The Family Learning Centre Pilot Project

Findings and Recommendations

Contents

1. Introduction

1.1	Project Description	1
1.2	About this Report - Aims, Contents and Format	2

2. Introducing the Family Learning Centre

2.1	Background	3
2.2	Profile of the Target Group	4
2.3	Mission Goal	4
2.4	General Goals	4
2.5	Basic Principles and Hypotheses Guiding Service	5
2.6	Process of Intervention	7
2.7	Stages of Intervention	9

3. About the Pilot Project

3.1	Overview of the Families Served	
3.1.2	Case 1	12
3.1.3	Case 2	13
3.1.4	Case 3	14
3.1.5	Case 4	15
3.2	Overview of Problems and Interventions	
3.2.1	Basic Data of the Therapeutic Process	16
3.2.2	A Hypothetical Cost Comparison	17
3.3.3	Description of Problems Addressed And Results	19
3.3.4	Effectiveness of the Problem Solving Processes	20
3.3	Statement of Accounts	
3.3.1	Actual Expenditure	21
3.3.2	Total Cost Inclusive of Expenditure on Manpower	21
3.3.3	Working Sheet for Expenditure on Manpower	22

Contents

3.4 **Overall Findings**
3.4.1 Positive Outcomes 23
3.4.2 Intensity of the Live-in 23
3.4.3 The Need for Live-in 23
3.4.4 Pre-requisites for Accessibility 24
3.4.5 Successful Collaboration 25
3.4.6 Concluding Comments 25

4. **Recommendations**

4.1 **Operational Matters**
4.1.1 Meet the Need for a Community-based Specialised Therapy Service 26
4.1.2 Complement Existing Generic Services for an Improved Integrated Family Support Service 26
4.1.3 Expand Range of Therapeutic Interventions 29
4.1.4 Share Expertise for the Long-term Development of the Social Work Profession 29

4.2 **Required Resources and Funding**
4.2.1 Premises 30
4.2.2 Capital Funding 30
4.2.3 Recurrent Funding 31

5 **Questions and Answers** 32

6. **Acknowledgements** 33

1 Introduction

1.1 Project Description

The *Family Learning Centre* is dedicated to providing specialised therapeutic interventions to the low-income community experiencing multiple problems. Its current speciality is a live-in family therapy programme conducted within a simulated home environment

It dispels the common belief that the low-income community is unmotivated to participate in therapy and operates on the principle that co-operative therapeutic relationships can be developed if the conditions are right. For instance, the low-income community will be receptive to specialised therapeutic interventions if its basic needs are taken care of. Hence, it views itself as a complementary part of an integrated family support service. It acknowledges that its target clientele would require both practical help as well as a specialised service of its nature. Hence, it is a specialised service operating hand-in-hand with generic front-line service providers.

During its pilot run, the *Family Learning Centre* operated within the Bukit Ho Swee Social Service Centre, providing intensive live-in therapy to four multiple problem families that were receiving practical help and generic social work interventions.

1.2 About this Report - Aims, Contents and Format

This is the third report since February 1995 when the conceptualisation of the *Family Learning Centre* was at its beginning stages. Since then, the concepts have evolved and it is not the intention of this report to provide a historical development of the *Family Learning Centre*.

Those interested in a historical perspective are advised to refer to the reports below:

- *A Dialogue Among VWOs on Low-Income Families With Multiple Problems - Report, Analysis & Follow-up Comments*
- *The Family Learning Centre - Basic Research, Concepts & Plan*

The basic aim of this report is to provide the resources utilised and the findings of the pilot phase of the *Family Learning Centre* executed from August 1995 to December 1996. The secondary aim of the report is to document our efforts for self-evaluation and learning. The documentation is also meant to be shared with other helping professionals with the intention of mutual learning through professional exchange.

Thus, there are two parts to this report:

- This first part will present the findings and recommendations of our pilot project, while
- The second part describes the processes and improvements during the different stages of intervention.

2 Introducing the Family Learning Centre

2.1 Background

Since 1991, the Bukit Ho Swee Social Service Centre had been dealing with an increasing caseload of low-income families with multiple problems. Most of their problems were associated with a long history of poverty. The agency responded by developing resources to meet basic needs with the intention of immediate short-term problem solving.

In 1994, the agency assessed that the provision of front-line generic social work interventions was insufficient or at best incomplete from an integrated family support perspective. Hence, began the process of seeking other possibilities to help these families break out of the poverty cycle or at least better cope with their life situation.

In February 1995, the agency initiated a dialogue among helping professionals to:

- Identify assistance provided to low-income families with multiple problems by VWOs; and
- Seek ideas to optimise or improve services for multiple problem families.

Together with representatives form the Ministry of Community Development and the National Council of Social Service, 16 other voluntary welfare organisations participated. The contents of the dialogue were analysed and it served as the basis for the conceptualisation and development of the *Family Learning Centre*.

In June 1995, in collaboration with the Counselling and Care Centre, the Bukit Ho Swee Social Service Centre decided to embark on the *Family Learning Centre* as a practice research pilot project. Funding of $12 500 was provided by IPC Corporation Ltd.

2.2 Profile of the Target Group

The *Family Learning Centre* targets the low-income family with multiple problems. In our context, such families normally:

i. Live in a rental flat with a gross family income below $1000;

ii. Seek help at a social work agency for more than 1 problem and these problems are usually inter-related;

iii. Come from a long history of poverty and problems;

iv. Have a family structure that cannot meet the developmental and socialisation needs of their members;

v. Lack self-help abilities (i.e. finances, poor health, emotional, developmental, psychological, etc.);

vi. Lack extra-familial support (i.e. community resources, extended family network, etc.); and

vii. have other problems associated with the delinquency or substance dependency sub-culture.

2.3 Mission Goal

To make specialised therapeutic help accessible and acceptable to the low-income community and those with multiple problems.

2.4 General Goals

While the staff work in partnership with the family to determine specific goals, the *Family Learning Centre* generally aims to :

i. Strengthen Family Relationships
ii. Support and Guide Parents
iii. Enhance Family Enrichment
iv. Improve Household Management
v. Promote Individual Growth
vi. Teach Life Skills

2.5 Basic Principles and Hypotheses Guiding Service

⇨ Integration of Reactive and Developmental Social Work

The problems of the low-income multiple problem family are pressing and we find ourselves often operating in a **reactive** manner providing **remedial** interventions. The *Family Learning Centre* is an approach that acknowledges the need for generic work but also sees its limitations. Thus, it advocates **intensive therapeutic and restructuring** interventions for the long-term **development** of the family. The *Family Learning Centre* hopes to create a comprehensive integrated family support service consisting of both: convenient assessable, concrete front-line help **and** suitable therapeutic restructuring.

⇨ Strengthening Relationships

Singapore being multi-ethnic, comprises families who are structured very differently. Without careful examination, all families appear similar but when cultural and socio-economic status variables are involved, family life is very diverse. This diversity is acknowledged and families have a right to be respected for their special cultural, racial, ethnic and religious traditions and practices. We view families in a broad sense and this may include any group of people who chooses to live together for mutual practical and emotional benefit. From this perspective, interventions aim to strengthen relationships rather than to tie.

⇨ Family Preservation

We will work towards family preservation but in circumstances whereby this is not possible, we will help our clients make the best of their situation. We believe that a **broken family** need not necessarily become a **broken home**.

