Chapter 2
Chapter 2. Embedding the notion of child- and family-centred care into organisational practice: Learning from organisational visioning

Abstract

Child- and family-centred care has permeated the practices of child welfare as a means to address fragmentation. Case management appears promising, but the approach is still in its infancy. This article aims to understand the emergent organisational vision of a new approach to case management at multiple organisational levels. We conducted a case study on the implementation of Intensive Family Case Management in a Dutch organisation providing Child and Youth Protection Services. We focus on the continuous and bottom-up process of visioning, which has helped to define the shared organisational vision. We found an emerging, widely shared vision that is congruent at many organisational levels, and which contrasts starkly with the old work approach. We conclude that innovative child- and family-centred approaches to case management are inherent to a multi-level organisational system that is consistent with the approaches it advocates, being embedded in organisational structures and embodied in practitioners’ mind-sets.

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2.1 Introduction

For more than 20 years, the system of child welfare in welfare states has faced complex challenges such as bureaucratisation and fragmentation. Among others, Meyers (1993) and O’Looney (1994) (cited in Wodarski, Holosko, & Feit, 2015) observed that organisations providing children’s services were highly specialised and provided care only for a small fraction of children and families in programmes concerned with child welfare, while mutual alignment, management and coordination of such services fell short. O’Looney (1994) described organisations that were working with incompatible objectives and sometimes did not even know that they were working with the same family. Besides fragmentation, Behn (1995) recognised that child welfare organisations were overwhelmed by redundant bureaucracy; standardised protocols and control mechanisms, although initially set up to provide clarity and direction for practitioners, ultimately created an infinite and costly cycle of micro management. Moreover, practitioners unintentionally used the protocols as a defence against their own responsibility and accountability. When something went terribly wrong with a child or a family, practitioners hid behind the cumbersome administrative systems, arguing that they had complied with the protocols. To exacerbate matters, the protocols encouraged stereotyping; children and families were classified according to problem typologies and referred to a corresponding programme or intervention, taking no account of the unique child and family context (Howell et al., 2004). We can only conclude that in such circumstances vulnerable children suffering abuse and neglect did not receive adequate support.

Thus, scholars have pleaded for rethinking the child protective services system, its child-centred approaches and its experts’ perspective (e.g. Waldfogel, 2000). The emergence of the theoretical notion of family-centred care (Shelton et al., 1987), practice (Allen & Petr, 1998) or service (Rosenbaum et al., 1998) was recognised as a promising perspective that could fulfil the need for more inclusive and holistic family-centred approaches. Roberts and Early (2002) noted that, as a result of the emergent family-centred approaches, the focus of the child protective services system has shifted from child protection in the twentieth century to the current emphasis on preserving families. Concepts including participation (Healy & Darlington, 2009; Van Bijleveld et al., 2015), family engagement and strengths-based care (Kemp, Marcenko, Lyons, & Kruzich, 2014) have begun to permeate the child protective services system. Though, critics of
the family-centred notion observe that professionals tend to adopt an adult-point of view, omitting the child’s perspective (e.g. Connolly, 2007; Michalopoulos, Ahn, Shaw, & O’Connor, 2012; Sandau-Beckler, Salcido, Beckler, Mannes, & Beck, 2002). Following Sandau-Beckler et al. (2002) we understand the notion of family-centred practice as seeking a proper balance between child-centeredness and family-centeredness and, hence, refer in this study to child- and family-centred care.

There have been many efforts to develop and implement new work approaches that reflect the notion of child- and family-centred care. A key role to provide integrated care for children in need of protection and overcome fragmentation in the child welfare system seems to be reserved for case management. The significant role of case management in complex fields such as child welfare is confirmed by literature in which it is generally seen as an integrative coordination mechanism (e.g. Moore, 1990; Rothman, 1991) with the potential to strengthen the mutual alignment and collaboration of the children’s services system. Rothman (1991) highlights two functions of case management; investing in individual contact with clients and counselling; and referring clients to external care providers or setting up informal care in the family network. Knowledge about how to give substance to child- and family-centred care in the practice of case management, is, however, scarce and a true transformation seems difficult to realise. Scholars suggest that practitioners in the field of child welfare tend to stick to their clinical care routines, rather than seeking out and applying the best evidence to help their clients (Grol & Wensing, 2004). Practitioners reason that the complex reality they face on a daily basis cannot easily be captured in a guideline, a handbook or a manual, because these ignore the individual context of their clients. In addition, scholars claim that practitioners receive insufficient training to use evidence-based programmes in complex real-world service settings, are not supported by organisational structures and receive limited feedback (Aarons & Palinkas, 2007). The daily struggles in child welfare practice result in the low adoption of evidence-based interventions and approaches, low programme fidelity and limited sustainability of implementation efforts, referred to in the literature as the implementation gap (Greenwood & Abbott, 2001; Haines & Jones, 1994; Haines et al., 2004).

Scholars argue that in order to improve organisational change, adopting a bottom-up approach to build an organisational vision is a first essential step in generating broad support for organisational change and providing direction to organisational practice
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(e.g. Kotter, 1995; O’Connell, Hickerson, & Pillutla, 2011). Visioning is a prevailing concept in the literature on organisational change to create broad support for it, by mobilising energy and commitment early on in the change process (Luecke, 2003), creating a shared vision or common direction (Kanter, Stein, & Jick, 1992), or by creating a guiding coalition and empowering broad-based action (Kotter, 1995). Scholars describe visioning as a powerful leadership process through which to reduce the increasing uncertainty experienced during organisational change (Coulson-Thomas, 1992; Stewart, 1993). But very little is currently known on how a successful visioning process may unfold.

Although we cannot learn from existing impact or outcome evaluations, because we are aware of very few organisations that have already gone through the entire organisational change process, we can learn from the process of visioning in organisations that have recently entered a process to develop a child- and family-centred case management approach. This matters because organisations with a broadly shared and supported vision are expected to be more successful in bridging the prevailing implementation gap in child welfare. This article aims to understand the emergent organisational vision on a child- and family-centred approach to case management at multiple levels in an organisation. We use a case-study approach because the case in question holds important lessons for the child welfare community with respect to child- and family-centred case-management practice and congruent organisational systems.

