The Use of Assessment Tools in Child Protection: An Ethnomethodological Study

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Abstract

This research focused on how child protection practitioners in the Department of Child Safety, Queensland used the Structured Decision Making (SDM) tools in their practice with children and families. SDM is a set of tools designed to assist practitioners with their decision making, promote consistency in practice and target the children most in need of a service. This research focused on how practitioners used four of the SDM tools in the intake and investigation stages of a case: the Screening Criteria (used to assess which cases should be accepted for investigation), the Response Priority Tool (used to assess the urgency with which an investigation should commence), the Safety Assessment Tool (used to assess whether a Safety Plan needs to be developed or a child needs to be removed from parental care) and the Family Risk Evaluation Tool (used to assign levels of risk to cases and assist in decision making about further Departmental intervention). More broadly, the research aimed to address a gap in the literature about how child protection practitioners use risk assessment tools in their practice with children and families.

Theoretically the research drew from ethnomethodology to explore the ‘unstated conditions’ (Garfinkel, 1967) in relation to how the tools were used by practitioners. Methods for data collection were drawn from ethnography and involved three months fieldwork at six Child Safety Service Centres in Queensland during 2007/08. The fieldwork involved observing the practice of practitioners in intake and investigation teams at the different offices, interviews with 46 practitioners and audits of 51 case files.

A significant finding of the research was that practitioners were not using the tools in the way that they were intended to be used by their designers (primarily to assist decision making). Rather the tools were considered as tools that met organisational requirements for accountability and consistency. The ‘unstated conditions’ that emerged from the research provide not only description about how the tools were used, but also explanation about why the tools were used in certain ways. These explanations provide insights which have implications more generally for the future development and implementation of tools to assist practitioners with assessment and decision making.
Declaration

This is to certify that

i. the thesis comprises my original works towards the PhD,

ii. due acknowledgement has been made in the text to all other material used,

iii. the thesis is less than 100,000 words in length, exclusive of tables, bibliographies and appendices.

Signed:

Philip Gillingham                                Date
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Introduction

This introduction provides an overview of the research presented in this thesis, an explanation of how I came to be interested in this area of research and an outline of the chapters.

Overview

This research focused on how child protection practitioners in the Department of Child Safety, Queensland used the Structured Decision Making (SDM) tools in their practice with children and families. SDM is a set of tools designed to assist practitioners with their decision making, promote consistency in practice and target the children most in need of a service. This research focused on how practitioners used four of the SDM tools in the intake and investigation stages of a case: the Screening Criteria (used to assess which cases should be accepted for investigation), the Response Priority tool (used to assess the urgency with which an investigation should commence), the Safety Assessment tool (used to assess whether a Safety Plan needs to be developed or a child needs to be removed from parental care) and the Family Risk Evaluation tool (used to assign levels of risk to cases and assist in decision making about further Departmental intervention).

The research was a formative rather than summative evaluation which explored both the spoken and unspoken rules or “unstated conditions” (Garfinkel, 1967) about how practitioners, from frontline practitioners to their Team Leaders, Senior Practitioners and Managers used the four SDM tools. More broadly, the aim of this research has been to address a gap in the literature about how child protection practitioners use risk assessment tools and to contribute to debates about the development of tools to enhance practice. The first section provides an account of how and why I became interested in this area of research.
The introduction of tools in child protection practice

I qualified as a social worker at the University of Keele in 1988 and worked for a local authority social services department in England for the next eight years. At this time, generic social work was in decline as local authority social workers were increasingly organised into specialist teams that dealt with child welfare, mental health, disability and older people. Somewhat reluctantly at the time I was placed in a ‘children’s team’. After two years experience as a social worker (Levels 1 and 2), dealing with ‘child welfare’ rather than what was considered ‘child abuse’ cases, I applied for promotion to Senior Social Worker (Level 3). At first I was unsuccessful as the panel considered that my experience of working with children and families was insufficiently broad and I was set specific tasks that had to be completed within a certain period of time. Six months later, the panel reconsidered my application and promoted me. Only then was I allowed to have case responsibility for ‘child abuse’ cases. After extensive training with the police, I specialised in the forensic investigation of child sexual abuse, focussing on younger children. This was part of government initiative to address the poor rate of conviction of suspected child sexual abusers. The initiative introduced the use of video taped interviews with the victim, conducted by a police officer and a social worker, which could be shown in criminal courts as the main statement of the victim. During this period, child welfare became redefined as ‘child protection’ and ‘child protection procedures’ grew as each year passed, as practice became increasingly proceduralised. In 1994 I became a Senior Social Work Practitioner (Level 4) in the same local authority, a role which involved dealing with a restricted caseload of the most complex cases, practice development and teaching. I spent much of the next two years conducting investigations with the police into organised sexual abuse of children in the South East of England.

