

Article

Bringing the Family Back in: On Role Assignment and Clientification in the Swedish Social Services

Ahmet Gümüşcü *, Lennart Nygren and Evelyn Khoo

Department of Social Work, Umeå University, Umeå SE-90187, Sweden;

E-Mails: lennart.nygren@socw.umu.se (L.N.); evelyn.khoo@socw.umu.se (E.K.)

* Author to whom correspondence should be addressed; E-Mail: ahmet.gumuscu@socw.umu.se; Tel.: +46-90-786-6191; Fax: +46-90-786-7662.

Academic Editors: Nathan Hughes and Carolina Munoz-Guzman

Received: 28 November 2014 / Accepted: 30 January 2015 / Published: 5 February 2015

Abstract: In Sweden, municipal social services provide help and support for vulnerable people with a variety of needs. Although the family has long been understood to be a focus of social work interventions, it is unclear how it is brought into the casework process in the highly individualised and specialised municipal social services. Therefore, in this study we investigated processes of client-making and role assignment in five service sectors: social assistance, child welfare, substance abuse, disability, and elderly care. We carried out focus group interviews with social workers in each of these sectors in a mid-sized community in central Sweden. Findings showed that clienthood and the family are interpreted in different ways. The family is brought into or kept out of service provisions in ways that are connected to social workers' construction of the family either as expert, client or non-client. However, the role of the family may also change during the casework process. Findings are examined in relation to theories of the welfare state and implications for family-focused practice are discussed.

Keywords: clienthood; family; social services; focus groups; familialisation

1. Introduction

In this era of globalisation, family policies and social welfare services are at the intersection of increasingly diverse family constructions and complex welfare environments. Although the family is

the primary unit of socialisation and is responsible for the economic and social well-being of its members, when it cannot fully carry out these tasks the family becomes a priority area of the social work profession. At the same time, how social workers provide service is highly dependent upon the social, political and organisational contexts in which they work. In Sweden, the state assumes a high degree of responsibility for citizens through broad ranging institutional involvement in service provisions carried out in the municipal social services where the majority of professional social workers are employed [1]. Enshrined in law, the state has been given the responsibility to provide necessary measures to promote “good enough” living conditions to all individuals and families living in Sweden’s 290 municipalities (Social Services Act, chap. 1, Section 1 [2])

Although the private (for profit or non-profit) and voluntary sectors also play a part in the overall provision of welfare [3], the municipal social services ultimately must offer information, support and help for vulnerable individuals and families. However, because of municipal autonomy, and since local structural conditions and access to resources may differ [4], there may be variations in how service delivery is organised [5]. Dealing with conflicting political, legal, organisational and public expectations may also lead to variations in how social workers target families as clients [6]. Finally, unlike “think family” developments in the UK [7,8], successive governments in Sweden have formulated individualising and defamilialising policies that have reduced personal dependence on both the labour market and family relationships [9].

And while criticisms have been levelled with regard to typologies of Sweden as an individualised [10], universalised and defamilialised [11] welfare state, these studies have emphasised examinations of choice, financing and service intensity respectively. There is less empirical evidence of how social workers as “street-level” bureaucrats implement the policies of the welfare state within the “rule-saturated” [12] environment of local social services. What happens to the family in a welfare environment that is suffused with ideals of individual rights and choice? How is the family given access to services that it may need or want? In addition, what happens to the family in the casework process? We explore these questions in this study of families and clientification in five key sectors of the social services. These are: (i) social assistance (SA); (ii) child welfare (CW); (iii) substance abuse (SUB); (iv) disability (DIS); and (v) elderly care (EC). Our interest was to uncover when and how social workers consider “family” in casework from intake and investigation to service implementation. We connect our analyses of the clientification of the family to the purportedly individualised and defamilialised Swedish social services as well as to the concepts of universalism and residualism that prevail in typologies of welfare states.

Clientification and the Family in Social Work

Clientification is a process whereby individuals or families become the objects of investigation and decision-making by social workers and other professionals [13]. As clienthood is a temporary social construction, the interventions received by individuals and family members depend on how they are constructed and accepted as clients by social workers ([14], p. 16) as well as how they see themselves in the client-worker relationship ([15], p. 12).