For this purpose, we studied the emerging organisational vision of Child and Youth Protection Services in the Amsterdam area (CYPsa) in the Netherlands. This organisation started to develop Intensive Family Case Management (IFCM) in 2010. CYPsa is a regional organisation responsible for case management in child and youth protection and probation services, and in this capacity handles a complex target population of families with multiple problems and unfortunate and lengthy histories in child welfare. The organisation plays a key role in the child welfare network of the Amsterdam region, as it is certified to manage, refer to care providers and monitor the progress of protection and probation cases. IFCM has been built around the evidence-based model of case management, the Functional Family Parole and Probation Services (FFP) (Busschers et al., 2016), originating in the United States (Washington State) where it was developed for juvenile probation (for more information on FFP see Alexander & Kopp, 2008; Lucenko, He, Mancuso, & Felver, 2011). CYPsa has translated and
adapted the FFP evidence-based model of case management to fit its specific practice across different types of case management with and without court measures. IFCM integrates the dual purpose of case management in order to break through the vicious cycle of problems in which these children are caught; through IFCM professionals invest in a relationship with the children, their families and the surrounding network of relatives and friends to get to the bottom of their problems and to motivate them to accept help, and they refer the children and their families to external care providers for specialist care.

Ellett, Ellis, Westbrook and Dews (2007), Ellett (2009) and Gibbs (2009) acknowledge the importance of human caring, self-efficacy beliefs and a professional organisational culture for the retention of professionals within the child protective services system. Retention of professionals is found to be important to accomplish positive outcomes for children in need of protection (Glisson & Green, 2011) and to positively affect the adoption of evidence-based practices on work floor level (Glisson et al., 2008; Hemmelgarn, Glisson, & James, 2006). CYPSA was well aware that organisational change could face resistance from the practitioners if it adopted a top-down approach, and so closely involved its professionals in the development and implementation process of the new approach. The management provided a set of guidelines and invited a group of case managers to give substance to its new practice of case management in many rounds of planning, action and reflection. This resulted in a broadly shared and supported vision on the practice of IFCM. In accordance with the spirit of the bottom-up visioning process, we take an insider’s perspective and articulate the organisational vision of IFCM in the words of CYPSA’s case managers.

2.2 Theoretical Background

The literature shows that both the retention of professionals within the child protective services system (Glisson et al., 2008; Glisson & Green, 2011; Hemmelgarn et al., 2006) and a congruent organisational system (Aarons & Palinkas, 2007; Kitson, Harvey, & McCormack, 1998; Zazzali et al., 2008) contribute to the successful adoption and embedding of evidence-based practices and result in positive outcomes for children in need of protection. Among others, Schein (1984, 1985) Hatch and Cunliffe (2006), and Dauber et al. (2012) have developed (dynamic) multi-level models of organisational culture to advocate for implementation of new approaches and the concomitant changes in practice and the multi-layered organisational context to increase the
adoption, fidelity and sustainability of the new approach. The relevance of congruence at multiple organisational levels begins with the articulation of an organisational vision, because the articulated organisational vision should concern not only the organisational culture, but also provide an action perspective (Kotter, 1995; O’Connell et al., 2011). In this article we use the model of Dauber et al. (2012) to better understand how the envisaged organisational system to embed child- and family-centred care translates into organisational case management practice.

Dauber et al. (2012) propose a configuration model of organisational culture, delineating the dynamic relationships between operations, structures, strategy and organisational culture. The model comprises several influential theoretical models originating in the fields of organisation theory and organisational culture theory, such as the dynamic model of organisational culture of Schein (1985) and the model of organisational culture of Hatch and Cunliffe (2006). The resulting model provides insight into organisational dynamics at different levels (Dauber et al., 2012); the level of artefacts (operations and structures), espoused values (strategy) and basic underlying assumptions (organisational culture).

All organisational dynamics are grounded in the organisational culture that captures an organisation’s basic underlying assumptions. Dauber et al. (2012) cite Schein, defining organisational culture as:

“…the pattern of basic assumptions that a given group has invented, discovered, or developed in learning to cope with its problems of external adaptation and internal integration…” (1984, p. 3).

The organisational culture reflects implicit basic assumptions, which permeate and reinforce the strategy and artefacts. The strategy of an organisation is defined as a distinctive pattern of practice to accomplish the espoused values (Dauber et al., 2012) that are often captured in an organisation’s mission or vision and shapes the operations and structures at the artefact level. At the artefact level, Dauber et al. (ibid) distinguish between operations and structures. Operations can be best defined as what practitioners do and how they do it, reflecting the practices of case managers working with children and their families to create a permanently safe setting for these children, working within their organisation, as well as collaborating with partner organisations in their network. Structures, on the other hand, can be defined as the visible organisational, management and work environment structures that support operations. The organisational culture,
strategy, structures and operations are dynamically and recursively connected: the elements shape and reinforce one another through processes of assessment and learning (Dauber et al., 2012).

Based on the model of Dauber et al. (2012) we formulated our research question as:

**How can the emergent organisational vision of the new child- and family-centred case management approach IFCM be understood at the organisational levels of artefacts (operations and structures), espoused values (strategy) and basic underlying assumptions (organisational culture)?**

### 2.3 Methodology

To better understand the emergent organisational vision of a child- and family-centred case management approach at multiple organisational levels, we used a case-study approach to gain insights into the case managers’ visions of the operations, structures, strategy and organisational culture of IFCM.

#### 2.3.1 Case description

CYPSA is a pioneering organisation in the Dutch child welfare system, and one of the first to fully embrace the philosophy of child- and family-centred care. To allow for radical organisational changes to occur, the CYPSA management employed Vanguard Nederland, a consultancy company that guides organisations in change processes, to initiate organisational change at multiple organisational levels (i.e. organisational culture, strategy, structures and operations). A Vanguard consultant guided the IFCM development team, a group of ten case managers and two team managers, through the process of check-plan-do. The IFCM development team put the previous work approach under the microscope to understand which steps were of value and which were not (check), made a plan for a new work approach (plan) and started to experiment in practice (do) (Coret, 2014). In the check-plan-do process three important steps for organisational change were aligned: creating a sense of urgency (check), developing a vision (plan) and taking action (do) (based on Kotter, 1995 and Seddon, 2003). Later on, the case managers in the IFCM development team were trained by the Vanguard consultant to guide the rest of the organisation (in different cohorts) through a condensed version of the check-plan-do process. In December 2011 a pilot was initiated.
in six teams (each consisting of five to seven case managers, one psychologist and one team manager) and, after a successful pilot, the remaining teams (about 20) were guided through the condensed check-plan-do process in three cohorts. Data collection in all phases of this study took place several months after the completion of the first check-plan-do (visioning) process, by which time a more robust vision of IFCM had been developed at multiple organisational levels.