In 1996, I moved to Australia and worked for the next eight years in a state government child protection department, as a case worker (or case manager), team leader and manager, before becoming an academic in 2004. When I moved to Australia, I was surprised to find that child protection work was not the exclusive domain of social workers, indeed very few of my new colleagues were qualified
social workers and many did not have a university education. Given my experience in England of having to qualify as a Senior Social Worker (Level 3) before undertaking child protection work, I was also surprised to find that relatively inexperienced practitioners were allocated what I considered to be relatively complex and serious cases of alleged and actual child maltreatment.

During both of these periods of employment as a practitioner, I was intrigued by the development and implementation of various ‘tools’ that were designed to assist with assessment and decision making, from the ‘Orange Book’ (DoH, 1988) in England to the ‘Victorian Risk Framework’ in Victoria, Australia. I have continued to be interested in how practitioners actually use these tools for two reasons. Firstly, from a personal point of view, when presented with a new tool, there was a process by which I had to make sense of how to use a tool in my practice. Secondly, as a Team Leader and Manager, I have been exposed to the processes that other practitioners also have to undertake in order to incorporate tools into their practice and the different ways that they do this. I have noticed how these processes change with time and familiarity and, moving from one child protection office to another, how they differ from place to place. While I have found tools useful in my practice, I have also found that the reality of using them has not necessarily lived up the rhetoric that accompanies their implementation.

When I returned to university education in 2001/2, I looked to the literature to inform my experience of how practitioners use decision making and assessment tools but could find very little to help me. In contrast to the extensive literature about the increasing use of risk assessment as a form of assessment to guide decision making, there was a lack of research about how practitioners actually use such tools. In 2006, while at the 10th Australasian Conference on Child Abuse and Neglect in Wellington, New Zealand, I attended a presentation about how and why the Department of Child Safety in Queensland had purchased and were implementing SDM to assist child protection practitioners in their decision making (Leeks, 2006). When I searched the literature, I could find no independent research about the SDM tools despite the fact that they had been implemented in a number of jurisdictions in
the USA. In particular, there was no research about how practitioners used the tools and that was the point at which this research began.

As can be inferred from the brief account of my career, I was professionally socialised to believe that child protection practice should be social work practice. As a professional social worker, I am committed to the five basic values of social work: human dignity and worth, social justice, service to humanity, integrity and competence (AASW, 2002). These values not only underpin my practice but also shape and reflect my worldview. Social work values in child protection translate into practice which aims to assist both children and parents to overcome structural inequalities that reduce their functioning. The emphasis within such practice is on working with families to improve parenting, with child removal to alternative care being a last resort (Lonne & Thompson, 2005; Pelton, 2008). To an extent, this research was conducted and written from my perspective as a professional social worker, but as explained further in Chapters Four and Five, my perspective was problematic. During the fieldwork, I quickly came to realise that professional social work played little, if any, part in child protection practice in Queensland. Most of the staff of the Department that I met were not social workers and some participants expressed their hostility towards the profession and were skeptical about any place that it might have in child protection. That did not necessarily mean that participants were opposed to the ethics and values of social work, but it did mean that, in order to gain insights into their practice, I had to suspend my belief about the role of social work in child protection. This process of suspending my own belief is explained further in Chapters Four and Five but deserves mention here in the introduction as it is important to note that this research was not about an activity that most of the participants would characterise as professional social work.

The thesis chapters

The Chapters of thesis proceed as follows. In Chapter One, a review of the literature that has informed this research is presented. The Chapter is divided into four broad areas of research and commentary: decision making in child protection, the use of risk assessment, the use of tools to improve decision making and ideology. This chapter describes how research about decision making in social work and
specifically child protection led to the development of tools to assist practitioners in their decision making. Further how the development of tools has also been shaped by the increasingly popular belief that forms of risk assessment can be used to enhance decision making in child protection practice. Lastly, literature that focuses on how ‘ideology’ can be used as a conceptual tool to explore and understand both policy and practice in child protection is presented.

In Chapter Two, the recent history of child protection services in Queensland and their redevelopment is reviewed and critically analysed. Child protection services in Queensland have, since 1999, been significantly reorganised and expanded and a new department, the Department of Child Safety, was created in 2004. In this chapter, the public documents that describe the developments in child protection services are analysed, alongside commentary from other researchers. In particular this chapter focuses on how problems in the former Department of Families were conceptualised and how this conceptualisation led to particular solutions, notably the purchase and implementation of the SDM tools.

In Chapter Three, a detailed description of the SDM tools and how they have been integrated into the Department of Child Safety Practice Manual is provided. While there has been no independent research conducted about the SDM tools, the research that has been conducted is presented. Commentary that has emerged from jurisdictions where it has been implemented is also presented.

In Chapter Four, the methodology that has guided this research and the methods used to conduct it are explained in detail and reflected upon. Briefly, this research drew from ethnomethodology and ethnography to focus on how the SDM tools were being used. The data collection and initial stage of analysis involved three months of fieldwork during which I spent two weeks each at six different Child Safety Service Centres (CSSCs). The main methods of data collection were by observing practice in the intake and investigation stages, interviewing staff and auditing case files.

