective full time units is obtained. This number of family aides correlated to the 916 families who constituted the current caseload would give a caseload of nine families per effective full time aide. There is an important relationship between the family aide program staff and agency staff in terms of ready access to other services for families and the availability of professional welfare workers to act as casework team members. Also in situations where the family aide program is not resourced for administrative personnel, workers depend on agency administration for support.

Forty six programs employ 48 family aide co-ordinators, the majority as part time workers; 15 are full time, 29 part time and three are casuals. One program had an unfilled co-ordinator position. The access to co-ordinators by their aides after hours is an issue both in terms of employment and case management. Survey data revealed that in 30 programs co-ordinators were on call for crisis situations and/or management issues out of hours.

Fourteen programs specify 31 family counsellors; five programs employ 12 full time, eight employ 17 part time and one employ two as casual workers. A further 43 agency family counsellors were recorded, spread over 34 agencies. In 14 programs there were no family counsellors either attached to the program or the agency. This situation calls for further investigation in the light of the high proportion of vulnerable families with whom the programs are working. It may reflect some situations where there is a 'contracting out' of agency family aides (using a family aide to work with a client family of an external agency) to counsellors in those external agencies.

A complicating factor in the ratio of counsellors to programs is that although a particular counsellor may be technically available to participate within the family aide team as caseworker and/or case manager and therefore to supervise a family aide in relation to a case, his/her orientation to the professional role may preclude such participation. The increase and spread of popularity of family therapy has led to an increasing specialisation of some family counsellors towards this method of family intervention away from the more traditional social work casework counselling support role. Also many families do not meet some of the criteria for therapy which underpin the family therapy approach. This issue of actual clinical practice and the role of family counsellors funded under the Family Support Program requires clarification in relation to family aide services.

Thirteen programs have 21 administrative staff, only four being part time. There were some comments that agency administrative staff were available to do work for the family aide program. Eight programs utilise 153 part time and casual volunteers (these are distinct from family aide volunteers).

The role of volunteers within programs is an area not adequately covered in the survey and which could be researched. The issue of accountability and responsibility needs to be clearly defined in situations where volunteers are supporting families where children are identified as being 'at risk'. Structured pilot or demonstration projects could if appropriate be developed to tap this community resource.

Hours of Work

The hours per week worked by family aides is summarised in *Table 1.* Results showed most family aides work part time; the largest groups were 27% of paid family aides working between 16-20 hours per week, and 21% of unpaid family aides working between 1-5 hours per week. One agency explained that their aides were part of a 24 hour, seven day per week roster and therefore shared caseloads rather than working with specific families.

The out of hours availability of aides to families they are working with is sometimes an important consideration. In several programs availability is at the discretion of individual workers, in others 'not usually', and in two 'not officially'. Eighteen programs have family aides on call for crisis situations and/or management issues. In two programs there is an on-call roster. Only two programs specified that out of hours work was covered by an on-call/re-call wage loading, two more commented that time in lieu was available instead.

Travel

Family aides often travel considerable distances both in reaching client's homes and in transporting clients. This is particularly difficult for country programs where the distances are often excessive and consume a considerable proportion of family aide hours.

Models of Family Aide Work

The Family Aide Projects Association Standards document states under a 'Procedures' heading that an agreement "is drawn up between the family, the co-ordinator, the family aide and the caseworker. This would seem to assume that the four components listed, constitute the team approach, which could be described as a 'basic model' of family aide service intervention."

There are, however, a number of variations on this basic model in operation and a lack of accurate information on the different models and the frequency of their use. Data collection is complicated when each family aide case is individually assessed, the combination of workers varies according to the family needs and resources available. There may be several different models operating within the one family aide program and the caseworker role may be carried out by an internal or an external agency worker. The research aimed to identify these variations as well as another important issue which relates both to practice and funding standards viz. whether or not co-ordinators and caseworkes have welfare qualifications and experience.

The survey findings confirm that there is an enormous range of variation of models which assist families and the number of team combinations reported ranged from one to 24. One program which listed eight alternatives added 'plus a myriad of combinations'.

The flexibility with which family aide service input to families can be tailored to meet the requirements of individual situations and settings — resource limitations permitting — has advantages and disadvantages.