Organisational rules further restrict whether individuals and families are accepted within a particular organisational framework. These rules can be established by both the organisation but also

by social workers as people are processed and transformed into the raw material of human service organisations [16]. Clients take on a bureaucratic identity that is standardised on the basis of pre-specified variables allowing a person to fit into a particular administrative category [17]. Swedish social work research has shown that clientification includes a categorisation process which transforms a human problem or need into a “case” which fits predetermined organisational frames of understanding before support and care can be provided [18–20].

Piltz and Gústavsdóttir [21] describe how the role of the family is not immediately considered by social workers given that society largely perceives the causes of and solutions to social problems as residing within the individual. When they do turn their professional gaze to the family, they may see it in terms of the kinds of roles it may play in the professional relationship. These roles include: the *consumer* who uses the offered services; the *consultant* holding important knowledge about family members’ backgrounds and personal circumstances; the *colleague* who may sometimes share tasks with social workers; and the *client* who has a problem or is in need of help. But, when are these roles taken on and why? Can roles change during the casework process and are roles established according to the sector in which services are being offered?

2. Method

2.1. The Focus Group Interview

To explore how social workers consider the family in the casework process, we carried out focus groups in the five key sectors of the social services. Focus group interviews have been used as an effective method in data collection in social work research [22–25]. They have been increasingly used to investigate experiences of service provisions [26], to explore discursive practices [27] and to approximate what social workers really do when more direct methods of data collection (such as ethnographic studies) are not feasible or are unethical. The focus groups enabled us to call upon group experiences of the client-making of families in the casework process and provided us the methodological advantages of being able to explore responses and reactions between group members [28], whose viewpoints about service provisions could vary. Participants knew each other through their work, which facilitated their interaction and could therefore complement, enrich and build on each other’s perspectives [29].

2.2. Sample Selection and Characteristics

Five focus groups were carried out in one municipality (population *ca.* 100,000 inhabitants) located in central Sweden in order to get a broad view of how families are processed through a social service organisation and become clients. Although there may be some variation in the organisation of social services in Sweden [5], almost all municipalities organise their social services into specialised practice areas. In this way, knowledge gained by studying this municipality may be transferable to other contexts.

Between ten and eighteen caseworkers were employed in each sector and we succeeded in recruiting five or six persons for each group ($N = 27$). All participants but one had a social work degree (one participant had 1.5 year vocational training in homecare work). Work experience varied widely between participants but the average work experience was about eleven years. The social assistance

and child welfare sectors were additionally divided into several specialised sub-units such as those working with different age groups and those working with specific types of problems.

2.3. Procedure and Ethics

The interview guide contained thematic questions about characteristics of the participants' work, defining "family", how families become involved in services, and the processes whereby families become clients and may be offered interventions. Each focus group interview was carried out in Swedish and lasted about 2.5 h. Both of the focus group facilitators spoke Swedish and one was also a native English speaker. The interview guide was semi-structured and allowed the authors to ask follow-up questions [29]. We posed open questions since it was important to get the group participants' own and group-wise co-constructed definitions and understanding of family and the meaning of family in relation to their work. The Regional Ethical Review Board approved this project [2010-390-31] and we carried out the study in conformance with the ethical principles of the Swedish Research Council [30].

2.4. Data Analysis

Analysis began with the verbatim transcription of the audio recorded interviews and importing all material to the software program NVivo10. The use of software is an efficient way to manage, sort and categorise data [31] from focus groups. Transcription and analyses were done initially in Swedish. Later in the process of manuscript development, quotes were translated to English. To ensure the veracity of translation, we (as native English and Swedish speakers) re-checked quotes. The authors adopted a qualitative content analysis approach to analyse the data [32,33]. We began with a cross-sector naïve reading of each of the transcripts, reviewing each several times to obtain a "sense of the whole" [34]. We then carried out a sector-by-sector analysis in which we identified meaning units and coded these; codes were derived mainly as *in vivo* codes and sorted into thematic categories. A cross-sector analysis then took place where we examined the transcripts for the presence or absence of thematic categories across the five sectors being analysed. These categories were clustered into two themes with varying properties that were found to occur in all five sectors. One theme describes how families are processed as cases and the second theme that describes the various roles that families take during the investigation process.