➾ Finding Ways of Growing Together

- Safety of all family members, especially children is a very important concern. However, wherever possible we would avoid out-of-home care which we believe
- may have the effect of fragmenting the family and creating adversarial relationships among family members.
- We believe that the best way for ensuring the safety of children in the long run, is to strengthen the existing intra-familial bonds and to support parents and other family members in doing a competent job.
- Children can be brought up in different kinds of families and one form should not be discriminated against in favour of another.
- We believe in approaching changes within the family very cautiously. Inappropriate interventions can do harm and may mean being disrespectful of the family's right for self-determination.

➾ Families as Partners

It is usually more effective to work in partnership with our clients rather than against them. It is our job to identify and appreciate the family's existing strengths and resources, involve them in decision making and goal setting processes with the aim of helping them experience and gradually acquire a sense of competency and control over their lives.

➾ A Doing Therapy

Our efforts are dedicated toward low-income families experiencing problems. However, these families may be resistant towards therapy forms which require verbal articulation of problems. Therefore, we believe it is our responsibility to develop alternative therapeutic approaches which our families find more practical and acceptable. We believe therapy can be both a **talking** and a **doing** cure. The Family Learning Centre emphasises on experiential learning and a **doing** therapy.

➪ Providing Therapeutic Space

Multiple problem families are overwhelmed and their difficulties often appear insurmountable. There is a need to provide these families the space and support to reflect and work through their problems within a different environmental setting (Live-in).

➪ Everyday Life Therapy

Daily living provides ample therapeutic entry points. Conducting therapy in a context that is close to normal routine makes therapy a down-to-earth, practical and relevant experience.

➪ Collaboration for Quality Service

The quality of service delivery is very much dependent on the competency, enthusiasm and well being of all workers concerned. As such, a teamwork approach towards practice is necessary to enhance professional and moral support. The resources of one agency may be insufficient for intensive work and inter-agency collaboration is essential.

➪ A Learning Culture

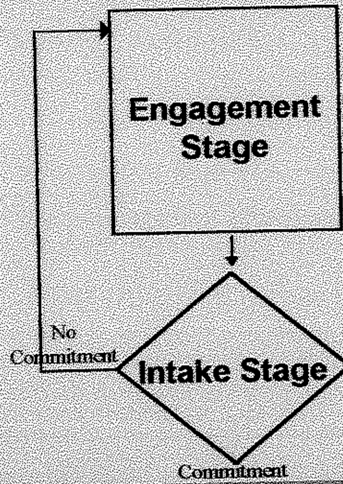
We realise that our work may not bring about explicit, immediate or sensational change. Our workers must have the ability, patience and courage to evaluate their performances openly. Thus, therapy is a learning process for both families and the workers. Learning in itself is a form of change and success.

2.6 Process of Intervention

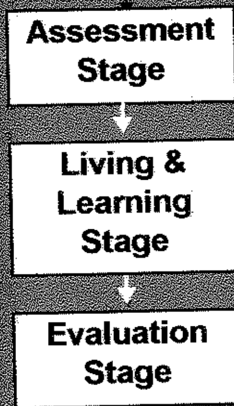
The entire process of therapy from the engagement phase to the termination/follow-up phase will be referred to as a cycle. There will be 6 stages of intervention during the 1st cycle of therapy. Subsequent cycles begin at Stage 3 and thus comprise 4 stages. At each stage, the focus will be different and the nature of participation from the family and the staff will also differ. The stages of intervention will also serve as a structure to monitor and evaluate the process of therapy.

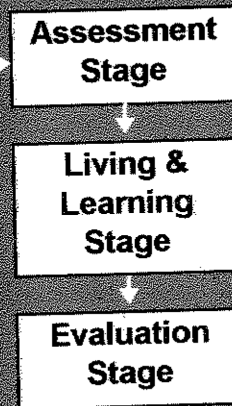
FSC
Front-line social work

Preparation

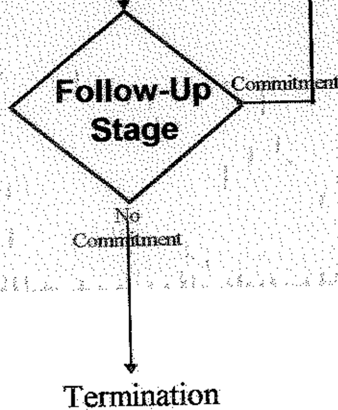


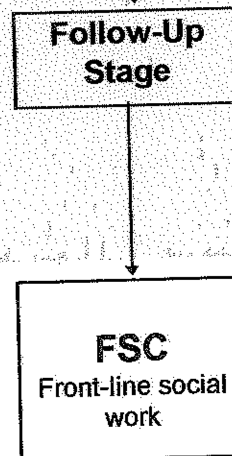
Live-in Therapy





System Evolvement





Termination

2.7 Stages of Intervention

The success of the FLC is largely dependent on the co-operation between the front-line and the FLC staff. An effective integrated family support service will materialise only if the staff works as an integrated team. Hence, effort must not only be directed at service delivery but also at co-ordinating, sustaining and supporting the staff. As such, the 6 stages will be described differentiated by 2 levels: Family and Staff.

1. Engagement Stage	
Family Level	**Staff Level**
What? ✓ To select families and to gauge their motivation to participate in the FLC programme ✓ To introduce the concept and work of the FLC **How?** ✓ Home visits and informal chats with the family in particular the executive system ✓ Raise life situations as entry points for further discussions e.g. family members impending release from prison, constant disagreements etc **Who?** ✓ Front-line social worker in contact with identified family	**What?** ✓ To reach a common understanding on the philosophy, organisation, aims and work of the Family Learning Centre ✓ To sort out the distribution of staff time and to clarify job specifics ✓ To address concerns raised by staff ✓ To identify potential families for the FLC **How?** ✓ Team conferences **Who?** ✓ The entire staff team

2. Intake Stage	
Family Level	**Staff Level**
What? ✓ To check out the family's: • Understanding of the FLC programme • Expectation and desired results of programme ✓ To orientate the family on the FLC programme ✓ To reassess the family's motivation and readiness to participate in the programme ✓ To establish a contract with the family to remain in the programme till Stage 6 **How?** ✓ To conduct an intake interview with the entire family ✓ To describe the schedule, basic rules and the role of the social worker to the family ✓ To observe the family's participation level during the interview to assess their readiness **Who?** ✓ Front-line social worker	**What?** ✓ To form a therapy team for the family as follows : • Comprising at least 2 social worker therapist and 1 facilitator • Preferably not gender biased • Preferably includes 1 social worker / therapist who is less involved with the family ✓ The facilitator may be a staff member but will serve as a consultant and will not be directly involved in therapy **How?** ✓ To hold a case conference : • Presenting problems • Working hypothesis • Intervention plans **Who?** ✓ Case Management • 1 Front-line social worker • 1 Therapist • 1 Facilitator ✓ Case conferences • Entire staff team

<table>
<tr><th colspan="2">3. Assessment Stage (Live-in: Day 1/5)</th></tr>
<tr><th>Family Level</th><th>Staff Level</th></tr>
<tr><td>
What?
✓ To help the family settle into the FLC
✓ To assess the strengths and weaknesses of the family
✓ To highlight possible issues affecting family functioning

How?
✓ To treat the family as guests and provide a welcome meal
✓ To show the facilities and to remind them of the agreed rules
✓ To provide the budgeted money for the entire week
✓ To instruct the family to organise themselves for the rest of the day
✓ To observe family structure by noting the inter-personal processes. Staff should note:
• Hierarchy
• Boundaries
• Rules and roles
✓ And to assess their effect on
• Task functions
• Individual development
• Relationships between the sub-systems
✓ To highlight possible issues affecting family functioning during dinner
✓ To arrange a breakfast meeting