Early in the visioning process, Busschers, Boendermaker and Dinkgreve (2016) identified the core elements of the IFCM vision at CYPSA at three levels, based on an expert Delphi study:

- Content of method level: family-oriented; engagement and motivation; activate and incorporate network resources; relational focus; focus on child safety; generalisation of change
- Procedural level: intensive case management; orderly and systematic process; transparency and client involvement
- Organisational level: work as a team

In this article, we follow a bottom-up approach to further articulate and adapt the IFCM vision from the perspective of the CYPSA case managers. This research on which this article is based thus also became integral part of the visioning process that was taking place at CYPSA.

**2.3.2 Data collection**

Qualitative research methods (Gray, 2004; Green & Thorogood, 2004) were used to make an in-depth study of the case managers’ visions regarding the operations, structures, strategy and organisational culture of IFCM. We distinguish three phases in the data-collection process (Table 2.1).

In phase 1, case exploration (December 2011), we conducted three timeline interviews with case managers who were members of the IFCM development team. The IFCM programme manager invited these case managers to participate in this study. Timeline interviews were used as a means to explore and visualise events as a means to explicate the participants’ implicit thoughts (Adriansen, 2012; Sheridan, Chamberlain, & Dupuis, 2011), and stimulate experiential learning (Kolb, 1984). We found that in order to understand the new operations, structures, strategy and organisational culture, it was
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helpful to contrast these to the old way (i.e. where did we come from?; where are we now?; and where do we want to be in a couple of years?). This was an important point of reference to further shape the second phase of this research.

In phase 2, in an in-depth study (March - June 2012) we interviewed 13 case managers, one psychologist and two team managers of the six IFCM pilot teams that had just completed the check-plan-do cycle and one IFCM programme manager (n=17) on their visions. The team managers were recruited by the IFCM programme manager. The case managers and psychologist were recruited by invitation of their team manager to participate in this study. In the interviews, we particularly asked the participants about their vision regarding the new operations, structures, strategy and organisational culture of IFCM in contrast to the old situation. After the interviews, four of the six teams of the IFCM pilot participated in a focus group discussion (FGD) to validate findings from the interviews, uncover challenges they encountered in starting to work with IFCM and co-create solutions to cope with these challenges. Through the FGDs, participants had the opportunity to share their experiences, language and frames of understanding (Kitzinger, 1995) and learn from the others’ experiences (vicarious learning) (Cox et al., 1999; Guba & Lincoln, 1989). To ensure a group of participants that could critically check the researchers’ interpretations, there was overlap between the participants in the interviews and FGDs.

<table>
<thead>
<tr>
<th>Study phase</th>
<th>Methods</th>
<th>Participants</th>
</tr>
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<tbody>
<tr>
<td><strong>Case exploration</strong></td>
<td>Interviews (n=3)</td>
<td>Case managers, members of the IFCM development team (n=3)</td>
</tr>
<tr>
<td><strong>In-depth study</strong></td>
<td>Interviews (n=17)</td>
<td>Case managers, involved in IFCM pilot (n=13)</td>
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<td></td>
<td></td>
<td>Psychologist, involved in IFCM pilot (n=1)</td>
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<td></td>
<td></td>
<td>Team managers, involved in IFCM pilot (n=2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IFCM programme manager (n=1)</td>
</tr>
<tr>
<td></td>
<td>FGDs (4, n=30)</td>
<td>Teams consisting of 5-7 case managers, 1 psychologist, 1 team manager (4, n=30)</td>
</tr>
<tr>
<td><strong>Validation</strong></td>
<td>Interviews (n=13)</td>
<td>Case managers, not involved in IFCM pilot (n=13)</td>
</tr>
</tbody>
</table>

Table 2.1: Overview of study phases, methods and participants
In phase 3, (April – June 2013), we conducted 13 validation interviews with case managers not involved in the initial IFCM pilot but who were part of one of the 20 teams of CYPSA enrolled directly after the pilot. In this way, we investigated whether the understanding of IFCM of case managers involved in the IFCM pilot were similar to the understandings of those who enrolled at a later stage. These participants were recruited by an invitation posted on the organisation’s intranet.

### 2.3.3 Data analysis

Interviews and FGDs were audiotaped and transcribed verbatim. A random selection of 10 interview transcripts was read several times by the first and second author independently, followed by a discussion about the interpretation of the data. Thematic coding was used to categorise the data along the three levels of the conceptual model (artefacts, espoused values, basic underlying assumptions). Next, open coding was used to uncover patterns within the three categories of data. Overall, there was a high agreement between the themes identified in the open coding process between the first and second author, the discussion mainly focused on semantics, giving the right words to the themes found. We constructed a table per category to summarise the outcomes of the data analysis process, comparing the old and new organisational system (Figure 2.1). In an iterative process, the first author verified all other transcripts against the three tables to enrich the analysis.