Chapter Five is the first of four chapters which present and interpret the findings of this research. In Chapter Five the context for the research is explored in terms of the experience of being in the Department of Child Safety, from my viewpoint as a
researcher, and those of the participants in the research. Understanding the context for the research, at the level of practitioners, was important to how I interpreted my observations and the data collected from participants and the case files. An important part of this process was the identification of the forms of ideology that underpinned both policy and practice in the Department.

In Chapter Six, an analysis of the statements made by participants in relation to SDM as a practice framework are presented and this begins the process of identifying how practitioners actually use the SDM tools. In the interviews with practitioners, the ‘unspoken rules’ about using the SDM tools emerged and became ‘spoken’. The analysis provided insights that went beyond the ‘official’ version of practice (how practitioners should use the tools) to articulating the ‘unofficial’ version (how practitioners actually use the tools).

In Chapter Seven, the process of articulating the unofficial version of practice is continued with the analysis focused on the statements made by practitioners about how they used specific SDM tools. This focus provides detailed information about which tools they found useful and those they found less useful, under what conditions and in what circumstances.

In Chapter Eight, a different perspective on how the tools are used is presented drawn from an analysis of the data collected from the case files. While the analysis confirms and adds to themes identified in Chapters Five, Six and Seven, it also adds some new insights into how the tools are used within the Department.

In Chapter Nine, the findings of the research are summarized and the conclusions that can be drawn from this research are presented. The contribution of this research to existing research about decision making in child protection and the use of risk assessment tools is identified. The limitations of the research are reflected upon and possibilities for future research identified which would contribute to knowledge about how practitioners use decision making tools.
In Chapter Ten, the implications of this research for the use of the SDM tools in Queensland and, more broadly, the future development of tools to assist decision making are discussed and recommendations made for both policy and practice.
Chapter One: Decision Making, Risk Assessment and Ideology

Introduction

The Structured Decision Making (SDM) tools are described in detail in Chapter Three but they are, in essence, a set of tools designed to assist child protection practitioners make decisions about children and families. The designers of SDM (the Children’s Research Centre, see Chapter Three) claim that the tools are based on empirical research and that they involve both actuarial and consensus based approaches to the assessment of risk of harm to children. This research, which focuses on how practitioners use the SDM tools, has been informed by research and theory drawn from several domains. This review of the literature is divided into four sections which separate these domains and explore each to identify both the current state of knowledge and theory and where the gaps in this knowledge lie. Links are made between the four domains by identifying how each contributes to the conceptualisation of and rationale for the research presented in this thesis.

The first section of this Chapter reviews research about how practitioners make decisions in their daily practice. It is this research which has provided the rationale for and guided the development of assessment tools such as SDM. The second section reviews research about the use of risk assessment in child protection and the third section focuses on research about how assessment tools are used by practitioners. The final section summarises and reviews theoretical perspectives about the use of tools and decision making in human services organisations, with reference to the notion of ‘ideologies’. These perspectives provide a further theoretical background against which some of the findings of this research can be understood and interpreted.
Decision Making in Child Protection

Munro (2008) identifies that there are two forms of theory and research about how professionals make decisions and, further that there is a disparity between the two. On the one hand there is theory that prescribes how decisions should be made and, on the other, there is research that demonstrates how practitioners actually make decisions in practice. This section will focus on research about how practitioners actually make decisions for three reasons. Firstly, research about decision making by practitioners has demonstrated the limitations of the human brain and the flaws that can arise in the process, which Gambrill and Shlonksy (2000) refer to as personal characteristics. This has (at least in part) led to the development of tools and frameworks to address these flaws and enhance decision making. Secondly, research about how practitioners make decisions takes into account the context of the decision making process (see Munro, 2008). Contextual influences include the need for practitioners to make decisions very quickly, or the pressure to make a number of important decisions on a range of cases so that they can be processed and proceed through the system (Gambrill & Shlonsky, 2000). They might also include high case loads, the nature of the work as ‘emotion laden’ and a limited range of service options (Proctor, 2002). Environmental characteristics (Gambrill & Shlonsky, 2000; Gambrill, 2000) such as the values and policies of the organisation which constitute the organisational culture also affect what decisions are made and how. This may be in contrast to the more ideal conditions suggested by more formal theory about how decisions should be made. Thirdly, research about how practitioners make decisions provides some insights into how practitioners might use tools in their practice. The following account of research about decision making in child protection practice traces the development of theory in relation to all three of these points.

Dingwall, Ecklehaar and Murray (1983) found that the decision-making of practitioners was affected by what they termed the ‘rule of optimism’. In applying this ‘rule of optimism’, practitioners tended to view the behaviour and intentions of families in the most favourable light. The ‘rule of optimism’ is made up of two cognitive devices. ‘Cultural relativism’ refers to the tendency to try not to be
judgemental about how other people live and stems from the belief that all cultures are equally valid and consequently that all ways of rearing children may be similarly valid. ‘Natural love’ refers to the belief that all parents instinctively love their children and want the best for them, despite how they may go about achieving this. Support for the application of the ‘rule of optimism’ and the selective ways in which practitioners recall information has been demonstrated by research that has shown that practitioners tend to underestimate the levels of violence present in the families they deal with when asked to recall such information from memory (Stanley & Goddard, 2002).