Who?
✓ Therapy team
</td><td>
What?
✓ To decide on a work schedule and the division of responsibilities
✓ To clarify and discuss the intervention strategies
✓ To raise possible concerns of the staff team with the facilitator

How?
✓ To compare notes, evaluate the day's activities and to prepare possible intervention strategies for the following day

Who?
✓ Therapy team
✓ Facilitator
</td></tr>
</table>

<table>
<tr><th colspan="2">4. Living & Learning Stage (Live-in: Days 2-4)</th></tr>
<tr><th>Family Level</th><th>Staff Level</th></tr>
<tr><td>
What?
✓ To follow up on previous day's activities.
✓ To define issues and begin intervention plans

How?
✓ Breakfast meeting to maintain rapport with therapy team
✓ Possible conversation starters include :
• What were your last thoughts before bed?
• What were your dreams about?
• What do you like or dislike so far?
✓ Depending on the family's needs, introduce appropriate interventions from the repertoire of techniques
✓ Evaluate the day with the family

Who?
✓ Therapy team
</td><td>
What?
✓ To execute and monitor intervention plans
✓ To evaluate daily programmes and to plan for following days

How?
✓ To execute interventions, monitor and plan for the following day

Who?
✓ Therapy team
✓ Facilitator
</td></tr>
</table>

5. Evaluation Stage (Live-in: Day 5)

Family Level	Staff Level
What? ✓ To assess the entire week with the family ✓ To assess the programmes and the impact on the family ✓ To show appreciation for the family's co-operation and participation **How?** ✓ To engage the family in a discussion. Useful starting points include : • What was different from usual life? • What was interesting during the week? • What was most enjoyable? • What was most disliked? • What did they learn? • What do they want to change or to do differently at home? (at least 1 point) ✓ Serve family a farewell meal **Who?** ✓ Therapy team	**What?** ✓ To evaluate the impact of intensive family work on staff ✓ To evaluate hypothesis and to plan for future actions **How?** ✓ To seek general feelings of the therapy team ✓ To note achievements and to highlight concerns ✓ To hold case conference to share experiences **Who?** ✓ Evaluation • Therapy team • Facilitator ✓ Case Conference • Entire staff team

6. Follow-up Stage (1 month later)

Family Level	Staff Level
What? ✓ To monitor the impact of the live in therapy on the family after approximately 1 month ✓ To help the family decide if they want to participate in a 2nd live-in experience **How?** ✓ Family conference **Who?** ✓ Therapy team	**What?** ✓ To help staff gauge effectiveness of their interventions ✓ To help staff make recommendations for future work **How?** ✓ Discussion **Who?** ✓ Therapy team ✓ Facilitator ✓ Entire staff team

3 About the Pilot Project

3.1 Overview of the Families Served

A Brief Description of the 4 Families Served:
All 4 families live in HDB rental flats allocated for families with a gross household income of less than $800.

3.1.1 Case 1 - The Teo Family

Family Structure: the members and their relationships		
A nuclear family with 3 school going children. The father is the sole breadwinner and the mother is responsible for household management and child care. The spouses have a history of relationship difficulties and have lived apart on various occasions. The children are closer to their mother but not adverse to their father. Among the children, the oldest daughter receives the least attention and is often an 'invisible' member in the family.	F 47, M 39; 11 C1, 9 C2, 7 C3	F, M, C3, C2, C1

The Problem(s)

Mdm Chan, the mother is worried about her eldest daughter Peck Fong. She hears non-existent radio music and conversations in the middle of the night. Also, at school the teacher has reported that her daughter laughs to herself in class. Peck Fong tends to be labelled by her parents as 'siou' (crazy) and her behaviour at home seems to be increasingly fitting the label. If no therapeutic intervention takes place, Peck Fong is at risk of being excluded from her family, dropping out of school or even hospitalised. The family's caseworker views the problem as one stemming from the parent-child relationship and feels that therapy can improve this relationship and preserve the family as a whole.

Issues Worked On	
Abnormal behaviour of child	Parent-child relationships
Stress management	Sibling relationships

Outcome at the End of the Live-in

The family was satisfied with our interventions and were convinced that the behaviour of their daughter Peck Fong was not abnormal but a normal way of showing that her relationship needs were not met. They also gained an awareness of the relationship predicaments experienced by their daughter, is now more sensitive to her needs and realise that there must be change.

Outcome at the Follow-up Interview (1 month later)

The was no reported reoccurrence of the presented problem. Also, instead of viewing her daughter as mentally unstable, the mother now recognises her daughter as being very intelligent.

The parents also informed that since the live-in they are more conscious about the way they treat their daughter.

3.1.2 Case 2 - The Oliveiro Family

Family Structure: the members and their relationships

A single mother with 3 school going children and 1 pre-schooler. The father passed away recently. Mother is the sole breadwinner and expects her eldest son to assume household management and child care duties. Since the father's death, parent-child relationships have become strained. The oldest son is disconnected from the rest of the family and the younger children move between their sibling group and other children in the neighbourhood.

The Problem(s)

Mother expressed much frustration and difficulty ensuring that her children, especially her eldest son stay out of trouble. She is under tremendous pressure from relatives and the school regarding his behaviour and is worried that he might get involved in drugs or gangsterism. She is also troubled by a sense of distance experienced among family members. Father's death left a substantial void in their lives. They were deeply affected but were unable to grieve together as a family.

Issues Worked On	
Grief management	Parent-child relationships
	Teenage delinquency

Outcome at the End of the Live-in

The family was in high spirits and the tension between mother and her eldest son evident on Day 1 was absent. They became more connected; brought togther by a better appreciation of how they were similarly affected by the father's death. They spoke of the peace and family togetherness that evolved during the live-in and were optimistic about family relationships. They were confident that they were over their relationship problems.

Mother regained her authority and inherent resourcefulness. She displayed composure when interacting with her children and did not seem to be burdened by other pre-occupations.

Family members appeared more affectionate towards each other and a sense of family togetherness and identity seems to have been restored. On the writing board, the children, on their own volition, wrote the phrase 'Family - Love & Concern' and below that 'Our family will go home after lunch.' implying that they looked forward to being at home together again.

Outcome at the Follow-up Interview (1 month later)

Mother updated us on some of the disagreements between family members but made it clear that the family would be able to handle these difficulties by themselves. This competency is attributed to the improved family relationships since the live-in.

3.1.3 Case 3 - The Gopal Family

Family Structure: the members and their relationships

A divorced mother with 2 sons and 1 daughter. The children were born approximately 7 years apart. The oldest son is almost an adult and his links with the family are appropriately less intense. The daughter, a teenager has just been released from an institution and the youngest son is in Primary 1.

The roles and boundaries within the family are unclear and this creates much tension straining relationships between mother and her children.

F M
42 Divorced 40
20 14 7
C1 C2 C3

M C1 C3 C2

The Problem(s)

Mother has a high level of anxiety regarding her daughter's impending return after 2 years away in an institution for troubled girls. She is worried about the adjustments the family has to make and the problems that may arise. This anxiety is also due to their troubled relationship in the past that was fraught with mistrust and hurt. Mother has problem assuming the parenting role and daughter is often entrusted with too much adult information and responsibilities. The children are also unhappy and often affected by their mother's drinking problem.