3. Results and Analysis

3.1. Processing Cases through the Social Services

The Swedish social services offer support in the form of "hard benefits" (cash, accommodation and "goods" of various kinds) and personal social services provided by caring professionals, including (but not exclusively) social workers. The legislative frameworks of social work practice regulate eligibility for support and the forms that support takes. Key legislative areas include: general or framing legislation found in the Social Services Act; compulsory care legislation in the Care of Young Persons (Special Provisions) Act (LVU), Care of [Substance] Abusers Act (LVM) and the Compulsory Mental Care Act (LPT); and rights based legislation such as the Law regulating Support and Service to

Persons with Certain Functional Disabilities (LSS). We theorise about legislation as a “mediating mechanism” in social work practice elsewhere [35].

Before support can be offered, a problem or need of assistance must first become a “case” by the social services intake unit which handles self-referrals/applications or reports of need or concern referred most often by schools, police or health authorities. The intake unit has a “gatekeeping” purpose that determines whether or not the client will be granted further access to the social services. If access is granted, the case is transferred for further investigation to the service sector specialised to meet that kind of need or problem. Each sector is then further divided into sub-areas and internal groups with a variety of specialisations based on the age of the client (e.g., child, youth, adult, or elderly), stage in casework process (investigation or on-going work) or by client type where on-going work is further specialised according to the objectives of work with highly specific client types (e.g., individuals who may or may not have the capacity to enter the labour market within specific time frames).

The processing of a “case” is, in and of itself, not unique in that a case is initially screened in the intake process before a more thorough assessment is carried out, followed by decision-making and the implementation of support and care services. What is important is that the family as a whole is not defined as the “case”. The individual is. When the family first meets the gaze of the social worker, it is deconstructed to fit the organisational constraints of the social services. As one child welfare social worker stated,

“...you could say that we are a really functionally divided organisation”. (respondent CW)

3.2. The Family's Roles and Functions in Social Service Processes

In all sectors, social workers described working individually but having the family in mind after receiving a referral or request for service, when assessing needs and when targeting interventions. In our analyses of their descriptions of the casework process, we observed that the family could take on a number of different roles and functions in its relationship with the social services. In sociological terms, a role can be understood as a positioned set of rights, obligations and expected behaviour patterns [36] that the family takes on in the social service process. Functions are the things that a person does in performing a particular role. In our study, the family could function as expert in the roles of consultant or colleague or it could function as a service user in the roles of client or consumer. Roles and functions are elaborated upon in the text that follows.

Although the social worker is primarily interested in serving the needs of the individual client, the family could be brought into the service process and be assigned different roles in it. As also described by Piltz and Gústavsdóttir [21], these roles included: consultant, colleague, consumer and client. However, we also uncovered a non-client role when the family is perceived as demanding, disruptive or in need of services outside of the mandate of the particular sector. These roles are not rigidly established but rather may vary depending on where in the social work process the service user is positioned (e.g., intake, investigation, service provision; Table 1). It is important to note that these roles are not explicitly defined by the social workers themselves. In the text that follows, we describe the various roles that the family takes on and the functions served by each of these.

Table 1. The family’s roles in casework and clientification processes.

Phases		Application/Report					Investigation					Service Provision				
		Consultant	Colleague	Consumer	Client	Non-Client	Consultant	Colleague	Consumer	Client	Non-Client	Consultant	Colleague	Consumer	Client	Non-Client
Sectors	Elderly care (EC)	X				X					X	X	X			
	Disability (DIS)	X		X			X				X	X	X			
	Substance Abuse (SUB)	X				X	X				X			X		
	Child Welfare (CW)	X		X	X		X	X	X				X	X		
	Social Assistance (SA)				X	X				X				X	X	

3.2.1. The Family as Expert

There are two ways in which the family can be constructed as an expert. In every sector of the social services except social assistance the family functioned as an expert source of knowledge about the primary client in the initial stages of the casework process *i.e.*, intake and investigation. As the casework process progressed, the importance of the family as a knowledge expert diminished and in some cases the family became expert as a service provider instead.