<table>
<thead>
<tr>
<th>Artefacts</th>
<th>Old organisational system</th>
<th>Illustrative quotes</th>
<th>New organisational system</th>
<th>Illustrative quotes</th>
</tr>
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<tbody>
<tr>
<td><strong>Theme</strong></td>
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<td><strong>Theme</strong></td>
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<tr>
<td>Protecting through coercive measures</td>
<td>...........</td>
<td>Protecting through changing family-patterns</td>
<td>...........</td>
<td></td>
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<tr>
<td>Following prescribed protocols</td>
<td>...........</td>
<td>Constructing a tailor-made plan</td>
<td>...........</td>
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<tr>
<td>Specialised case management</td>
<td>...........</td>
<td>Generic case management</td>
<td>...........</td>
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<table>
<thead>
<tr>
<th>Espoused values</th>
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<tr>
<td><strong>Old organisational system</strong></td>
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<tr>
<td><strong>Theme</strong></td>
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<td>Solution-driven care</td>
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<td>Standardised care</td>
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<td>Protection-oriented care</td>
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<td>Process-oriented care</td>
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<th>Basic underlying assumptions</th>
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<tr>
<td><strong>Old organisational system</strong></td>
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<td><strong>Theme</strong></td>
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<td>Top-down control</td>
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<td>Protocols</td>
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<td>Process accountability</td>
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Figure 2.1: Tables for data analysis

### 2.3.4 Ethical considerations

Interviews and FGDs were conducted at the main office or regional offices of CYPSA in line with the participants’ wishes by the first and second author in their role as independent researchers. Participants were informed about the study design at the start of the interview or FGD, and researchers answered questions. Participation was voluntary and participants could withdraw at any time, without giving reasons and with no consequences. All participants gave verbal permission for the interviews and FGDs to be audiotaped, transcribed and analysed for publication. At the individual level (for the interviews) and team level (for the FGDs) summaries of the sessions were sent to the participants to validate the researchers’ interpretation. Participants were informed about research proceedings during several team presentations. Moreover, participants were invited to access various research updates on the organisation’s intranet. The third, fourth and fifth authors were only involved in the research design and during the writing process of this paper, guaranteeing the anonymity of all participants. Dutch law did not require the formal approval of a medical ethical committee, given the non-invasive
nature of this study. At no point were participants asked for personal or sensitive information such as an individual client’s history.

2.4 Results

During the data-analysis process, in all phases of our study we found widespread consensus and hardly any dissenting opinions among the participants in how they saw the main differences between the previous approach and IFCM in terms of the artefacts, espoused values and basic underlying assumptions. In some sessions the emphasis was somewhat more on the operations and structures, in others participants focused more on the underlying strategy and organisational culture, making the sessions complementary. The level of detail in the participants’ visions, in particular regarding the operations and structures did, however, increase substantially as the study progressed. This was probably due to the participants’ greater understanding of the practical implications of implementing IFCM towards the end of this study. At that time, many case managers surrounding the participants had started to work with IFCM in practice. In this section, we present the main differences between the previous professional approach and IFCM in terms of organisational culture, strategy, structures and operations as envisaged by the case managers and those directly involved in IFCM practice (team managers, psychologists and IFCM programme manager) in an initial stage of developing and implementing IFCM.

2.4.1 Espoused values: Strategy

At the start of each session, we asked case managers what future they envisaged for the children under their supervision. This helped us to begin to articulate IFCM’s emergent organisational vision. They foresaw safety for all children, a permanent safe setting to grow up, and a child surrounded by family, relatives and friends, reflecting key values for children’s well-being, such as safety, stability and permanence as established in the United Nations Convention on the Rights of the Child (United Nations, 1989). These key values resonate the IFCM organisational strategy as voiced by the participants. The case managers express their vision of IFCM in contrast to the previous approach. All case managers highlight the change (1) from problem-driven to pattern-oriented care; (2) from standardised to tailor-made care; (3) from protection-oriented to strength-based care; and (3) from process-oriented to purpose-driven care (Table 2.2).
From problem-driven to pattern-oriented care

Pattern-oriented care is one of the distinct strategies of IFCM highlighted by the case managers in the interviews and FGDs. Before the development of IFCM, the persistent and recurrent problems of children and their families were the starting point for case managers working at CYP SA. The problems were considered separately from the wider child and family context and often children were torn from their families when the very first crisis presented itself. The case managers’ focus on apparent problems created a blind spot regarding the patterns underlying their clients’ visible problems, and as a result, case managers became caught in the family’s vicious cycle of distress and recurrent problems, fighting crisis after crisis. As one of the case managers says:

We were used to treating symptoms, but the lesson [of IFCM] is, search until you have found the underlying cause and try to do something about that.

The case managers’ perspective indicates that with the development of IFCM, case managers agreed that they had to learn more about the child and the family behind the complex and recurring problems by investing in a relationship with the family, delving into the family system, and adopting a more holistic perspective to find the deeper causes of problems. A case manager explains:

Before, I mainly noticed the problems and I often responded with a short-term solution. I now get to know the child and the family behind the problems, [because] I see them [the families] much more often. (...) I understand the family better; I can better assess the impact of a crisis, and I get a better understanding of a family’s demands.

Several case managers explain that a holistic perspective reveals entrenched patterns in a family’s behaviour, communication and interaction, which may form the basis of the problems and crises they observe. They no longer consider manifested problems as separate from the entrenched patterns. This coherence is also reflected in the family plan, which includes a detailed analysis of strengths and weaknesses in the family’s interaction, communication and behaviour to gain insight into the entrenched family patterns. Case managers consider it their task to break through family patterns and to prepare children under their supervision to be able to participate in society. One of them indicates:

IFCM propagates that each individual in our society could manage his own joy and happiness in its own way. We [as case managers] should contribute by breaking through family patterns.
Only in this way will it be possible to prepare the next generation to manage themselves in the future society.

Several case managers explain the underlying rationale. They believe that by breaking the vicious cycle of distress in families under supervision of child welfare programmes, the next generation is offered the opportunity to develop to its full potential.

*From standardised to tailor-made care*

Several case managers explain that during the visioning of IFCM, a close and profound examination of past cases showed them that in most cases they had failed to improve children’s safety and to break through the family’s vicious cycle of distress. Frequently, children and their families returned within a few months after another incident or report of child abuse or neglect. Many case managers say that for years they sensed that they were controlled and steered by standards and protocols, adding that these did not consider the child and family context beyond the immediate problem, or leave room to leave the beaten track. Case managers had the feeling that they were entangled in a web of protocols, procedures and legislation:

*We primarily tried to reach targets, to please the organisation and partner organisations.*

Most of the case managers say that, before, they often tended to refer children and their families to care providers based on the available provision in the Amsterdam region. They attributed this mainly to the numerous protocols, which prescribe in detail each step a case manager should take, leaving little room for alternative thinking and tailor-made care. As one of the case managers illustrates:

*Within our organisation, we used to refer children and families to care programmes as soon as possible. Moreover, we used to match children and families to existing care programmes of care providing organisations. We just said to each other: ‘We cannot offer a programme that is better than this one.’ Now, we insist on a tailor-made care programme, meeting the specific demands of the child and family. Perspectives have changed 180 degrees.*

IFCM case managers widely share the vision of tailor-made care. One case manager states that she feels that it allows her to go back to the essence of child welfare practice, although this requires a completely new mind-set:

*Actually, we are reminded of why we have chosen this profession in the first place, just to help out children and their families. That is the best part of this whole thing [the IFCM approach],*
constantly asking questions such as: ‘Is this really the best option for the client, or just the easiest way out for you? How does it benefit the child and the family?’.