Issues Worked On	
Parent-child relationships	Alcoholism
Post institution family re-entry	Sexual preference

Outcome at the End of the Live-in

Mother felt that many unexpected issues were raised but she acknowledged that it is preferable they surfaced. She appreciated the opportunity to hear her daughter speak her mind.

Mother's drinking problem was highlighted and she gained a better understanding of how it had affected her children.

Mother and daughter agreed upon an action plan to re-establish the trust between them. Appropriate boundaries between mother and daughter were established to overcome the problem of enmeshment that they had in the past.

The children found the live-in an enjoyable and meaningful way of strengthening their relationship.

Outcome at the Follow-up Interview (1 month later)

The family recognised that the live-in highlighted various areas of concerns which otherwise would have been ignored until they developed into serious problems. They now view therapy as a possible problem-solving alternative and agreed to continue coming for counselling.

3.1.4 Case 4 - The Awang Family

Family Structure: the members and their relationships

A family traumatised by an abusive father. Comprising a divorced mother and 4 youths, the family has been experiencing much difficulty dealing with the post trauma. The eldest 2 children have just been released from detention for drug consumption and parent-child relationships are characterised by much anger and disagreement.

M
42
Divorced
20 18 17 14
C1 C2 C3 C4

M C4 C1 C2 C3

The Problem(s)

Mother is highly anxious about her children who have been recently released from a drug rehabilitation centre for a second time. She is worried that they may relapse.

Tuminah, the oldest daughter is not confident that she will be able to keep drug-free without the support of her family. She feels that family support is not forthcoming.

Tuminah is still very traumatised by her father's abuse and cannot seem to move on with her life.

The children are unhappy with their mother's supervision and this is a source of conflict in the parent-child relationships.

Issues Worked On	
Parent-child relationships	Understanding the pull of the drug system
Communication within the family	Post institution family re-entry

Outcome at the End of the Live-in

The family felt that the goal of creating lines of communication among themselves was achieved. They reported that they had acquired a much better understanding of each other.

Rashid, the son found the entire experience completely new and enjoyable. His childhood was fraught with deprivation and he had spent much time in institutions. Thus, he found the mixture of recreation and therapy a meaningful experience for the family as well as for himself.

The live-in provided a context for the family to connect with each other in a manner never before. Unlike previous encounters with each other which were often stressful, they were able to enjoy each other's company.

The family had gained a better understanding of the push-pull factors of the drug system. They realised that family support is of paramount importance in helping Rashid and Tuminah combat their drug dependency problem.

Outcome at the Follow-up Interview (1 month later)

The family appeared to be coping well and did not see the need for further therapy. The 2 older children had regular jobs and mother reported that she was enjoying the company of her children and found family life very fulfilling.

3.2 Overview of Problems and Interventions

3.2.1 Basic Data of the Therapeutic Process

Stages 1,2 & 3 - Preparation, Assessment & Intake

Sessions & Hours

	Case 1		Case 2		Case 3		Case 4		Total	
Stage	No. of sessions	# hours	No. of sessions	# hours	No. of sessions	# hours	No. of sessions	# hours	No. of sessions	# hours
Assessment	3	6	2	2.5	2	4.5	2	6	9	19
Intake	1	1	1	1	1	1	1	1	4	4
sub-total	4	7	3	3.5	3	5.5	3	7	13	23

Stages 4 & 5 - Live-in Therapy

Sessions & Hours

	Case 1		Case 2		Case 3		Case 4		Total	
Stage	No. of sessions	# hours	No. of sessions	# hours	No. of sessions	# hours	No. of sessions	# hours	No. of sessions	# hours
Live-in	6	9.5	4	4.5	7	9.5	6	8	23	31..5

Stage 6 - Follow-up

Sessions & Hours

	Case 1		Case 2		Case 3		Case 4		Total	
Stage	No. of sessions	# hours	No. of sessions	# hours	No. of sessions	# hours	No. of sessions	# hours	No. of sessions	# hours
Follow-up	1	1.5	1	1.5	1	2	1	1.5	4	6.5

Overall Sessions & Hours

	Case 1		Case 2		Case 3		Case 4		Total	
Stage	No. of sessions	# hours	No. of sessions	# hours	No. of sessions	# hours	No. of sessions	# hours	No. of sessions	# hours
Overall	11	18	8	9.5	11	17	10	16.5	40	61

Live-in days

	Case 1		Case 2		Case 3		Case 4		Total	
Stage	No. of days	# nights	No. of days	# nights	No. of days	# nights	No. of days	# nights	No. of days	# nights
Live-in	4	3	3	2	4	3	4	3	15	11

Language used

	Case 1	Case 2	Case 3	Case 4
Language	Hokkien	Malay/English	English	Malay

No. of staff deployed

	Case 1	Case 2	Case 3	Case 4
Therapy Team	2	2	2	2
Discussion Team	2	2	2	2
sub-total	4	4	4	4

Summary

No. of families served	4	No. of sessions	40
No. of persons	19	Therapy time	61 hours
Live-in days	15 D/11N	# staff per case	4

3.2.2 A Hypothetical Cost Comparison

Whenever social services are provided, cost effectiveness is always a legitimate concern. Thus, we are concerned that the Family Learning Centre being an intensive live-in therapeutic programme is relatively cost effective. As such a hypothetical cost comparison was made for Case 1 because if the referring problem persisted, the identified patient's school would have referred her to a government children's clinic. The children's clinic is appropriate for comparison because it is similar to the Family Learning Centre in the following ways:

a) it is a specialised service and
b) it has a structured intervention plan.

For this calculation, expenditure on manpower was based on the mid-point of the staff's salary range (mid-point of salary grade x 15 months x 2288 working hours a year) from both services. The average of the actual operating cost of the pilot project was also added.

At the children's clinic, the identified patient will meet with a medical officer or a consultant over 12 appointments. The Intervention Plan is as follows:

s/no.	Activity	Time	Appointment Date
1	Information Gathering and Diagnosis	1 hr.	N.A.
2		0.5 hr	2 weeks later
3	Monitoring Treatment	0.5 hr	1 month later
4	Monitoring Treatment	0.5 hr	1 month later
5	Monitoring Treatment	0.5 hr	1 month later
6	Monitoring Treatment	0.5 hr	1 month later
7	Monitoring Treatment	0.5 hr	1 month later
8	Reducing Medication	0.5 hr	1 month later
9	Taking Off Medication	0.5 hr	1 month later
10	Preventing Relapse	0.5 hr	1 month later
11	Preventing Relapse	0.5 hr	2 months later
12	Preventing Relapse	0.5 hr	3 months later
	Total	**11.5 hr**	**13 months 2 weeks**

Based on the above, the findings below were discovered.