A positive outcome can be predicted with a fair degree of confidence if there can be an accurate assessment of the family stress and functioning levels and potential for change, sufficient resources for a sensitive match with an appropriate family aide and mutually agreed goals can be negotiated within the framework of a *service plan* specifying roles, tasks and accountability. However the multiplicity of settings and models makes the development of, and adherence to, standards complex. Further study is required to determine the most effective and efficient team combination and the impact of setting and auspice on the model employed.

Location of Work
The survey shows, *Table 2,* that only 29% of family aide work is conducted solely in the client's home, with 45% being partly in the client's home and either agency or non-agency premises.

This data would seem to refute the sometimes mistaken perception that most of family aide work is confined to families in their homes and equates with the home help service provided by councils. Many families indeed require home help but the issue of overlapping roles, and models of combination family aide and home help service needs clarification and research.

Method of Family Aide Intervention
The method of family aide intervention varies between individual work with families and children on a one to one basis, working with people in a group work setting, a combination of both individual and group work and other combinations of working with people in the community. *Figure 4* shows the percentage use of these alternative methods. The focus of and emphasis for centre-based group work varies between task/activities, education, social, emotional and mutual support. However all groups aim at increasing self esteem, assertiveness and skills in users.

Supervision
There are two components to supervision for family aides — case supervision and overall management pertaining to administration, education and support of aides.

A considerable proportion of family aide work centres around critical aspects of family functioning as reference to the section on case data will uphold and the access to and quality of supervisors is of paramount importance. This requirement seems an unacknowledged part of working conditions, only one program reporting that aides were not able to make contact with the co-ordinator out of work hours.

There is also the issue of who is supervising and supporting supervisors. In seven programs co-ordinators do not receive supervision and in one, only 'sometimes'. In one program supervision was 'as requested' and provided 'informally' in another. One program provides an external agency supervisor for the co-ordinator at agency cost and in two programs co-ordinators obtain external agency supervision at their own cost. One program commented that external agency supervision was 'desperately needed'.

Management Supervision for Aides
In 46 programs co-ordinators provided overall management supervision to aides. In seven programs this supervision was also provided by another person, and in one program only by a person other than the co-ordinator. In one program three aides receive no management supervision but do receive case supervision from a co-ordinator.

Case Supervision for Aides
The program frequencies for the different types of case supervision are not straightforward as family aides were split between the categories within individual programs, but to summarise, 30 programs had aides supervised by the co-ordinator, 24 by combined co-ordinator/agency caseworker, 18 by combined co-ordinator/external agency caseworker, 10 by an agency caseworker, and nine by an external agency caseworker.

In three instances case supervision was provided by a visiting child health nurse although one program commented 'just for the record we feel this is quite inappropriate for a visiting child health nurse to supervise a family aide'.

Case Data
The current caseload at the survey completion date constituted 916 families, children under five numbered 870, children between six and twelve years 647 and children 13-17, 225. The predominant focus of family aide work being with families with young children is reflected by the great number of children under five years of age.

The fact that family aide work has always been with low socio economic and disadvantaged families, would seem supported by the large proportion of people on some form of benefit. From 44 programs 673 people were benefit recipients.

Fourteen programs have a waiting list with 77 cases waiting for family aides.

Referrals
The 916 cases were spread over 60 different referral sources with the source of four unknown; 80% of the referrals came from 20% of referral sources. The greatest proportion of referrals originate from Community Services Victoria sources. In terms of the Government's Social Justice Strategy and the principle of access to services, the fact that the second largest proportion of referrals can be considered *self referrals* (by combining the self, friend/neighbour and relative categories) would seem to indicate the accessibility of services to those in need of help. The third grouping, that of referrals which originate from other services within the same agency or auspice, would indicate the importance of family aide programs being delivered along with other family support services.

Periods of Family Aide Involvement in Cases
Figure 5 shows the percentage distribution of caseload by period of family aide involvement in current cases. The length of time in which family aides work with individual families has important implications for policy and funding of family support services.