Since the development of IFCM, case managers are equipped by the organisational system to organise, or even create, if necessary, the best possible care for their clients and to avoid second-best options. Numerous examples of tailor-made care are mentioned:

One of my clients, a boy suffering from an autism related disorder and problems with concentration, bad, over the years, made an attempt to fit in the care programmes offered by care providers, without any success. Due to the implementation of IFCM, I took some time to rethink the whole situation. Together with several care providers, we developed a new intervention in line with the demands of this boy.

A girl from Poland came into contact with crime and the wrong friends. For her own safety she was placed out of home in a closed setting for three months. This was not beneficial for this girl. The involved case manager worked really hard to find a better place for her. This place was found on a large horse farm in Belgium, where she was offered a safe and warm place to grow up. She had the opportunity to work with animals and to develop to her full potential.

Some case managers say that leaving the beaten track helps them to expand prospective actions of themselves and others.

From protection-oriented to strengths-based care

Previously, the child was often depicted as a victim of abuse and neglect in need of protection. Several case managers explain how they felt responsible for solving the problems of the child and the family, thus facilitating a relationship of dependency. A case manager explains:

We adopted the problems of the child and the family [as we were the ones to solve the problems] and thereby made them dependent. They do not know how to handle their own problems, they say: ‘that is their [referring to the case managers] responsibility’.

In contrast, IFCM stimulates case managers to invest in a more equal relationship with the family from the start, using a strength-based approach. One of the case managers reflects on this empowering relationship as follows:
I hope that I can provide them insights into their actions, without immediately presenting clear-cut answers. I hope to ask questions that force them to think about their actions and that they themselves unravel certain things.

Many case managers indicate that the report of child abuse or neglect is no longer the starting point for the conversation with the child and the family. Instead, they now first seek a connection with the family, to get to know them and to motivate them to accept help.

I now hear more often: ‘I am confident that you can help us out’. Before, they [the families] never said that. You had no real connection with the family, you visited them once or twice, took a number of important decisions, and the child and the family often disagreed. Now, I still have to take important decisions, but I take them together with the family, so that they accept the decisions and feel responsible. That is a major and valuable change.

Ownership is created by the active participation of children and their families in their care process. Case managers help children and their families to solve their own problems, thereby fostering independence rather than dependence. Several case managers mention that they seek to guide the family towards sustainable change.

The families have to go their own way. I have learned that it is not my problem, it is the problem of the family and they should make an effort to fundamentally change the situation. I am only an instrument to guide them in a certain direction or to show them different solutions, but I do not have the power to solve their problems, they have to solve their own problems.

Case managers become an instrument for guiding the family and it is also easier for them to take some distance from their work.

From process-oriented to purpose-driven care

A fourth identified strategy was purpose-driven care. All participants indicated that the omnipresent bureaucracy of the previous approach had unintentionally created a focus on the justification of processes in child welfare. Routines and control mechanisms were deeply rooted in the case managers’ mind-sets. Case managers felt as if they were constantly justifying their actions, for example by keeping a detailed contact record. Several case managers say that if something went wrong, they had at least followed the procedures and could justify their actions with the up-to-date contact record. This made them feel as if they were held accountable for the care process, instead of for the
outcomes of the process for the children and families under their supervision. As one of the case managers explains:

    Before, we were more busy defending our own position, than [creating value] for our clients. If we just handled our cases according to the protocols, and we demonstrated that we did everything we could, than it was good enough. It was not the child, nor the family who decided when it was good enough.

According to the case managers, it was necessary to create trust, transparency and shared responsibility by making the right expertise available at the right time:

    Before, we were defending our own position, trying to justify our actions, cleaning our caseload (...) and the organisation constantly monitored and verified what we did. [With IFCM] we would like to create trust and provide the right expertise at the right position. If I encounter any difficulties, than I can call in the help of my colleagues, including a psychologist and team manager.

All participants agree that outcomes and impact for children and their families should guide the actions of case managers and no individual case manager can now be held responsible if something goes wrong as decisions are now considered a joint effort. Purpose-driven care offers a solution to go back to the basics of case management. A case manager illustrates this as follows:

    Currently, I think more about what I do and whether or not it makes sense for the family. (...) [I try to] create more value for the families, so that we can avoid that we work with families for years without any result.

### 2.4.2 Artefacts: Operations and structures

The articulation of IFCM’s vision at the strategy level is by no means mere rhetoric, and the case managers have thought through the implications of the vision for the organisational structures and operations. When asked what the most prominent implications of the envisaged organisational strategy are on the organisational structures and operations, case managers mention three major differences between the old approach and IFCM: (1) from protecting the child through coercive measures to protecting the child through changing family patterns; (2) from following prescribed protocols to constructing a family plan; and (3) from specialised to generic case management (see Table 2.2).
From protecting through coercive measures to protecting through changing family patterns

All case managers indicate that they previously focused more on protecting and solving the problems for the individual child by using coercive measures, whereas now they also consider the child’s wider family context. Several case managers explain the importance of this turnaround. They state that the vicious cycle of distress in which these families are captured is often perpetuated by damaged relationships in the family network. The problems experienced by the children are merely expressions of entrenched family patterns.