Consultant Role

It makes intuitive sense that at the intake stage, the family is often brought into the casework process as a source of vital information regarding the client. Worried family members or others in an individual’s wider social network, including authorities such as health care, schools or the police, may submit referrals. Then, during an investigation, the family is often involved in the process by providing information regarding the individual who is the subject of investigation or the family may be a source of support for the individual because of the knowledge they bring regarding the person’s circumstances.

“If there is a person with dementia, for example, then relatives come here first.”
(respondent EC)

The consultant role is something that can be initiated by the family at the intake stage but, in cases where the client is an adult, the client’s consent is required in order for the family to be able to remain as a knowledge provider in the casework process. A social worker in the substance abuse sector describes it this way:

“So maybe a parent calls us as says, ‘I’m so worried, we have to do something’...and I say, I hear what you’re saying, you can definitely tell me what you know...but I can’t say so much. And so that gap is so great if now Kalle doesn’t say ‘it’s ok, go and talk to mom and dad or whoever’...of course it would be easier if he did.” (respondent SUB)

Colleague Role

In some cases, the family may be drawn into social services in a collegial way. All social workers, except for those who worked in social assistance, identified the family as a source of support and help

for the client. The kind of helping role that was expected of the family differed between sectors but, regardless of the specific kind of input they provided, their contributions reduced the extent of involvement by the social services. As a colleague, the client's children, parents or relatives could provide support by helping to complete an application, taking part in meetings, helping the client with information, choosing available services and convincing the client to accept these. Family could also provide care during the daytime or evening so that the social services would not need to be called in. In some cases, the colleague role could become blurred and overlap with the client role such as when a family itself was provided short-term relief in order to be better able to cope in providing care itself over the long-term.

“...say there's a child, 4–5 years old. Their parents do not *have to* go on a short-term stay but we grant the intervention anyway in order to give the parents the strength to cope (...) so that the child may continue to live at home...” (respondent DIS)

Within the substance abuse sector, respondents said that family was often non-existent but that they would still ask relatives and persons in the client's network for help that could reduce isolation and maybe even motivate the client to accept help. They could only pursue this contact if they had the consent of the client who was over age 18. The family could be the source of a referral to social services. By being engaged with the individual, they would also be assisted in getting help and support to handle the substance abuse problem. In the following quotations, L, H and K are labels we put on group participants in order to keep their utterances separated.

“L: ...The family can call and report their worries to us...”

“H: ...We offer family treatment for them out there also...”

“K: ...So maybe if a parent calls with a worry...” (respondents SUB)

When the social worker sees the family as a resource or source of help to the client, collaborative efforts become less problematic. The example below illustrates a problematic situation where an elderly person cannot express his needs and the social worker tries to involve the family in a collegial way so that intervention can begin.

“...maybe that person needs to come into a care facility...we can hope that there is a relative or trustee who can certify or tell us that the person needs help from time to time...we assume the relatives will agree because you have to think that our intentions are good anyway...” (respondent EC)

3.2.2. The Family as Service User

In recent years, social work has been challenged to critically re-think terms used to describe the relationship between those who provide a service and those who are recipients of these. Attaching a label to relationships is never unproblematic because these reflect different kinds of power relationships [37,38] but also may bear with them nuanced meanings understood in various ways by different people. Hübner [39] further problematises the use of terms such as service user, client, and consumer in the Swedish social services. For the purposes of this study, we use the term “service user” to describe the general function of the family as receiving some kind of service. To carry out this

service user function, the family must take on the role of consumer or client in their relationship with the social worker and social services.

Consumer Role

When the family assumes the role of consumer, it may apply for or purchase measures of its own choice. These measures are directly connected to the individual's needs and can be sought by either family members or relatives. Our study found differences between how cases involving exclusively adults or also involving children are handled. Nevertheless, the family may be considered a "consumer" of measures offered if these are made available to ease the problems or stresses of everyday life. As consumers, they may actively apply for these types of services, which are offered in addition to those connected to formal needs-assessment.