Dingwall et al. (1983) also expand their critique of decision making to cases where they observed the phenomenon of ‘defensible decision making’. This refers to a rationale for making a particular decision that can be promoted as the best decision, sometimes because it is presented as the only decision that could have been made. ‘Defensible decision making’ adds a new influence to the process of decision making in the form of accountability. Accountability and its influence on decision making is not straightforward because there may be a tension between to whom the decision maker feels more responsible, the client or the organisation. In an organisation that is perceived to be overloaded, the decision not to take action may be the more defensible because it means the commitment of scarce resources does not have to be justified. Defensible decision making itself is also defined by prevailing views within an organisation about its purpose (see discussion below about ideologies). For example, Spratt (2000), in his analysis of decision making at the point of first referral, found that a pre-occupation with the management of risk led to child care problems receiving a quasi child protection response. The explanation for this was that most referrals about children and families contain information that could be construed as placing a child at risk of harm if the practitioners assessing the information are pre-occupied with identifying and managing risk.

The presentation of parents and their levels of co-operation have also been found to affect the decisions made by practitioners. Holland (2000) found that the outcomes of ‘Orange Book’ assessments were affected by the verbal presentation of parents.
More articulate parents, who demonstrated co-operation with rather than hostility to the assessment, were able to establish more rapport with the practitioner and so there was an increased likelihood that they would agree an explanation of the family situation. At the other extreme, Stanley and Goddard (2002) found that child protection practitioners may also be behaving like hostages in the face of actual or potential violence from parents. Practitioners in these circumstances may make decisions about action or inaction that are affected by their need to avoid or appease their ‘captor’.

Research has shown that people are not rational thinkers who have occasional lapses; rather, they create rules that reduce difficult judgemental tasks to simpler ones by restricting the amount of information they consider (Munro, 1999). These cognitive short-cuts to aid decision making, known as heuristics, may take different forms and may be combined in use (Vaughan & Hogg, 1995). A particular example is the ‘availability’ heuristic, which guides decision making about the likelihood of an event occurring according to how quickly similar instances or associations come to mind. Another is the ‘false consensus effect’, in which people tend to see their own behaviour as typical and assume that, under similar circumstances, they would behave in the same way (Vaughan & Hogg, 1995). Such theoretical constructs, borrowed from the disciplines of cognitive and social psychology, may account for some of the observations of researchers in child protection practice. More specific to child protection practice, Reder, Duncan and Gray (1993) identified ‘automatic thinking’ in decision making by practitioners, which also served to restrict the range of information considered. They also identified two categories of ‘fixed views’ held by practitioners about families which affected the process of decision making: sociopolitical attitudes (which are differentiated views about how people should behave according to class status) and strong personal or professional views.

Munro (1999) made the following observations of the way that information was used to make decisions in child protection practice. Practitioners were found to be uncritical of new information about a child or family if it supported their view of the family and, conversely, they tended to be sceptical about new information if it...
conflicted with their view. This led to practitioners being very slow to revise their judgements about families and to focus on a narrow range of information about a family. Munro’s (1999) research also supported the notion that facts are more memorable if they are vivid, concrete and emotive and that the most recent information comes to mind more easily. For practitioners, this led to a preoccupation with what was happening at the time in a case, which also serves to narrow the perspective taken of the case. This preoccupation prevented practitioners from standing back from the case and considering patterns of behaviour and cumulative factors in chronic abuse and neglect. This finding is supported by observations that the use of risk assessment tools may lead practitioners to minimise the effects of abuse on children, in particular, cumulative harm (Goddard, Saunders, Stanley & Tucci, 1999; Bromfield, Gillingham & Higgins, 2007).

Research has also been conducted into how groups of professionals in child protection make decisions. Kelly and Milner (1996), for example, conducted research into how decisions are made at Child Protection Case Conferences in the United Kingdom. Their research refutes the idea that decision making through consultation with professionals from other disciplines in a group setting necessarily improves decisions, or that the process decision making is any more rational. Kelly and Milner (1996) identify the factors which influence decisions in a Child Protection Case Conference as follows: “shared rationalisations to support the first adequate alternative suggested by an influential group member, a lack of disagreement, a belief in unanimity and cohesiveness, a direct pressure on dissenters and a high level of confidence in the group’s decision.” (p. 93). They also describe how groups tend to polarise around a certain view of a case and demonstrate the ‘certainty’ effect, whereby individuals become risk seeking when decisions are framed in terms of choices between possible losses. Munro’s (2008) review of similar studies about how groups make decisions also demonstrates that group decision making is affected by its own particular biases, in particular ‘groupthink’ (Janis, 1982). Groupthink is defined as the need for groups of professionals to seek consensus rather than what might be the best decision. Horwath’s (2005) research demonstrates how ‘groupthink’ is not only an influence on decision making in formal group settings. Her research demonstrates how practitioners rarely make decisions
on their own as cases are discussed in teams, and teams develop their own approaches to assessing and intervening in situations.