Summary		
	Children's Clinic	Family Learning Centre
a) # of persons served	1	5
b) # of sessions	12	11
c) # of therapy hours	11.5 hrs	18 hrs
d) Rx time span	54 weeks	7 weeks
e) # of staff	1	4
f) Staff cost	$433.54	$ 1061.24
g) Operating cost	$95.50	$ 381.31
Total (f + g)	$529.04	$ 1442.55
overall unit cost	**$529.04**	**$ 288.51**
Cost of therapy per person/ hour	**$46.00**	**$16.00**

Comments and Interpretations:

Although we maintain that the calculations are hypothetical and are limited by controlled variables, they do reveal various interesting observations.

a. A Lower Unit Cost

At first glance, the overall cost of the Family Learning Centre is more than the Children's Clinic. However, the FLC has a lower client unit cost of $288.51 compared to $529.04. As such, therapy cost for each person served per hour is significantly lower. The cost of each therapy hour at the Children's Clinic is $46.00 or 287.5% more than that at the Family Learning Centre which is at $16.00.

b. More Therapy Hours

Despite the lower unit cost, more therapy hours were provided - 18 hours compared to 11.5 hours.

c. More Clients Served - Early Relapse Prevention

The Family Learning Centre adopts a family systems perspective and as such seeks to serve and strengthen the family as a whole. Besides serving more people it acknowledges at the start, the importance of a supportive home environment in the rehabilitation of the identified patient. In a sense, relapse prevention begins early and is looked into from the pre-intake assessment stage compared to Session 10 at the Children's Clinic.

d. A Shorter Treatment Time Span - Lower Drop-out & More Efficient Problem Solving

The FLC offers intensive interventions within a shorter period while treatment at the Children's Clinic would stretch for more than a year. Approximately, the FLC takes up only 13% of the treatment time span recommended by the Children's Clinic. The advantage of a shorter treatment plan is that it reduces the drop-out rate of the client. Also, the chances for having the client overcome the presenting problem are earlier and this means that the client would have participated in a shorter problem solving process.

e. A Family Experience versus A Clinical Experience

Finally, the intervention plans were conducted within different settings. It is felt that the FLC would have the advantage of a less clinical setting that provides the identified patient and her family an enriching family experience that would also be an important contribution towards rehabilitation.

The chances of rehabilitation are also increased by the systemic approach of including the entire family in the problem solving processes where the problem solving abilities of the family are strengthened as a whole.

3.2.3 Description of Problems Addressed and Results

Problem/Issue Description	Frequency Presented by client or perceived by Worker	How was it addressed?	Was the Goal of therapy reached?
Abnormal behaviour	1 x P	Fully	Yes
Alcoholism	1 x W	Highlighted	N.A.
Conflictual parent-child relationships	3 x P 4 x W	3 x Fully 1 x Partly	4 x Yes
Drug dependency	1 x P	Partly	Partly
Family re-entry	2 x P	2 x Fully	1 x Yes, 1 x Partly
Grief management	1 x W	Fully	1 x Yes
Parenting difficulties	4 x PW	4 x Fully	1 x Yes, 3 x Partly
Poor parenting skills	4 x W	4 x Partly	1 x Yes, 3 x Partly
Post trauma depression	1 x PW	1 x Partly	1 x Partly
Teenage delinquency	3 x P, 2 x W	2 x Partly	1 x Yes, 1 x Partly

Not all issues presented were addressed in equal depth. Some issues were intentionally played down as they were deemed unhelpful at the point of therapy. Also, we only started on issues where there was a clear mandate from clients. At times, as therapy progressed we were able to address non-mandated issues.

3.2.4 Effectiveness of the Problem Solving Processes

		Presented by Clients	Worker's Assessment
Number of Problems		15	17
Percentage of the problems addressed	partly	26%	47%
	fully	67%	29%
	total	93%	76%
Rate of Success Percentage of intervention goals reached			
	partly	50%	61%
	fully	50%	39%

The above table show that problems are more frequently defined by the worker rather than the family. Nearly all presented problems by the families could be addressed. As for worker-assessed problems, 3/4 were addressed. Thus, there is a high likelihood that problems initially not presented by the client can be worked on. But for intensive problem intervention, it is preferable that the client shares the assessment of the worker. This implies that adequate and quality preparation through generic services is a necessary pre-requisite for success.

The success rate of the FLC is high if it deals with the presented problems. Half of the presented problems were deemed to be fully solved within the short therapeutic time-span of the live-in. Where worker assessed problems are concerned, the rate of success is lower but still acceptable.

3.3 Statement of Accounts
as at 31st December 96

3.3.1 Actual Expenditure

	($)	($)
Income :		
Donation from IPC		12,500.00
Expenses :		
Rental of Premises	520.00	
Transport	133.00	
Subsidy for Families	550.00	
Food & Refreshments	190.25	
Training Aids	132.00	
		1,525.25
Balance		**10,974.75**

The above statement reflects the actual expenses of the pilot project. During the pilot project, staff from both the Counselling and Care Centre and the Bukit Ho Swee Social Service Centre were shared without charge. However, expenditure on manpower was calculated and it showed that just like most social service budgets, it takes up the bulk of the expenses. EOM was calculated at current salary x 15 months divided by 2288 hours per year x actual time spent.

3.3.2 Total Cost Inclusive of Expenditure on Manpower

Expenses :		
1. Actual cost	1525.25	
2. EOM (23 hours)	4321.07	
		5840.07

3.3.3 Working Sheet for Expenditure on Manpower

Case 1

STAGES 1 & 2			STAFF						
s/no	Date	Activity	Time	A	B	C	D	E	F
1.	110895	Home Visit	1 hr	✓			✓		
2.	160895	Pre-intake Assessment	1.5 hr	✓		✓	✓	✓	
3.	230895	Intake Interview	1 hr						
		Sub Total	3.5 hr	2.5		1.5	2.5	1.5	

STAGE 3			STAFF						
s/no	Date	Activity	Time	A	B	C	D	E	F
1.	040995	Pre-therapy Assessment	3.5 hr			✓	✓	✓	
		Sub Total	3.5 hr			3.5	3.5	3.5	

STAGE 4			STAFF						
s/no	Date	Activity	Time	A	B	C	D	E	F
1.	040995	Session 1	1 hr			✓	✓	✓	
2.	050995	Session 2	2 hr			✓	✓	✓	
3.	050995	Session 3	2 hr				✓	✓	
4.	060995	Session 4	1 hr			✓		✓	✓
5.	060995	Session 5	3 hr					✓	✓
6.	060995	Closing Activity	2 hr					✓	✓
		Sub Total	8.5 hr			4	5	8.5	3.5
		Others	2 hr			2		2	2

STAGE 5			STAFF						
s/no	Date	Activity	Time	A	B	C	D	E	F
1.	060995	Evaluation Session	1 hr	✓		✓		✓	✓
		Sub Total	1 hr	1	1	1	1	1	1

STAGE 6			STAFF						
s/no	Date	Activity	Time	A	B	C	D	E	F
1.	101095	Follow-up Interview	0.5hr			✓	✓	✓	✓
2.	101095	Staff Discussion	1 hr			✓	✓	✓	✓
3.									
		Sub Total	1.5 hr			1.5	1.5	1.5	1.5

Total no. of hours	55.5
EOM	$985.07

Case 3

STAGES 1 & 2			STAFF						
s/no	Date	Activity	Time	A	B	C	D	E	F
1.	200696	Pre-intake Assessment	1 hr	✓	✓	✓	✓	✓	✓
2.	010796	Intake Interview	1 hr			✓	✓	✓	
		Sub Total	2 hr	1	1	2	2	2	1

STAGE 3			STAFF						
s/no	Date	Activity	Time	A	B	C	D	E	F
1.	070795	Pre-Therapy Assessment	3.5 hr			✓	✓		
		Sub Total	3.5 hr			3.5	3.5		