Previously, the Delta model for child and youth protection services (Montfoort & Slot, 2008), supported how child protection was understood. Though, this child-centred model also had negative side effects, for example, it happened that coercive measures were used to force parents to cooperate. The FFP case management model replaced this in order to do better justice to the family-centred vision of IFCM. During the development and implementation of IFCM, all case managers are trained to use the FFP case management model. Like FFP, the case managers identify three distinct phases in their approach. Many case managers explain that in the first phase of IFCM, they have intense contact with the family, making home visits every week or as often as necessary. They try to connect with the family and help to motivate them. As one of the case managers explains:

*The value of FFP is that I do not primarily focus on the coercive measures, but that I mainly focus on the child and the family. I attempt to establish a match with the child and the family, because only when I have a match with the family, it will be possible to bring about change. (...) This is not necessarily new knowledge, many studies have shown that a match between client and care provider increases the probability of success.*

After case managers have established a match with the family, they jointly develop a plan to create a sustainable safe setting for the children. Many case managers emphasise that families are referred to formal care providers, and the network of relatives and close friends is also accessed. The second phase starts when appropriate care for the family has begun.

*When the core of the problems is clear, I will try to find a care programme that fits the demand of this family; then [when a family starts with the arranged care] we move to the second phase of IFCM.*
In the second phase, the contact between the family and the case manager is less intense than during the first phase. Every six weeks, case managers organise a meeting with the family and all involved informal and formal care providers to support the family and monitor progress.

*The meetings with the family and all involved care providers save me a lot of time, because earlier I had separate meetings with all care providers and next to that also family meetings.*

Moreover, several case managers explain that these meetings minimise the loss of information and confusion about who is saying what. They stress that most families feel more accepted by the care providers as equal partners with important things to say about their own care process.

When the agreed goals are met and the setting is considered to be sufficiently safe for the children, case management enters its third phase. Many case managers say that in this phase they have intense contact with the family to generalise and to anchor the lessons learned in the family behaviour and interactions in order to be better able to handle future conflicts. These agreements are captured in the family plan, to contribute to a long-term safe setting.

Many case managers indicate that FFP has become an integral part of IFCM:

*Within IFCM, FFP is completely embedded in the organisation and in our weekly team meetings.*

They stress that regular supervision leads to greater programme fidelity. In each team, one of the case managers receives additional FFP training to become a senior case manager and supervise FFP in the team. Several case managers indicate that setting up a clear supervision structure is something that had previously gone wrong. Several years before the development of IFCM, the small-scale implementation of FFP in the youth parole division of CYPSA was hampered by problems with adoption, fidelity and long-term sustainability in practice, because of limited staff training. A case manager and former youth parole officer indicates that, in particular, supporting structures were lacking and difficult to organise:

*Before, I also used some FFP techniques, but the old work approach did not provide the right context to thoroughly apply FFP. We just did not have enough time and we faced many barriers setting up the supervision.*
From following prescribed protocols to constructing a tailor-made family plan

A second prominent difference between the previous approach and IFCM, envisioned by all case managers, is the change from numerous protocols and control mechanisms to one family plan. They explain that previously their work was directed by generally accepted protocols and control mechanisms, with little room to leave the beaten track. For each situation, a protocol prescribed what a case manager had to do, for example, filling out an individual form for each child in a family. In contrast, the case managers say that they now work with one integral family plan.

How many different report formats we had? I think more than twenty-five. For this you had to use this format, for that you had to use another. The whole day you were cutting and pasting pieces of text from one document to another, and this often caused chaos. It took us hours to find the right piece of information in the contact journal. Now, we only have one family plan, so we can save time that we can spend on family visits. It is a living document; the things that you wrote down in your contact journal, now immediately get a place in the family plan.

Many case managers write the integral family plan together with the family, translating the family history into a tangible and understandable document. A joint analysis is made of safety in the family, including an overview of strengths and weaknesses, family patterns and the family’s goals on the path towards a safer setting. The family plan is updated if there are significant changes in the family situation. Furthermore, several case managers stress that the family plan also forms the basis of collaboration with partner organisations, such as serving as a referral document that is sent to care providers or as the document needed to request for (an extension of) court measures.

Working together with the family on their family plan also sets specific requirements for the information-management system. Several case managers explain that they are equipped with several structures that enable them to work for example at a family’s home or at one of the partner organisation’s offices. The organisation provides all case managers with a mobile phone and laptop to make family visits more efficient. Case managers have direct access to the up-to-date digital family plan and all related registration regarding the safety of the children. This information-management system minimises the loss of information and ensures the active participation and ownership of the family regarding their plan.
Complementing IFCM with work environment structures, it offers us [case managers] the chance to be where the work should be done, without the restrictions of an office. Support for all struggles in our work, can be retrieved at the main office [in Amsterdam]. Regular consultations with fellow case managers remain important, but this mainly takes place during the MDTMs [multidisciplinary team meetings].

In this quote one of the case managers highlights the importance of work environment structures and at the same time describes the changed function of the main office, as a support unit and a place to meet with fellow case managers, in order to offer more tailor-made care.

From specialised to generic case management

Third, all case managers mention that the vision entails a change from numerous transfers and unclear responsibilities to one case manager. Several say that until a few years ago Dutch Child and Youth Protection Service (CYPS) organisations comprised three autonomous case management silos, respectively in voluntary child and youth care, child and youth protection and youth probation. Each silo had its own case managers and there was minimal collaboration and alignment between them. At that time, families under supervision of CYPS were confronted with transfers from one silo to another, or with two or three CYPSA officers from different silos at the same time. As one of the case managers describes:

There were many internal transfers, from one department to the other. After every transfer from e.g. voluntary child and youth care to child and youth protection, a new analysis was made [by a different person], so you practically started from scratch.

In addition to one or more CYPSA officers, many other care providers and social workers were involved with the family, depending on the nature of the problems. These care providers and social workers had their own plans that were not fully aligned with the other professionals involved. Several case managers indicate that more often than not, the system resulted in a loss of information due to transfers and the lack of clarity about who was in charge. To the benefit of the families, the independent silos at CYPSA were dissolved when IFCM was developed. Now only one case manager is appointed to be in charge for the entire period that a family is under CYPSA supervision.
As a result of the new organisational structure I can now help a family on my own [i.e. only one case manager in charge], while before different case managers were assigned to the family, which caused a lot of confusion.