Munro (2002, 2008) proposes that practitioners use two different forms of reasoning when making decisions in their work with children and families: analytic and intuitive. Analytic reasoning invokes the use formal theories and research and draws from positivist approaches to science and the generation of knowledge. Intuitive reasoning draws more from the personal knowledge and experiences that practitioners bring to their professional roles. Munro describes the debates that have ensued about which form of reasoning should prevail in professional practice and argues that such debates have created a false dichotomy between the two forms of reasoning. She argues that both forms of reasoning are required in professional practice and that they exist on a continuum. An important part of this debate, with reference to this research, is the recent emphasis on the importance of analytic reasoning, expressed in exhortations for an increase in ‘evidence based practice’. As Munro explains, the move towards evidence based practice has strengthened the case for developing and implementing assessment frameworks to assist decision making processes.

Munro (2008) describes how practitioners use the two different forms of reasoning in their practice. Practitioners are required not only to be able to gather information to describe events and behaviours, but also to interpret them, particularly in terms of the intentions of parents when a child may have suffered harm. Munro (2008) describes how this part of the decision making process involves a moral dimension, as practitioners have to assess what has happened to a child (or what may happen) with respect to what is considered as socially acceptable or unacceptable. To make this interpretation, practitioners use mainly reasoning drawing on their expertise (in terms of knowledge and experience). Expertise may be informed by formal theory but, as Munro (2008) explains, it is used intuitively at this stage. Formal theory, as represented by tools may subsequently be used as a form of analytical reasoning to check and perhaps modify the practitioner’s original assessment and decision. Munro’s account about how intuitive and analytic forms of reasoning are used in different proportions at different times may provide some insights into how tools that
are based on formal analytic forms of reasoning are used by practitioners. Applied to this research, Munro’s description suggests that the SDM tools are more likely to be used after the practitioner has already made a decision based on intuitive reasoning.

Research about decision making that demonstrates the fallibility of practitioners points to the need to develop strategies to improve decision making (Gambrill & Shlonksy, 2000). As discussed in a later section (and subsequent Chapters), the strategies developed are shaped by epistemological perspectives and forms of ideology. From a constructivist perspective, authors such as Horwath (2005) and Holland (1999) argue that practitioners need to develop ‘reflective practice’ approaches and require professional supervision in order to compensate for the influences that may adversely affect their decision making. From a realist perspective, the most obvious strategy is the development of tools to assist decision making. From this perspective, the problems that such models or instruments are designed to deal with are, specifically, “inconsistency across decision makers and the weak ability of human services professionals to predict important outcomes of interest” (Schwalbe, 2004, p. 563).

The development of the SDM tools is clearly aligned with the realist perspective about how to improve the decision making of practitioners. But as Munro (2002) argues, the development of tools and frameworks to assist decision making should not be at the expense of intuitive forms of reasoning, which most experienced practitioners regard as indispensible in their work. How different approaches to improving decision making may be combined are discussed further below and in later Chapters, but the choice of one at the expense of the other has consequences for this research. If decision making tools disregard the importance of intuitive reasoning, then their acceptance by practitioners is, as Munro (2002) argues, only going to be ‘lukewarm’. The level of acceptance by practitioners of decision making tools, in this research the SDM tools, is an important factor to consider in assessing how the tools are used.
Summary

This overview of research about how practitioners make decisions is not exhaustive. It does demonstrate how practitioners, either individually or in groups, tend to use information selectively when making any assessment or decision for action and that they may be subject to influences that are not readily apparent to themselves or an observer. This research also provides some insights into how practitioners might use tools designed to assist their decision making. As discussed further in Chapter Two, there were serious concerns about poor decision making and the lack of consistency in decision making within the then Department of Families identified by the CMC Report (2004). Improving decision making (in terms of outcomes for children) and consistency (according to a notion of rationality) subsequently became an important goal for the newly formed Department of Child Safety (Leeks, 2006).

Risk Assessment

As explained in the previous section, research about how practitioners make decisions has led to the development of various tools to assist with and ‘rationalise’ the process. Many of these tools are based on various forms of risk assessment and risk management, notably the topic of this research, SDM. Much has been published about risk assessment in child protection and this review can only provide a brief and selected overview of the literature in order to highlight how it informs this research.