STAGE 4			STAFF						
s/no	Date	Activity	Time	A	B	C	D	E	F
1.	030796	Session 1	1.5 hr	✓		✓	✓	✓	
2.	030296	Session 2	1.5 hr			✓	✓	✓	
3.	030796	Session 3	0.75 hr			✓	✓	✓	
4.	040796	Session 4	1 hr		✓	✓	✓	✓	
5.	040796	Incidental Session 1	2 hr				✓		
6.	040796	Incidental Session 2	0.75hr					✓	
7.	030796	Family Outing to P Ubin	2 hr			✓	✓	✓	
8.	040796	Closing Activity	1 hr			✓	✓	✓	
		Sub Total	7.5 hr	1.5	1	4.7	6.7	6.7	
		Others	3 hr			3	3	3	

STAGE 5			STAFF						
s/no	Date	Activity	Time	A	B	C	D	E	F
1.	040196	Evaluation Session	2 hr		✓	✓	✓	✓	
		Sub Total	2 hr		2	2	2	2	

STAGE 6			STAFF						
s/no	Date	Activity	Time	A	B	C	D	E	F
1.	101096	Follow-up Interview	1 hr		✓	✓	✓	✓	
2.	101096	Staff Discussion	1 hr		✓	✓	✓	✓	
		Sub Total	1.6 hr		2	2	2	2	

Total no. of hours	60.5
EOM	$1176.00

Case 2

STAGES 1 & 2			STAFF						
s/no	Date	Activity	Time	A	B	C	D	E	F
1.	160895	Pre-intake Assessment	1.5 hr			✓	✓	✓	✓
2.	301195	Intake Interview	1 hr		✓	✓	✓	✓	✓
		Sub Total	2.5 hr		1	2.5	2.5	2.5	2.5

STAGE 3			STAFF						
s/no	Date	Activity	Time	A	B	C	D	E	F
1.	061295	Pre-therapy Assessment	1 hr			✓	✓	✓	✓
		Sub Total	1 hr			1	1	1	1

STAGE 4			STAFF						
s/no	Date	Activity	Time	A	B	C	D	E	F
1.	061295	Session 1	1.5 hr		✓	✓	✓	✓	✓
2.	061295	Session 2	1.5 hr		✓	✓	✓	✓	✓
3.	071295	Session 3	1 hr		✓	✓	✓		✓
4.	061295	Family BBQ	2 hr			✓	✓		✓
5.	081295	Closing Activity	2 hr			✓	✓	✓	✓
		Sub Total	4 hr		4	4	4	3	4
		Others	4 hr			4	4	2	4

STAGE 5			STAFF						
s/no	Date	Activity	Time	A	B	C	D	E	F
1.	081295	Evaluation Session	0.5 hr		✓	✓	✓	✓	✓
		Sub Total	0.5 hr			4	4	2	4

STAGE 6			STAFF						
s/no	Date	Activity	Time	A	B	C	D	E	F
1.	101095	Follow-up Interview	0.5hr		✓	✓	✓	✓	✓
2.	101095	Staff Discussion	1 hr		✓	✓	✓	✓	✓
		Sub Total	1.5 hr		1.5	1.5	1.5	1.5	1.5

Total no. of hours	58
EOM	$1044.12

Case 4

STAGES 1 & 2			STAFF						
s/no	Date	Activity	Time	A	B	C	D	E	F
1.	261196	Pre-intake Assessment	1 hr		✓	✓	✓	✓	✓
2.	301196	Intake Interview	1 hr		✓		✓	✓	
		Sub Total	2 hr		2	1	2	2	1

STAGE 3			STAFF						
s/no	Date	Activity	Time	A	B	C	D	E	F
1.	021296	Pre-therapy Assessment	5 hr			✓	✓		
		Sub Total	5 hr			5	5		

STAGE 4			STAFF						
s/no	Date	Activity	Time	A	B	C	D	E	F
1.	031296	Session 1	1 hr		✓	✓	✓	✓	
2.	041296	Session 2	1.5 hr		✓	✓	✓	✓	
3.	041296	Session 3	1.5 hr		✓	✓	✓	✓	
4.	031296	Incidental Session 1	1.5 hr				✓		
5.	041296	Incidental Session 2	1.5 hr			✓			
6.	051296	Accompanying Client	1.5 hr			✓			
7.	051296	Family Outing to P Ubin	4 hr			✓	✓		
8.	261296	Closing Activity	2 hr			✓	✓		
		Sub Total	7 hr		4	5.5	5.5	4	
		Others	7.5 hr			7.5	6		

STAGE 5			STAFF						
s/no	Date	Activity	Time	A	B	C	D	E	F
1.	051296	Evaluation Session	1 hr		✓	✓	✓	✓	
		Sub Total	1 hr		1	1	1	1	

STAGE 5			STAFF						
s/no	Date	Activity	Time	A	B	C	D	E	F
1.	120197	Follow-up Interview	0.5hr				✓		
2.		Staff Discussion	1 hr			✓	✓		
		Sub Total	1.5 hr			1	1.5		

Total no. of hours	57
EOM	$1115.89

3.4 Overall Findings

3.4.1 Positive Outcomes

➯ **End of Live-in**

All 4 cases reported they were satisfied with the experience. They felt that it was time well spent and their concerns were adequately addressed.

➯ **Follow-up**

All cases reported that their situation had stabilised. They continue to maintain contact with the Centre receiving practical help. One family continues with therapy. The working relationship developed during the live-in has encouraged them to accept therapy as a coping strategy.

➯ **A Lingering Impact**

All families informed their case-workers that they often think about the live-in experience. Even after 6 months, the first 2 cases draw on the live-in as a reference point in their discussions about the family. It appears that this lingering effect can be attributed to experiential learning.

3.4.2 Intensity of Therapy

While the experience was positive, it was also very intensive. All families opted not to have a 2nd live-in at the follow-up interview. The period between live-ins stipulated in the model is too short.

3.4.3 The Need for Live-in Therapy

As the project progressed, we started differentiating between issues requiring live-in therapy and those that did not. Live-in therapy is a viable medium because of the following reasons.

➯ **The Fixed Time-Frame**

Multiple-problem families have lived with their problems for so long that they acquire a high threshold level. Thus, they either do not see the need to address their problems or they are incapable of prioritising problems. Going away to work on a problem creates a context that helps them focus at the conceptual, emotional and practical levels.

⇨ **A Different Experience of the Family Dynamics**

Live-in therapy also provides the family a time-out or respite from their problem fraught routine. We have found that the live-in context can enhance the family dynamics positively. Family members begin to experience each other differently

and rediscover some fulfilment in family life. During the pilot phase, all cited the time away as a change of pace that brought family members closer to one another. Thus, a positive shared experience contributes immensely to the well-being of the family.

⇨ **The Need for a Realistic Problem Solving Context**

Often it is difficult for multiple-problem families who are unfamiliar with therapy to appreciate the relevance therapy can make in their daily lives. Spending time together in a 'natural' environment makes it easier for the therapists to observe family dynamics and highlight areas of concern. As for the families, this reduces the need to articulate their complex situations because the therapy context brings forth the actions that speak louder than words.

⇨ **Relevant Therapeutic Entry Points**

During the course of the live-in, the therapists were constantly presented with incidental experiences as therapeutic entry points. For example the manner in which the family pose for a photograph sometimes provide clues to the family dynamics. Such incidents can help move therapy if utilised appropriately.

The technique is parallel to 'Enactment' from the Structural School of Family Therapy but it is definitely less artificial and perhaps more palatable for the family. Enactment requires families to recreate a problematic situation in the therapy room so that the therapist may help them address their difficulties realistically. In the context of the Family Learning Centre, the therapists literally walk into problematic situations.