Target Groups
Although only a few programs are specifically funded to work with special target groups the data summarised in *Table 3* indicates that programs are in fact working with particular target groups. One program pointed out that there were a large proportion of depressed people among their caseload who were not actually diagnosed as having a psychiatric problem.

One program added a detailed comment specifying that they had 17 children identified as being 'at risk' of ending up in long term substitute care if the parents were not supported and another five identified as being 'at risk' of immediate protective action if support services not supplied.

The high proportion of children 'at risk' (50% of the total caseload) and of domestic violence/spouse abuse (20%) in the survey results support the view that family aide work is involved with critical aspects of family functioning. It is also a compelling argument to ensure that programs are funded at a level which can attract experienced and qualified workers. Further it should raise discussion about the way in which human services in the United States have recognised the failure of child protective services and have swung attention to an emphasis on family support, funding pilot/demonstration blended programs which provide comprehensive social support to families with children 'at risk'. Attention should also be given to the research which has demonstrated that it is possible to pre-natally identify people at risk of maladaptive parenting, and pilot early intervention programs for vulnerable parents similar to models such as the New Parent Infant Network Project[1] operating successfully and cost effectively in the United Kingdom.

Given that single parents are often considered to constitute vulnerable families the 42% represented within the caseload is a significant figure.

CONCLUSION

The survey has produced a more comprehensive picture of the operation of family aide services than was previously available. It has shown variations between services both in auspice/sponsoring organisations and service delivery yet similarities in target groups and referral sources. The information is not only of immediate application to specific issues but provides a basis for further research which, with the proposed Family Aide Projects Association computer based management information system, will provide data on which future policy and program decisions may be made. Some findings of particular interest were:

Vulnerable families — reference to the categories of major reasons for family aide intervention within the section on case data reveals the large number of instances in which families can be considered vulnerable to high stress levels.

Referral sources — the number of self referrals would seem to reflect the acceptability of family aide style of work by the community.

Auspice/sponsoring organisations — the research showed up an interesting range of auspice and settings for services reflecting the diverse way in which family aide work has been recognised as an important component of wider family support services.

Length of Family Aide Involvement in Cases — the survey suggests that there are families for whom long term intervention/support is essential for their viability. This issue is not always understood by policy makers.

The information generated by the survey and its process has led to the following conclusions:

The program is making an important contribution to child welfare in Victoria. With 916 families encompassing 1,742 children being supported by family aides with a further 77 cases waiting.

The majority of programs have a keen appreciation that monitoring, evaluation and research not only in family aide services but all family support services, is needed if the quality of services is to be improved for the benefit of everyone involved — *users,* workers, local and auspice management, the Association and Government Departments.

This positive co-operative attitude to evaluative structures and processes by the grass roots of family aide services means they will be able not only to empower users, but themselves, as agents of change, by participating in data collection both through the proposed computer based management information system and audit surveys to generate the information essential for informed decision making.

REFERENCES

1. The Family Aide Projects Association *Report on Survey of Family Aide Programs,* April-July, 1988.
2. Family Health and Support Branch of Community Services Victoria *Report of the Family Aide Review Steering Committee, 1988.*
3. Pound, A., Mills, M., & Cox, T., A Pilot Evaluation of 'Newpin', a Home-Visiting and Befriending Scheme in South London.

Table 1
SUMMARY OF HOURS PER WEEK WORKED BY FAMILY AIDES

FAMILY AIDES				
	Paid		Unpaid	
Hours	*Nos.*	*Percent*	*Nos.*	*Percent*
1-5	6	2%	57	21%
6-10	33	12%	4	1%
11-15	41	15%	23	9%
16-20	73	27%	2	1%
21-25	14	5%		
26-30	7	3%		
31-35	3	1%	Note: 270 people working as family aides	
36-40	7	3%		

Table 2
LOCATION OF CURRENT FAMILY AIDE WORK

CATEGORY	NUMBER
Solely in Client's Home	283
Solely at Agency's Premises	139
Solely at Non-Agency Premises	27
Partly Home & Agency Premises	189
Partly Home & Non-Agency Premises	253
Other	80
TOTAL	**971**

NOTE: Total includes some people not listed on caseload but who are included in FA activities