"From the age of 15 you can apply yourself although you might still need to have the custodial parent's approval. For example, if you want to have a guide for something that costs money, you need to pay yourself and then the parents can automatically say no. So the best thing is for both parents and youth to apply together. And, services offered under [disability] are voluntary so you can't force anybody to accept a service." (respondent DIS)

In child welfare, parents can choose for themselves to apply for counselling services or parent education courses as long as there are no immediate signs of risk to a child's well-being.

"It is an offer to the parents, that there is a support if they want it... But it is voluntary. They have to choose for themselves." (respondent CW)

Client Role

In most cases, when an application or referral is received, the social worker will direct attention to the individual as a means of narrowing down the problem. As a case investigation begins, social workers assess how the family constellation might impact the individual. Many social workers described how those who seek help from the social services are the most vulnerable and isolated in society. The problems may be seen as located either within the individual or in the family. When social workers assess individual needs, it may be discovered that family members or the family as a whole needs support or services. However, their needs are generally passed laterally to other service sectors, which then carry out their own needs or risk assessments. A social worker in social assistance expressed it this way:

"Pure delegation-wise, if it shows up that the rent is in arrears and the electric bill isn't paid and then it lands with us. Then, if there is a child or if there are concerns about...it can get into addiction or mental illness...with young people, it's often a neuropsychological diagnosis...they may be investigated by social workers [in other sectors]." (respondent SA)

Even though family members may also receive services within the same sector, the social worker must carry out an investigation of each individual. Casework becomes problematic if these needs are seen to be in conflict with each other. In child welfare, the child is identified as the primary client but parents can receive supportive counselling and other services. In this sense both the child and the

parents are understood as clients. A shift to child-centred practice occurred with the implementation of a new child welfare approach which, translated to English, is called “Child’s Needs in the Centre (BBIC)”. BBIC is a framework for assessing, planning and review in child welfare. It is a systematic approach including structured tools to collect and document information on children and young people’s developmental needs in relation to their parents’ capacities to meet these needs and the environmental contexts in which they live. BBIC is based on England’s Framework for the Assessment of Children in Need and their Families.

“But it is individual ... even if there are for siblings that are the subject of investigation, there is one investigation and one measure for each child.” (respondent CW)

“...It’s very individually focused—on each individual; it’s because of how we use BBIC, how we investigate, how we document. But I mean it is very important that even in the guide book and the internal education we got that you should actually think of the family as a system. It’s really tricky. Once I investigated two children with two completely different needs. One was autistic and the brother had Tourette/Asperger/ADHD. Their needs were diametrically opposed and to try to help this poor mother who had to parent according to each child’s individual needs.” (respondent CW)

Support for the family is often connected to the needs of the primary service recipient. In elderly care, disability care and substance abuse, commonly the client has family members who need information or support to cope or understand the client’s problems. In such cases, family members can receive measures such as relief, respite or shared care so that they will be able to continue to care for the client in the long run. A social worker in elderly care expressed it this way:

K: “Yes, exactly if you are caring for a relative or feel like you need a rest...you can come here and apply for respite...”

V: “Or rotating care...”

K: “Yes but it’s just if it is regular and on-going, then you can have short term care if your daughter want to go on a trip or something.” (respondent EC)

3.2.3. The Non-Client Family

Respondents were quite clear about who was (and who was not) included as a client within each service sector. The client was perceived as being the person who was the main subject of an investigation. Even as families were given roles as consultants, colleges, consumers or clients, they could also be perceived as being non-clients, to be sorted and passed on or be excluded as ineligible for services but at the same time disruptive or demanding. In child welfare, non-custodial parents must have the permission of custodial parents to participate in investigations. Therefore, sometimes one biological parent can be kept out of participating in a child welfare investigation. With the non-client family, social workers felt that their hands were tied in ways that limit the work that they might otherwise want to do with whole families.

“Well, we just see whether or not we can provide financial assistance. If there are other problems we usually pass them on to those who work with the family or children. But, then

we have to take all of that into consideration in our decisions but it's not we who sit and investigate a child's needs...that's how it is". (respondent SA)

In the above example, the family really has no role or function if it does not fit within the institutional frames of a particular service sector. When the individual's family is seen as a hinder or interruption to the casework process, social workers may then want to close themselves off from this disruptive element and work exclusively with the individual.