All case managers agree that the case manager is now the central contact person for the family as well as the relevant partner organisations. The case manager has in-depth knowledge about what is going on in the family and is therefore equipped to develop an integral plan and make important decisions together with the family.

IFCM requires that you take control, but also that you build a relationship with the family. It requires collaboration with a lot of different partner organisations at the same time and a transparent work approach. On the one hand you have to be nice and understanding, but on the other hand you also have to take heavy and undesirable decisions.

Being a case manager at CYPSA is not an easy job. Case managers explain that they work in multi-disciplinary teams (MDTs) that support them in the important decisions that they have to make. At the time the silos were dissolved, the existing teams were remixed and the expertise regarding voluntary child and youth care, child and youth protection and youth probation was evenly distributed among the new MDTs, comprising five to seven case managers. The expertise of the individual case managers was expanded with the inclusion of a psychologist and a team manager. The MDTs reflect on what they do and how they do it in weekly three-hour meetings.

If we think about solutions with the whole team, various options are put forward, more than I could come up with on my own.

This contrasts with the earlier approach in which the CYPSA officers only had irregular bilateral consultations with a psychologist or their team manager.

Part of the multi-disciplinary team meeting (MDTM) is devoted to questions that case managers have in relation to the content of cases. This part of the meeting mainly addresses the what. Another part of the MDTM is devoted to FFP supervision guided by a senior case manager. In preparation for the supervision, case managers write case notes about their conversations with the family. During the FFP supervision the how is addressed, by discussing in detail the application of FFP conversation techniques. Over time, these two parts of the MDTMs have become increasingly intertwined.
The psychologist and the team manager also have a specific role in the MDTMs. The team manager guides the dialogues and chairs the MDTMs, asking critical questions and providing direction as necessary. If asked, the psychologist offers insights into normal and abnormal child development and psychological disorders of children and their parents.

In the MDTMs, case managers also share difficulties and barriers in the collaboration with partner organisations or organisational barriers that restrict the case manager in their principal process. When case manager cannot solve the difficulties, the issue is referred to the team manager.

The role of the team manager significantly changed from a monitoring role to a more supportive, substantive and constructive role. Previously, team managers were expected to monitor targets and related measures and had a more distant role with respect to case managers. In contrast, the new IFCM team manager maintains a close relationship with the case managers. The team manager makes an effort to retrieve insights into the stories and context behind the problems of the children and the families under supervision of the case managers and so can coach the case manager in making the right choices in the primary process. The new role of the team manager is also reflected in competence management. Team managers have annual meetings with each of the case managers to reflect upon their competences, what they have learned and what they would like to learn in the coming year. This provides insight into their learning process and provides direction to the development of competences.

The three operations of IFCM (protecting the child through changing family patterns; creating a tailor-made family plan; generic case management) are also referred to as one family, one plan, one case manager.

2.4.3 Basic underlying assumptions: Organisational culture

The organisational culture supports both the strategy and artefacts described above. With respect to the organisational culture, all case managers indicate that they envisage significant changes between the culture underlying the previous approach and the culture underlying IFCM: (1) from top-down control to ownership; (2) from protocols to reflection; and (3) from process accountability to shared responsibility (see Table 2.2).
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From top-down control to ownership

Many case managers indicate that they feel that IFCM promotes ownership over their work. They explain that, where previously they often felt restricted by the bureaucratic overload and the top-down imposed control mechanisms, IFCM provides room for interpretation, for example in developing a tailor-made family plan, and thereby promotes ownership.

From protocols to reflection

Case managers indicate that the organisational culture stimulates reflection in and on action, whereas before protocols and control mechanisms left little room for interpretation and reflection. Reflection in and on action makes a particular feeling more explicit:

[Presently], I am forced to reflect on what is really going on in the family. (...) Perhaps, earlier, I had a gut feeling that something was going on, but by writing things down I can make things more explicit.

In particular, many case managers see the MDTMs as a platform for learning and reflection. They explain that the MDTMs contribute to a deeper understanding of their complex practice:

In the MDTM you are supposed to reflect on your own actions. You learn a lot. [For example], why does this woman get on my nerves? Why can I no longer enter the home of this boy? Sometimes you have those moments [when it is hard to handle the feedback of your colleagues] when you wonder, ‘why me?’ or ‘not now!’; but you learn a lot.

All case managers agree that the MDTMs yield clear and new ways of looking at the problems of children and their families. Colleagues’ experience and critical questions help case managers to look at their cases from a different perspective.

Everyone is really motivated [during the MDTMs]. You are forced to review your cases, for example by giving safety scores. What safety score do you give and what does it mean?

The safety scores force case managers to critically think about the safety in a family at any given point in time. By collecting the safety scores over time in a safety chart, including a short argumentation, case managers are provided with a transparent and low threshold instrument to monitor safety.
**From process accountability to shared responsibility**

Many case managers acknowledge that the organisational culture of IFCM fosters shared responsibility for cases (and thus clients) at team level and beyond. They recall that previously everyone was working on their ‘own island’, guided by standard protocols and process control mechanisms, but this has changed significantly with the implementation of IFCM. Several case managers say that they no longer feel that they stand alone, but that they experience, for example, a shared responsibility for the cases in their team, because all of them are discussed regularly and important decisions are made together. One case manager indicates:

*The clients are no longer my clients, but the clients of CYP SA.*

Another case manager adds:

*BBecause of the shared responsibility I feel more confident to make tough decisions.*

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Chapter 2

| Specialised case management | - Organisation is structured in three silos  
- Irregular expert consultations | Generic case management | - One case manager as central contact for family and care providers  
- Expertise spread over MDTs  
- Weekly MDTMs |

**Organisational culture**

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Table 2.2: Prominent differences between the previous professional approach and IFCM

2.5 Conclusion and discussion

This paper has offered insight into the emergent organisational vision of IFCM at CYPSA from the perspective of its case managers. By doing so, we have shed light on the concepts of child- and family-centred care in an organisational context in a detailed way. The unfolding vision shows that a family-centred theory or practice is just a means to reach child safety, not an end in itself. We have shown that the new organisational vision is driven by the values of pattern-oriented, tailor-made, strengths-based and purpose-driven care, which are believed to be key to reach positive child and family outcomes. These values are reflected in the artefacts and are resonated in the basic underlying assumptions of the organisation. In contrast to Sandau-Beckler et al. (2002) who propose incremental changes in the child protection system to implement family-centred values, the sharp contrast of the organisational vision of IFCM with the previous approach shows that embedding the theoretical notion of child- and family-centred care requires radical, rather than incremental, organisational change at multiple levels.