Risk assessment might be considered to be a central tenet of good practice in many jurisdictions but as Corby (2006) notes, while jurisdictions in the USA have continued to adopt and develop various forms of risk assessment, jurisdictions in the UK have moved on to consider risk of harm as only one facet of the needs of a child. Indeed there has been considerable debate about whether risk assessment should prevail as the most significant approach to child protection practice and a growing critique concerning its efficacy and application. One of the first critiques was Wald and Woolverton’s (1990) extensive review of the widespread introduction of risk assessment tools in the USA. In their review, they pointed to problems with definitions of maltreatment, the limitations of instruments then in use and the multiple
uses to which they are sometimes inappropriately put. Many of the criticisms they made, though aimed at tools designed over twenty years ago, resonate throughout subsequent critiques, as discussed further in this section. In jurisdictions where risk assessment is the preferred approach, there has also been debate about what forms of risk assessment should be used. This section will review the debates and research about risk assessment as an approach to child protection practice. The first subsection discusses why, from a sociological perspective, risk assessment has arisen as a response to dealing with children and families. Parts of this review are drawn from Gillingham (2006).

Why Risk Assessment?

In 1992, Ulrich Beck introduced the term ‘risk society’ to describe the dominance of the discourse of risk in current society. Although Beck claims that we now live in a ‘risk society’, this is not to say that life is now more risky than it was before; rather, that a concern with risk and its management has become central to everyday life (Ferguson, 1997). In this subsection, the wider social context of the ‘risk society’ (Beck, 1992) will be explored and the influence it has had on social policy and the organisation and practice of child-protection services will be examined.

Changes in the meaning of the word ‘risk’ can be traced to specific periods in history and the current meaning of risk has its roots in the rise of science and mathematics, in particular the language of probability. In modern thinking, rationality and scientific knowledge have been combined with a belief that the natural world can be measured, controlled and predicted (Kemshall, 2002) and this has been extended to produce the belief that the social world can be similarly controlled (Lupton, 1999). The implication of a rationalised discourse of risk is that risk is ultimately controllable, as long as expert knowledge can be properly brought to bear on it (Lupton, 1999). Because the modern notion of risk presupposes that a decision can be made regarding how it is possible to avoid a hazard or danger (Joffe, 1999), liability and accountability have become key features of risk: when an event occurs resulting in adverse consequences, someone must be held to account (Douglas, 1992). In this
way, failure to negotiate a risk adequately is constructed as an individual failure rather than understood as a result of social processes outside the individual’s control (Kemshall, 2002). Social problems become reconstructed as individual choices and responsibilities and, consequently, governments are able to avoid risk to themselves by displacing responsibility onto the individual or, as a last resort, on the mediating professionals within the agencies of social welfare provision (Kemshall, 2002). Therefore, ‘risk society’ has a tendency to become a ‘scapegoat society’ (Beck, 1992).

Formalised assessment and bureaucratic risk management systems have become a key response to the uncertainty of risk (Kemshall, 2002) and this has been mirrored in child protection practice as it has become increasingly prescribed by bureaucratic procedures, risk assessment tools and the use of information technology (Howe, 1992; Ferguson, 1997; Goddard et al., 1999; Webb, 2006). The language and concepts of risk assessment have also found their way into the practice of agencies that deal ostensibly with family support rather than child protection (Spratt, 2001). This new discourse of risk in child protection practice has changed the nature and focus of social work with children and families, affecting the relationships between practitioners and clients and the organisation of practice (Parton, 1998).

Historically, the agenda for the assessment and treatment of abuse was set by the medical profession because it was doctors who ‘discovered’ child abuse (Goddard & Carew, 1993) and perhaps it was doctors who also set the agenda for the role of risk assessment in child protection. For example, Kempe and Kempe (1978) claimed that they could predict, with remarkable accuracy, those families at risk of abusing their children. The specific implication of the modern discourse of risk for child protection practice is that harm to children can be prevented (Lupton, 1999). Understanding how the concept of risk and its management has become a dominant and pervasive discourse in ‘Western’ society is essential to understanding why the use of risk assessment tools in child protection practice has been so readily and uncritically accepted by policy makers and practitioners.
Forms of Risk Assessment – actuarial, consensus and blended

Risk assessment has been subjected to extensive debate about whether it can be used to predict maltreatment to children (for example, Rycus & Hughes, 2003) and critique about its efficacy (for example, Thorpe, 1994; Parton, Thorpe & Wattam, 1997; Goddard et al., 1999; Krane & Davies, 2000; Gillingham, 2006). There has also been considerable research and debate about which of the various forms of risk assessment, consensus based, actuarial or blended (Ryan, Wiles, Cash & Siebert, 2005) is the most efficacious. This section provides a review of definitions of the various forms of risk assessment, as both actuarial and consensus based approaches are included in the SDM tools.

Both actuarial and consensus forms of risk assessment tools aim to discriminate between different groups of people in terms of predicting the future occurrence of a particular outcome. It is the factors that they use to make this determination that differ, particularly the way that these factors are identified. Actuarial risk assessment “incorporates criteria that have been demonstrated, through prior statistical assessment, to have a high level of association with reoccurrence of maltreatment” (Rycus & Hughes, 2003, p. 21). Consensus models of risk assessment “rely on a preponderance of professional agreement about which variables or conditions are most associated with reoccurrence of child maltreatment” (Rycus & Hughes, 2003, p. 21). Unlike actuarial forms of risk assessment, though, consensus based tools do not weight different variables of factors differently (Rycus & Hughes, 2003).