3.4.4 Family Accessibility

⇨ **Pre-requisites for Accessibility**

A concern prior to the implementation of the pilot project was the accessibility of families. 'Why would a family come away with us and let us into their lives?' was a doubt that frequently surfaced even among the most enthusiastic of the staff team. So far, it appears that live-in therapy is viable as long as the following conditions are present.

- Good rapport between the case-worker and the family;
- Mutual trust and respect between the worker and the family;
- Clear problem definition and realistic expectations; &
- The family's practical needs(e.g. make-up pay) are attended to.

⇨ **Having a Break - A Helpful Variation**

Originally, we wanted families to carry on with their daily lives by offering them a live-in facility nearby. But since such a facility was unavailable, 2 families had to take a break from their routine and 1 specifically instructed us to conduct the live-in during the school holidays so that the children's education would not be

disrupted. However, this arrangement had been successful in providing a mental and physical space for families to address their problems and it is definitely an appropriate variation of the original intervention plan. Also, breaking away from normal routine hinted of a holiday. Providing that element of fun proved to enhance and enrich family dynamics.

⇨ **The Need to Gain Credibility with the Authorities**

So far, all 7 families who have been deemed suitable by staff at the pre-intake stage have been opened to the idea of live-in therapy. We were unable to proceed with 3 families because of technical difficulties such as electronic tagging and probation curfews.

3.4.5 Successful Collaboration

The concept of sharing resources between 2 organisations has worked well. Because of the collaboration, a 'new service' has emerged meeting the needs of clients which otherwise would not have been provided for.

3.4.6 Concluding Comments

It was not just the therapy sessions or therapeutic exercises that made the experience therapeutic, educational or meaningful as a whole. Rather it was also the experience of breaking out of their problem-filled routine and doing something different in an attempt to take charge of the lives that makes the experience memorable. Finally, experiential learning also meant experiencing family members and the family as a whole differently. Thus, providing hope or at least perspectives that challenge the unpleasantness in the present.

4 Recommendations

4.1 Operational Matters

4.1.1 Meet the Need for a Community-Based Specialised Therapy Service

The role of the social work professional is wide-ranging but falls within the gamut of generic and specialised service. On one end, the social worker develops services or matches clients to resources and on the other provides therapeutic interventions.

Family Service Centres which are mushrooming all over Singapore are basically generic in nature. There is of course therapeutic counselling provided at such centres but in general, counselling provided is more often of an informative, instructional or supportive nature. This is so because of the conceptual configuration of the current Family Service Centre Model.

The multiple problem family that the Family Learning Centre aims to serve often require both generic and specialised interventions. Currently, there is no specialised service dedicated to this client group and counselling or therapy centres are not community-based and usually operate without the support of a generic social work centre. Thus, because of this scenario and the absence of the accessibility pre-requisites listed in our findings, the multiple problem family often will not receive any specialised help to work through their problems.

It is recommended that the Family Learning Centre be established as a community-based specialised therapy service that will serve 100 families or approximately 400 persons in its first year of service.

4.1.2 Complement Existing Generic Services For An Improved Integrated Family Support Service

The Family Learning Centre initially hopes to support the existing generic services provided by the Bukit Ho Swee Social Service Centre. Over time, it could also receive referrals from other Family Service Centres or Welfare Agencies. Two charts are provided below to describing the modus operandi from the Management and the Social Work perspectives.

Service Structure from a Social Work Perspective

Families and individuals with the ability to better help themselves and are better integrated into the community.

Specialised Services

The Family Learning Centre

- Live-in Therapy
- Outpatient Therapy
- Men in Recovery Groups
- Support and Recovery Groups for Abused Women
- Recovery Groups/Programmes for Recovering Substance Abusers
- Support Groups for Family Members of Substance Abusers & Juvenile Offenders
- Grief Management
- Family Mediation for Juvenile Offenders
- Training of Helping Professionals
- Regular Sharing of Project Evaluation Results with other VWOs

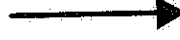
Families referred from other FSCs

Collaboration with other FSCs

Generic Services

Nazareth Centre
(Existing FSC)

- Advice and Information
- Advocacy
- Concrete Practical Help
- Crisis Control
- Family Life Education
- Financial Help
- Food Ration
- Supportive Counselling



The Hangout
(Proposed Youth Centre)

- Casework
- Groupwork
- Programmes

- Families in the community with multiple problems
- Family violence cases referred by the police

- Youths-at-risk in the community
- Juvenile delinquents referred by police

Service Structure from a Management Perspective

Bukit Ho Swee Social Service Centre Management

Generic Services

Nazareth Centre
(Existing FSC)

The Hangout
(Proposed Youth Centre)

Juvenile Cases

Family Violence Cases

Other FSCs

Police

Specialised Services

The FamilY LearninG

4.1.3 Expand Range of Specialised Therapeutic Interventions

Currently, Family Therapy conducted in a simulated home environment is the speciality of the Family Learning Centre. While the medium of therapy may be novel, it is not the only helpful or necessary way.

More importantly, the Family Learning Centre exists only in response to the needs of families and individuals with multiple problems. The Family Learning Centre is first and foremost concerned with meeting the needs of its targeted clientele and in the process would be willing to explore or create other mediums of therapy should clients' needs warrant so.

As such, the Family Learning Centre will initially operate as an outpatient therapy centre with live-in therapy as a viable option. Also, in the light of Singapore's current concern with Family Violence and Juvenile Delinquency, the service configuration of the Family Learning Centre may be as follows :

- ⇨ Live-in Therapy
- ⇨ Outpatient Therapy
- ⇨ Men in Recovery Groups (MR. Groups are for male perpetrators in family violence cases)
- ⇨ Support and Recovery Groups for Abused Women
- ⇨ Recovery Groups/Programmes for Recovering Substance Abusers
- ⇨ Support Groups for Family Members of Substance Abusers & Juvenile Offenders
- ⇨ Family Mediation for Juvenile Offenders
- ⇨ Grief Management
- ⇨ Training of Helping Professionals e.g. Therapists and Senior Social Workers
- ⇨ Regular Sharing of Project Evaluation Results with other VWOs

4.1.4 Share Expertise for the Long-term Development of the Social Work Profession

The pilot project has in some aspects proven to be a viable medium of therapy for the disadvantaged low-income community with multiple problems. A big part of this success can be attributed to the professional collaboration and exchange of ideas between the Bukit Ho Swee Social Service Centre and the Counselling and Care Centre. Collaboration provided the impetus for the development, sustenance and execution of the programme.

The wealth of knowledge and expertise derived from the collaboration can be utilised for the training of human service professionals and shared with other organisations who may want to duplicate the service. The Counselling and Care Centre is experienced in the area of training and development and would be able to implement such programmes should the demand arise.

Also, a specialised therapeutic facility is a start toward providing employment opportunities for senior social workers who have progressed in their professional development and seek new challenges. Thus, such facilities play a part in keeping social workers in the profession.

4.2 Required Resources and Funding

4.2.1 Premises:

Approximately, 190 sq. m are required. The lay-out of the premises should include the following facilities:

a) 1 mock-up one-room rental flat;
b) 1 therapy/activity room;
c) 1 office;
d) 1 storeroom;
e) 1 pantry/kitchenette;
f) 2 toilets

The above facilities may be located at a void deck space, within a HDB block or a disused building. However, the capital costs estimates below are based a HDB void deck location.