"Relatives can be terribly difficult at times... they may even interfere with the individual we are trying to help (...) *one* would sometimes say *you* (family) may sit here and we can go to another room and talk to the individual, and we should really do that sometimes... one has to say that... now you should sit here so I can talk to the one who needs the help if possible... something like that..." (respondent EC)

In other cases, conflict arises when the family may be perceived as being demanding and absolving itself of responsibility toward the client. The family may have another opinion about their perceived responsibilities and what should be the social worker's. In the substance abuse sector, the family is often perceived as demanding, having given up on having a sense of responsibility for the client.

"L: But sometimes...people in the surroundings think we can [should do more than we can]...like providing transportation back and forth between places...we might think that the individual should be here on a short term basis only [in the social services] and then go out and be independent. But, sometimes I feel like parents and family think, 'it's your responsibility'..." (respondent SUB)

"K: Yeah, social services has been like that where they think we should be like, an extra appendage to the family, a long arm". (respondent SUB)

3.3. Functions and Patterns of Family Involvement in the Social Services

When the family takes on or is given different roles in relation to social work this may be understood to be part of a clientification process. However, although social workers bring the family into consideration in the casework process, the family is not always made into a client in the broader sense of that word. Our analyses revealed two functions carried out by the family in connection with the different roles that it is given. These are: (1) an *expert* function wherein the family acts as either an expert consultant providing knowledge about the primary client or when family members become colleagues in relation to social workers, acting as auxiliary service providers; (2) a *service user* function where in the family is a consumer of services in its own right. It may purchase these *supplementary* services or family members may be seen as clients with needs of their own. The *non-client* maybe understood as having a non-function in the casework process. The non-client is seen as unhelpful to the social worker who instead sees this client as disruptive, demanding or someone else's responsibility. Although roles and functions may change as the family moves through the casework process, particular patterns emerged as we examined the roles and functions consigned to the family in the different sectors.

At the intake stage, the family almost always assumed the role of consultant, functioning as an expert in providing information. This was not the case in the social assistance sector where the family was seen as a client only. Indeed, it exclusively maintained a client role through the entire casework process. Families in the child welfare sector were most similar to those in social assistance. The family assumed a client role immediately at the intake stage although it could also be assigned a consultant role—or even choose to be a consumer itself by attending open services (drop in pre-school, parenting groups) that do not require a prior investigation. The strongest consumer and colleague roles could be found in disability and elderly care. These roles were strongly connected to the social workers' recognition of the family's right to support itself but also its role in providing for the needs primary client. The role of the family was most varied in the substance abuse service sector. It began its relationship to the social worker as either a knowledgeable consultant or demanding non-client (which it often remained as). When possible, it would be brought in to help or support the substance abuser (*colleague*) and eventually could be identified as needing services itself to eventually support the primary client.

In our examination of five sectors of the social services it became clear that there are essentially two ways of bringing the family back in to the casework process from intake and investigation to service provision. Social workers could bring the family back in to function as experts or as service users. However, we observed that particular patterns emerged. In the disability and elderly care sectors, the family was most often seen as having a *consumer* role connected to its service user function. When the family was not in a consumer role, it was brought into casework as a “*care*” *expert*. In the case of child welfare and social assistance (and to a lesser extent substance abuse) the family were residual clients of the welfare state.

In the substance abuse sector, the family's role as a client of the social services was less clear. They could reluctantly be given a client role when the services they received could be seen as helping the primary (substance abusing) client. However, when the primary client was an adult, their expert knowledge was uni-directional. They could give information but were not entitled to more than general information about the dynamics of addiction. Consideration of the family looked different in the child welfare and social assistance sectors with the immediate clientification of the family. Indeed, the family never shed its primary *client* role but it could take on the additional role of “*knowledge*” *expert*.

4. Discussion

We acknowledge that local variations and different organisational approaches to specialisation set limits on the degree to which the results of our study can be transferred to other social service contexts. Nevertheless, we maintain that our findings allow us to analytically generalise to broader constructs and theory surrounding welfare state development. The Swedish welfare state has been described elsewhere as the “crown jewel” of the Scandinavian welfare model [39] with its extensive and publicly funded social services being regarded as “keys” [40] in the promotion of universalism and facilitation of reduced dependence on the family [10] to meet the needs of individuals. Services are provided in the highly specialised organisational context of the social services. Bergmark [1] calls this specialisation the most far-reaching and exhaustive trend of the last 30 years.