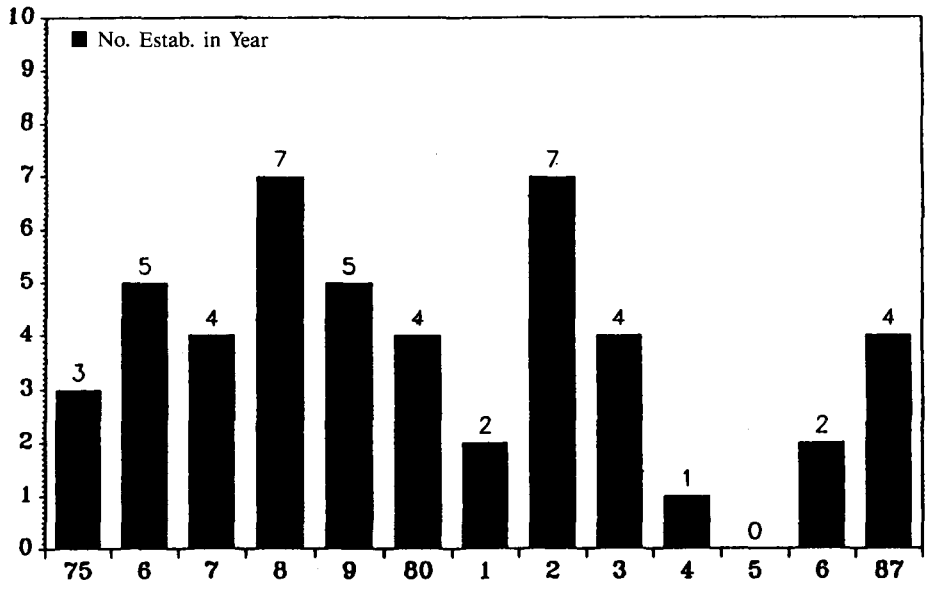
Table 3

Question: Please list the number of families within the current caseload where the following is a major reason for family aide intervention

CURRENT CASELOAD MAJOR REASON FOR FA WORK	INSTANCES	% TOTAL CASE LOAD
Adult Psychiatric Disability	163	18%
Adult Intellectual Disability	93	10%
Adult Physical Disability	40	4%
Special Needs Child	183	20%
Non-English Speaking	59	6%
Single Parent	389	42%
Alcohol/Drug Abuse	135	15%
Children Residing in Institutions	32	3%
Children in Other Forms of Substitute Care	75	8%
Children Identified as Being 'At Risk'	460	50%
Children at Present Under Statutory Orders	178	19%
Children Previously Under Statutory Orders	83	9%
Health Problem	145	16%
Domestic Violence/ Spouse Abuse	185	20%

Data from current caseloads at survey completion date: 916 families
Note: more than one category may apply to a family