These findings may lead other organisations to learn from the value-driven vision that is reflected on multiple organisational levels and the radical organisational changes that it requires. In this study, however, we have only provided limited insight into the organisational change process itself and the leadership strategies deployed to initiate and propel radical organisational change. Also, we did not address the immense effort, conviction and persistence of the management that is needed to bring about this transition, since we have only included the case manager’s perspective. In another
research paper, that we plan to finish by the end of 2016, we will elaborate more on the management perspective, the change process and the deployed leadership strategies (Van Veelen, Broerse, & Regeer, n.d.).

Following the expert Delphi study of Busschers et al. (2016), this article further articulates the emergent organisational vision of IFCM, now following a bottom-up approach. By comparing both studies, we see how dynamic a continuous process of visioning can be. Both studies are, in essence, an integral part of the visioning process of this child- and family-centred case management approach. The emergent organisational vision is in this study further specified and adapted to the insights of the case managers and structured according to multiple organisational levels, and thus provides clues for the further implementation of IFCM in CYPSA, as well as lessons for other organisations in child welfare. It is remarkable to witness how meticulous CYPSA has been in approaching the organisational visioning process. All case managers emphasise the added value of IFCM compared to their old work approach.

The four values (i.e. pattern-oriented, tailor-made, strengths-based and purpose-driven care) outlined in this paper, that are deployed to break the vicious cycle of distress in which families being supervised by the child protective services system are often captured, are also reflected in the literature. For example, Graves and Shelton (2007) demonstrate that, of different mechanisms employed in family-centred care, family empowerment (corresponding to our understanding of strength-based care) stands out as an important change mechanism. It is striking that purpose-driven care, although implicit in literature on family-centred care, is not explicitly recognised as an important change strategy. Other fields of scholarly literature put purpose at the centre, emphasising its importance in distinguishing means from ends (e.g. De Wildt-Liesveld, Bunders, & Regeer, 2015; Hart, 2012), which may also provide a valuable frame of reference for child welfare.

To get a clear understanding of the purpose and to choose the right means to attain it, case managers repeatedly mention the critical importance of reflection in and on action with their colleagues in the weekly MDTMs. Ruch (2007b) confirms the importance of case discussions in, what she calls, thoughtful child welfare practice. She calls for a case discussion model to overcome external and internal obstacles to thinking to create safe spaces in which practitioners can share uncertainties and think creatively. These safe spaces enable practitioners to make difficult decisions in daily practice. In the context of
patient-centred care, Hobbs (2009) uses the concept of rule flexibility for health professionals in patient-centred practices, which is required to determine “*when and how to deviate from established norms and standards when the patient situation dictates*” (p.55). Rule flexibility can be recognised in IFCM’s tailor-made care strategy, which requires case managers to leave the beaten track and to experiment with alternative solutions that may better meet families’ needs. The organisational culture as understood by case managers contributes to rule flexibility, as it promotes ownership, stimulates reflection and fosters shared responsibility. This is congruent with the argument of Smith and Lewis (2011), researchers in the field of organisational behaviour, who claim that a learning environment is required to facilitate flexibility and resilience and make optimal use of human potential.

In this light, there are several study limitations that should be taken into account. The current study uncovers insights into a unique and pioneering organisation, allowing only for limited generalisability of the results. Furthermore, in our study design we mainly relied upon the narratives of case managers in which they share their perspective on reality, rather than verifying their narratives in observations. Argyris and Schön (1974), reflecting on potential discrepancies in this respect, refer to two theories of action: the implicit *theory-in-use* (how people act) and the explicit *espoused theory* (how people say they act). For the same reason, we are critical on the self-selection of case managers to participate in the interviews of this study. This convenience sample might have resulted in a biased perception of reality. All teams and, thus, all case managers were, however, covered by the FGDs.

Moreover, it is important to note that we have studied IFCM’s emergent organisational vision and did not conduct an impact or outcome evaluation, since it was too soon to do so. It may well be that the widespread consensus about the rhetoric (espoused theory) does not translate into practice (theory-in-use) on the longer term. Although we consider it essential to undertake an impact or outcome evaluation, an important first step is an emergent organisational vision that is as widespread and supported as IFCM’s. We anticipate that the findings of this study will constitute an important lesson in how case management may function as an integrative mechanism in child welfare that is based on child- and family-centred care.

By articulating the emergent organisational vision of IFCM on multiple organisational levels, we have shown that IFCM is more than a generic description of a child- and
family-centred approach that can be captured in a handbook. IFCM is highly contextualised in the organisation of CYPSA at the macro level and embodied in mind-sets of individual case managers at the micro level. Case managers experience unique support from the organisational structures, and the strategies and culture are embodied in their mind-sets. This has implications for both implementation practice and research. For implementation it implies that it is no easy task to disseminate an approach that is so embedded in its organisational context (Dearing, 2009; May & Finch, 2009). The characteristics of IFCM, explored in this paper, can be explained only in the organisational context of CYPSA. The challenges facing practitioners are also context-specific and might not be the same in different organisational settings and contexts. The significance of an approach, like IFCM, in a new organisation depends strongly on the organisational context and the niches it offers, and so is best determined from an adopter’s perspective (Dearing, 2009; Hoes, Beekman, Regeer & Bunders, 2012; May & Finch, 2009). We suggest that more research is needed on the dissemination of highly contextualised and embodied work approaches. For research, we have to reconsider the concept of evidence-based, because also evidence is highly dependent on the context and mind-set that complement the generic understanding of a professional approach. The notion of linear implementation models is increasingly obsolete and implementation processes increasingly resemble innovation processes (Dearing, 2009; Hoes et al., 2012; May & Finch, 2009); the boundaries between implementation and innovation become gradually blurred. We suggest the need for more research to study the boundaries of implementation and innovation in contextualised and embodied approaches.