While organisationally specialised social workers may be able to target a narrowed area of problems, unless they receive advanced education and training there is no certainty that they will be more competent or equipped to solve complex problems. Rather, clients with multiple problems will increasingly encounter an array of specialists instead of one or perhaps two social workers. From the perspective of clients there will only be an increased complexity in contacts with the social services. Efforts to coordinate services within such organisational structures become difficult with resources diverted away from client support and consumed by the coordination requirements of the fragmented organisation. We have described elsewhere [41] that functional specialisation does more than just make accessing services difficult for families. The family itself is “deconstructed” into the raw material of the social services, making whole family approaches to service provision impossible if the family’s problems or needs span several sectors.

Social workers, as “street-level bureaucrats” [42,43] and the dominant profession in the social services, are also tasked with the responsibility of working out the complexities of the welfare state in their interactions with individuals and families. Their tasks are carried out in a specialised workplace but are socially organised according the supposedly universalised and individualised intentions of the Swedish welfare state. This too has implications for the positioning of the family in its engagement with the social services (Figure 1). This article has shown that a much more complex picture emerges when the family is considered in relation to the Swedish social services. Visions of the de-stigmatised client meeting in solidarity with a social worker within the macro-context of a universal and individualised welfare state are muddled by the realities of a highly specialised social service.

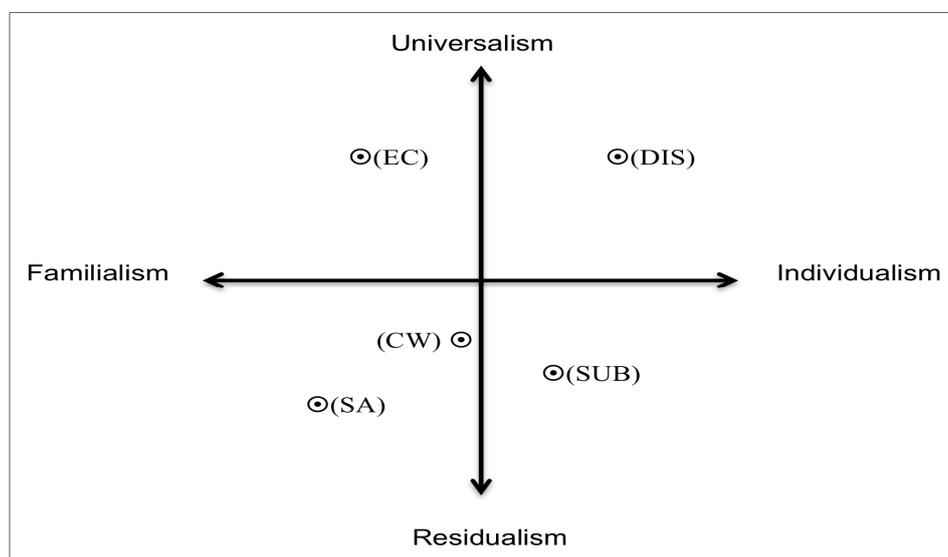


Figure 1. Positioning the family in relation to welfare state dimensions.

On the one hand, universalising trends were clear in the disability and elderly care sectors. There was at least a presumption on the part of respondents that universal social services were to be provided to all citizens in need of the respective service. Entitlements of the primary service users as consumers means that they can make choices about who shall supply services and decline services if they are viewed as unsatisfactory [9]. We found that the family also becomes a consumer of the universal welfare state when it is given access to *supplementary* support services. Only to a limited extent are

eligibility tests and fee-for-service costs supposed to restrict access to these kinds of services. Supplementary services are meant to relieve to some extent family members from care obligations but perhaps also further the independence of care-dependent individuals.