Figure 1
PROGRAM ESTABLISHMENT



Years 1975 to 1987

Note: 48 respondents from a total of 52 programs

Figure 2
AUSPICE/SPONSORING ORGANISATIONS FOR PROGRAMS

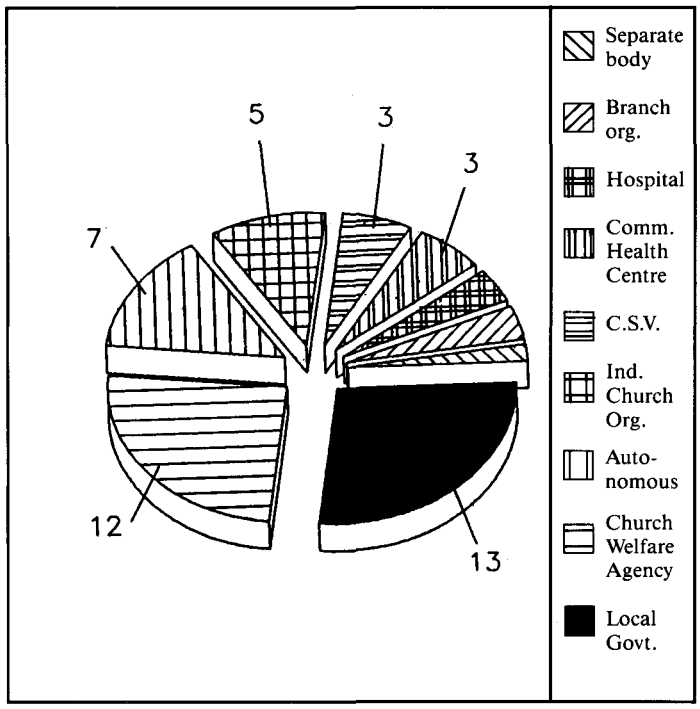


Figure 3
SOURCES OF PROGRAM FUNDING

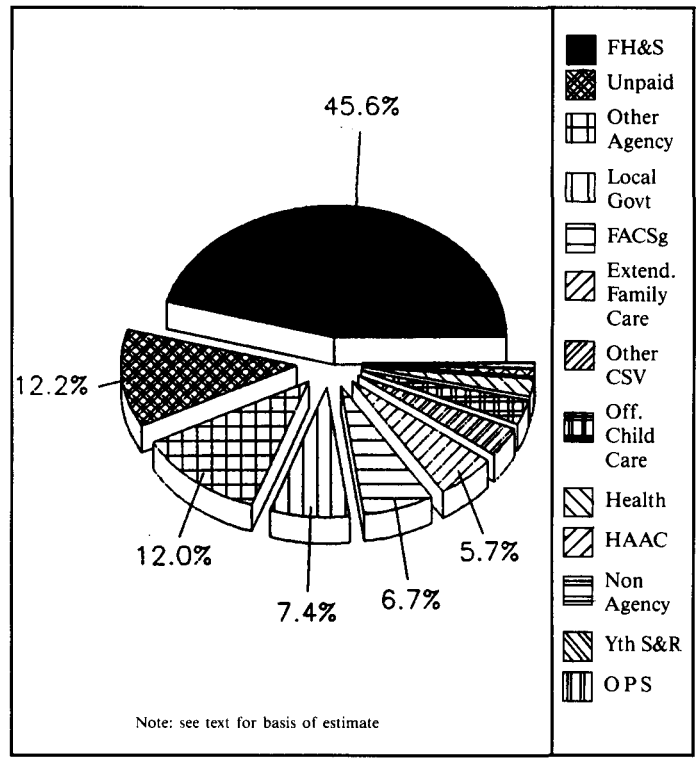


Figure 4
METHOD OF FAMILY AIDE INTERVENTION

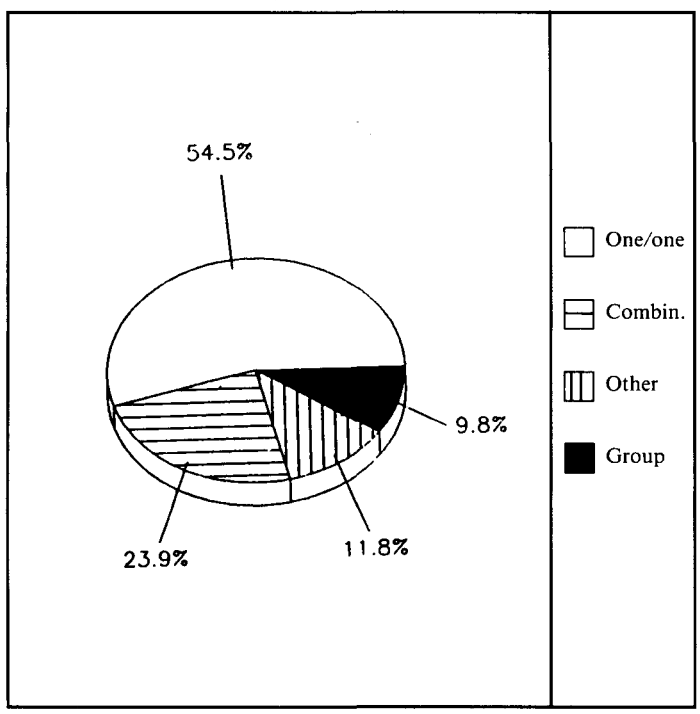


Figure 5
PERIODS OF FAMILY AIDE INVOLVEMENT IN CURRENT CASES