It has been consistently argued that actuarial forms of risk assessment to assist decision making are superior to both consensus based tools and clinical judgement by practitioners (for example, Gambrill & Shlonsky, 2000; Rycus and Hughes, 2003; Munro, 2002; 2008). However, researchers have also had to qualify their positive statements with reference to the problems that have emerged with the design, use and evaluation of actuarial risk assessment tools, which is expanded on in the next subsection. Rycus and Hughes summarise the current state of risk assessment as: “Some formal risk assessments can accurately categorise families into high risk,
moderate risk and low risk groups, based on the statistical likelihood of a reoccurrence of maltreatment at some time in the future. This is the best that current research and technology have to offer” (p. 28). So, while risk assessment may, as claimed by the developers of SDM (see Chapter Three), assist with prioritising which families need an intervention by child protection services, it cannot predict which children will be abused without intervention.

Critiques of Risk Assessment

Although it has been argued that risk assessment has provided child protection practitioners with the opportunity to manage risk better and prevent child maltreatment (Ferguson, 1997), there has, at the same time, been a growing critique of the application of risk assessment to practice. This critique ranges from social constructionist perspectives that challenge the application of a positivist epistemology to a socially constructed problem to empirical research about how risk assessment is used to construct the phenomenon of child abuse and guide the decisions of practitioners. In this subsection, this critique will be explored, starting with concerns about the research that underpins risk assessment.

Because there is no clear definition of what constitutes child abuse, research about child abuse has been hard to interpret and, consequently, it has been hard to identify strategies to deal with it (Parton et al., 1997). What constitutes abuse and risk of abuse in one jurisdiction may differ considerably from another, making comparative studies very difficult (Bromfield & Higgins, 2003). Methodological problems also arise over definitions of the substantiation of abuse and risk of abuse. Concepts such as risk of harm and actual harm are, in practice, used interchangeably, as are categories of maltreatment, such as physical and neglect (Bromfield, Gillingham & Higgins, 2003).

Since child abuse was ‘discovered’ by the medical profession, much of the research on child abuse has followed the medico-scientific model of causation (Goddard &
In summary, this model of causation has directed researchers to identify factors and characteristics associated with abuse, to assume that these are qualitatively different from the rest of the population and are in some way related to the cause of the problem. Identifying these causative factors should then lead to the identification, prediction and prevention of abuse (Parton et al., 1997). However, much of the research into child abuse has only been drawn from children who have been reported to child protection agencies and no control groups have been used. Consequently, it is not known whether the factors identified by such research are specific to this group or not (Parton et al., 1997). The findings of this research have also been inconsistent. For example, a review of 10 decision-making/risk-assessment models in the US found that there was no apparent consensus on what should be considered as the most important abuse-related criteria (DePanfilis and Scannapieco, 1994). Even when there does appear to be some consensus, the validity of the findings has been questioned: “...while alcohol and drug abuse are often cited as principal risk factors in child abuse, the evidence is very uncertain” (Parton et al., 1997, p. 53).

A further level of complexity is introduced when considering the cultural sensitivity of risk assessment tools. As English and Pecora (1994) argue, some risk factors may be present in families regardless of culture, but there is evidence to suggest that how factors should be weighted and interpreted may need to be modified to reflect cultural considerations. Factors such as parental mental illness, substance abuse and a history of maltreatment have been found to be risk factors regardless of culture (English & Aubin, 1993). English’s (1993) literature review found that factors such as attitudes towards physical punishment, supervision, physical disability of the child, medical care and gender appear to be culturally related in their capacity as predictive factors.

The reliability of risk assessment tools in child protection agencies in predicting future harm to children has also been questioned. Child protection practice in the UK rarely exceeds 70% in accuracy of predictions in protecting children from future abuse (Anglin, 2002). Although some research has shown that actuarial models of
risk assessment may have the greatest potential to improve decision making in child protection practice, it has been argued that they are also limited in their usefulness because they are derived from statistical generalisations believed to be predictive of the behaviour of groups of like individuals (Goddard et al., 1999). However, child protection services are not concerned with groups of individuals; they are expected to make predictions about individual children in families (Parton et al., 1997; Goddard et al., 1999). A particular problem that arises is that practitioners may be lulled into a false sense of security in believing that generalisations about behaviours automatically apply to specific cases and are therefore reliably predictive (Reder et al., 1993). Although the identification of various risk factors associated with the abuse of children may assist in informing policies concerning priorities in the allocation of resources, because of the complexity of child abuse, they cannot be used to predict with any accuracy who (individually) will or will not be abused (Parton et al., 1997). The difficulty of predicting the behaviour of individuals is demonstrated by research on the Washington State Risk Assessment Matrix, which showed that the matrix exhibits high levels of measurement error and increasing instability over time, which limits its capacity to predict new allegations of abuse (Camasso & Jagannathan, 2000). Actuarial models of risk assessment have been found to be seriously flawed by the number of false negatives they produce (failing to identify children who go on to be abused) and the number of false positives that are mistakenly included (children who will never be abused) (Parton et al., 1997). There is also confusion among practitioners about the predictive ability of risk assessment tools in term of how likely it is that the results of using them are accurate (Munro, 2004).