On a rhetorical level, primary service users have a right to service but this is legislatively conditioned in that the right is limited to those “whose needs cannot be met in any other way” (Social Services Act, chap. 4, Section 1 [2]) or—by their own families. Thus, when the family is brought into casework as the “care expert” it is brought in to limit the utilisation of services by the primary service user. By bringing the family back in to manage the limits of universalism, the elderly care and disability sectors become re-familialised [44]. To some extent, adult children are expected to provide for their aging parents. Similarly, parents of disabled children are expected to provide for their needs. Where the disability sector stands apart from elderly care, however, is in the case of the disabled adult. Here, individualisation of service provision dominates. People with disabilities are entitled to receive the support they need to live as independent a life as possible. This is connected to political ideological efforts to normalise the lives of people (adults) living with disability. Another normative ideal of family is brought into the equation when there is a child with a disability. In normalising the parent-child relationship, expectations are placed on parents to carry out their responsibilities toward the disabled child if the child is otherwise seen as functioning at a normal developmental level. That is, social workers appeared to normalise the disability to the extent that they assigned little social significance to the disability in connection to their expectations of parents’ capacity to meet their children’s needs.

In the child welfare, social assistance, and substance abuse sectors the family becomes or remains a residual client of the welfare state. Walton [45] calls people with these social problems “residuals” who are stigmatised and excluded from the market economy. As recipients of residual services they risk the debilitating effects of dependency whilst social workers manage and screen them from the “comfortable majority” [38]. It has been argued elsewhere that Sweden has a family service orientation particularly in the child welfare sector [46]. This perspective refers to a familialised way of thinking where problems are perceived as symptoms of dysfunctional families and where interventions are aimed at reducing dysfunction through therapeutic measures involving the family and its members. However, even the socio-ecological foundations of BBIC may be prevented from being truly whole family approaches as services now emphasise a child-perspective and the individualised child at the centre of casework planning.

The position of the family in need of social assistance is slightly different. Means testing places stringent limits on the family as a household in which members have varying responsibilities to each other. Adults have financial responsibility for children (up to the age of 21 in some conditions) and cohabitating couples have responsibilities to each other. Social assistance thus remains both highly residualised and familialised. In the area of substance abuse, the reintegration of socially or economically marginalised individuals is in focus; the family may either facilitate or stand in the way this objective. Therefore, supplemental family-oriented services are aimed at supporting the family to help the individual [47]. In contrast to social assistance, the family only has rights and responsibilities for the substance abusing young person until they reach the age of eighteen. This creates a discrepancy in how social workers in different sectors are able to respond to the needs of the family where there is a substance abusing youth.

When a family with complex needs seeks support for its problems, it may encounter not a universalised and defamilialised social service but a highly fragmented and specialised organisation with potentially conflicting service orientations. These orientations range from universal to residual and familialised to individualised. Transformations in social service provision are on-going. Nevertheless, this paper's ambition has been to contribute to the academic discourse surrounding welfare regime typologies by problematising considerations at the level of social work where welfare policy meets municipal social services and the family.

5. Conclusions

The service sectors that we studied are all affected by ongoing transformations in social service provision, where New Public Management, increased specialization and reduction of resources are influential external pressures on social workers' professional autonomy. The social work profession can learn from our study about how their constructions of and relationship with clients—and especially families with complex needs—are conditioned by these transformations. More research is also needed to fully grasp the consequences of the roles and functions that client can take in this landscape of fragmentation, specialisation and individualisation. This already complex situation is even more complicated by the increasing diversity of new family forms, migrating families and refugees. Different cultural backgrounds and experiences of crises and wars indicate a more complex catalogue of needs that social workers will meet. In a sense, social workers are caught between structural pressures that steer their work conditions and an inflow of new challenges in terms of their professional knowledge and practice.

Acknowledgments

This work was supported by the Swedish Research Council for Health, Working Life and Welfare. The authors also gratefully acknowledge those social workers that participated in this study.

Author Contributions

Ahmet Gümüşcü wrote, conducted and transcribed the focus group interviews. He carried out the coding and analyses and generated the first draft of this paper. Lennart Nygren assisted at various stages in the analysis and contributed to the re-drafting of the paper. Evelyn Khoo co-facilitated the focus groups, co-analysed the data and generated subsequent revisions of this paper. All authors discussed analyses together and contributed to the final draft of this paper.

Conflicts of Interest

The authors declare no conflict of interest.

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