4.2.2 Capital Funding

Item	Amount
Pre-construction Costs	10,000
Civil Works & Building Costs	20,000
Office Furniture & Equipment	15,000
Furniture & Equipment	10,000
HDB/PUB/TELECOM Deposit	10,000
TOTAL	**65,000**

4.2.3 Recurrent Funding

Item	Amount
Salaries, CPF & SDF, Bonus	157,700
TOTAL EOM FOR PROGRAMMES	**157,700**
Staff Benefits	2,400
Staff Training	3,200
Maintenance of Land & Building	2,500
Maintenance of Equipment	1,000
Rental of Building	8,000
Rental of Equipment	1,000
Supplies & Materials	7,000
Utilities	3,000
Transport	2,000
Communications	2,000
Insurance	2,000
Professional Fees & Services	1,000
Volunteer Development & Recognition	2,000
TOTAL OOE FOR PROGRAMMES	**38,600**
TOTAL OPERATING BUDGET	**196,300**

N.B. Staffing

The Family Learning Centre will require fairly experienced staff with an advanced level of competency in family work. During the pilot phase, there were 4 staff deployed to help out with documentation and to provide professional support. Also, being a pilot project, staff were deployed to benefit from the learning opportunities presented. It is foreseen that in practice, 3 experienced staff with competencies in family work would suffice.

EOM Calculation :

1 Social Worker Grade IIa	$3717	(mid point of salary range)
2 Social Workers Grade II	$2521 x 2	(mid point of salary range)
Total salary plus bonus	$8759 x 15 mth x 1..2	= **$157,662**

5 Questions and Answers

Question 1:
Why Not Maintain Status Quo?

Isn't it possible to continue collaborating with the Counselling and Care Centre and treat the Family Learning Centre as a low-key value added service? Absorb the expenditure of manpower into existing budgets, and seek sponsors (as it is currently the case) to fund the programme on a yearly basis?

Answer
Yes, but this strains the organisational infrastructure. Although staff joke that the current project is treated as an extra-curricular activity which they enjoy, many extra hours and effort are put in to ensure its success. In the long-run, such a situation will cause burn-out, kill enthusiasm or deter staff from participating in pilot projects and providing an improved quality of service for their clients.

Question 2:
Why Can't The Family Service Centre Provide Specialised Therapy?

Answer
There may be criticism that therapy can be conducted using the current FSC Model and premises. After all, counselling is a core-programme and there is no need to separate therapeutic activities. However, over the years, we have learnt that we cannot provide counselling isolated from a range of support programmes. There will be no clientele from the disadvantaged low-income community. Also, the FSC model aims to be a generic centre serving the masses and over time there will be insufficient organisational space for specialised work as long as we are based in a disadvantaged low-income community.

Question 3:
Why Not Create Organisation and Physical Space Within the Family Service Centre?

Create the organisational space in the existing premises by removing all services for children and youths. Make this 'FSC' strictly for 'family' activities with support programmes targeted at families. For instance, a family recreational drop-in centre and soccer teams comprising parents etc. Children and youths can come only if they are with their families. Assuming that these activities and clientele are more orderly and quiet, there may be sufficient space left conducive for therapeutic work. This is also in line with the current FSC Model mainly support the family unit.

Answer
Keeping the specialised and generic within the same premises has its advantages but this is provided an intensified family service does not bring us back to where we are now in terms of the high noise level and the lack of a conducive environment for therapeutic work.

Acknowledgements

This report is a result of the successful collaboration within the Family Learning Centre Pilot Project Team comprising:

Anna Tee, Gerard Ee, Ng Bee Leng, Rebecca Tan,

Juliana Toh and Tan Boon Huat.

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About the Cases

Contents

1. The Teos

1.1	Preparation Stage	
1.1.1	Brief Background	1
1.1.2	Case 1 At A Glance	3
1.1.3	The Key Players	5
1.1.4	The Genogram	6
1.1.5	Pre-intake Assessment	7
1.1.6	Intake Interview It's my daughter you should be talking about.	9
1.2	Assessment Stage	
1.2.1	The Initial Live-in Assessment When will I see him again?	13
1.3	Live-in Stage	
1.3.1	Session 1 We have no favourites! Right?	16
1.3.2	Session 2 Peck Fong? Oh, here she is.	20
1.3.3	Session 3 Whew! I am not mad.	25
1.3.4	Session 4 A nice house and we will live happily ever after.	29
1.3.5	Session 5 High anxiety	33
1.4	Evaluation Stage	
1.4.1`	Session 6 This flat is great for hide and seek	36
1.5	Follow-up Stage	
1.5.1	The Follow-up Interview We are fine, thank you.	39

2. The Oliveiros

2.1	Preparation Stage	
2.1.1	Brief Background	42
2.1.2	Case 2 At A Glance	44
2.1.3	The Key Players	46
2.1.4	The Genogram	47
2.1.5	Pre-intake Assessment	48
2.1.6	Intake Interview- Let's get to the way we were.	52

Contents

2.2	**Assessment Stage**	
2.2.1	**The Initial Live-in Assessment** Getting started.	55
2.3	**Live-in Stage**	
2.3.1	**Session 1** Father's funeral - Samsudin seeks understanding	57
2.3.2	**Session 2** The family grieves.	60
2.3.3	**Session 3** Jack will be remembered and the family moves on.	64
2.4	**Evaluation Stage**	
2.4.1	**Session 4** Life after FLC - The family hopes.	68
2.5	**Follow-up Stage**	
2.5.1	**The Follow-up Interview** We have problems but we have family.	71
3.	**The Gopals**	
3.1	**Preparation Stage**	
3.1.1	**Brief Background**	73
3.1.2	**Case 3 At A Glance**	75
3.1.3	**The Key Players**	77
3.1.4	**The Genogram**	78
3.1.5	**Pre-intake Assessment**	79
3.1.6	**Intake Interview** A better tomorrow - hopefully but not likely.	83
3.2	**Assessment Stage**	
3.2.1	**The Initial Live-in Assessment** Kids-in-Charge	89
3.3	**Live-in Stage**	
3.3.1	**Session 1** About last night	92
3.3.2	**Session 2** You oughta know!	96
3.3.3	**Session 3** Love her if you love me but not too much.	99
3.3.4	**Session 4** Is that our family you're talking about?	102
3.3.5	**Other Incidental Sessions** a) Dad was my pal, b) The past will prevail	106
3.4	**Evaluation Stage**	
3.4.1	**Session 5** Learning to trust again.	109

Contents

3.5 **Follow-up Stage**
3.5.1 **The Follow-up Interview** 114
You're big enough to know but too small to decide.

4. The Awangs

4.1 **Preparation Stage**
4.1.1 **Brief Background** 118
4.1.2 **Case 4 At A Glance** 120
4.1.3 **The Key Players** 122
4.1.4 **The Genogram** 123
4.1.5 **Pre-intake Assessment** 124
4.1.6 **Intake Interview** 127
Let us trust again.

4.2 **Assessment Stage**
4.2.1 **The Initial Live-in Assessment** 129
We are organised.

4.3 **Live-in Stage**
4.3.1 **Session 1** 132
Children versus mum.
4.3.2 **Session 2** 136
Mum speaks
4.3.3 **Session 3** 140
Just a little concern, please.
4.3.4 **Other Incidental Sessions** 143
a) Alone with Sarah,
b) DRC, my family & me.

4.4 **Evaluation Stage**
4.4.1 **Session 4** 145
We feel good.

4.5 **Follow-up Stage**
4.5.1 **The Follow-up Interview** 147
We were so busy being family!