Both Rycus and Hughes (2003) and Munro (2002) mention that an important factor which impedes the utility of many models is that they have not been evaluated and subjected to ‘rigorous scrutiny’ to test their accuracy. Munro (2002) proposes that such evaluation needs to include measures of whether the specific tool is more accurate than the clinical judgement it replaces and whether it is culturally sensitive. The need for independent evaluation of tools and frameworks is also important as their “developers and marketers cannot always be expected to present disinterested critique” (Rycus & Hughes, 2003, p. 24). The lack of independent evaluation leads, in
practice, to “child welfare professionals making decisions about children and families with little more accuracy than flipping a coin, while believing they are using technologies that reduce subjectivity and bias, and that increase the quality of their decision” (Rycus & Hughes, p. 23). As discussed further in Chapter Three, there has been a lack of independent evaluation of the SDM tools.

Research has also drawn attention to the way that risk assessment tools are applied in practice. The use of risk assessment checklists may limit the assessment of a child’s situation by leading practitioners to focus their assessment only on the factors it contains (Reder et al., 1993).

Practitioners may resort to a mechanical check down the list of risk factors rather than processing their information and observations, when it may the interaction between factors rather than just their existence that is significant to the prediction of future harm (Reder et al., 1993; English & Pecora, 1994). Focusing on combinations of risk factors, or even the interactions between them, has serious implications for the way that practice is conducted. Practice no longer takes the form of face-to-face relationships between the professional and client and tends to be more focussed on managing and monitoring a range of abstract factors deemed liable to produce risk for children (Parton, 1998). The consequent lack of contact between practitioners and clients may result in the thoughts, feelings and words of children not receiving sufficient attention (Goddard et al., 1999). In trying to predict the future for a child, the meaning of a particular episode of abuse that has already occurred may be ignored and harm that they have already suffered becomes minimised (Goddard et al., 1999). The effects of cumulative harm to a child, by a series of episodes of abuse or chronic neglect, may also be ignored by focusing on what may happen to a child in the future (VCDRC, 2002).

Although it can be argued that the application of standardised risk-assessment tools may serve to identify and counteract the ‘flaws’ that arise in decision making in child protection practice, it also has been argued that these ‘flaws’ exist within, and are even masked by, the application of risk assessment tools. These ‘flaws’ exist within
the practice of risk assessment for two reasons. One reason is that, as Sheppard, Newstead, Di Caccavo and Ryan (2000) point out, the application of knowledge in practice, however strong its claim to being empirical in the positivist sense, is not a straightforward process and is contingent on human agency. The second reason relates to the imposition of a positivist epistemology to a problem that has its causes in the less easily rationalised domain of the ‘social’ rather than the ‘physical’ world (Parton, 1998). Such ‘flaws’ are masked by risk assessment because of the current dominance of the risk discourse in Western societies (as argued above) and the elevation of positivist epistemologies, as represented by evidence based practice in social work (Webb, 2001). The potential for tools to exclude and oversimplify matters is also referred to by Gough (1998): “[the] danger...is the creation of a technology of assessment that. . . . uses the myth of technical solutions to hide and disregard the social values inherent in decision making. . .” (p. 141).

The accountability of practitioners for decisions and actions that arises from the use of risk assessment instruments has also emerged as an important issue in practice (Parton, 1998). It has been suggested that risk assessment instruments are used by bureaucratic, managerialist organisations to protect themselves from blame when tragedies occur (Goddard et al., 1999). Having found individual practitioners to blame for tragedies, a wider agenda is served in that the basic social order remains unchallenged (Hallett, 1989). The concept of blame, arising from the construction of responsibility when using risk assessment, also applies to the parents of children (Bromfield et al., 2007; Gillingham & Bromfield, 2008) as parents become pathologised (Thorpe, 1994). A consequence of blaming individuals is that no consideration is given to the process of socialisation that leads adults to harm children, or to social values that sanction a power imbalance between men, women and children or to the harsh and depriving conditions in which many families live (Hallett, 1989).
Summary

Reviewing the literature about risk assessment in child protection reveals the following points. A sociological consideration of why risk assessment should be such a significant approach to practice reveals that its justification is to be found in current societal beliefs that the future (especially in terms of negative or harmful outcomes) both can and should be predicted and managed. Despite the current faith in risk assessment, there is considerable debate about its efficacy, what form it should take and its negative impact on practice with children and families.

The pertinence of the debates about the use of risk assessment in decision making to this research is as follows. Given that there is a widespread belief that we both can and should be able to predict and manage risk to children, practitioners may embrace risk assessment tools as the most rational choice to improve outcomes for the children they work with. A tool which claims to enable practitioners to predict the future and so prevent harm to children may appear to be particularly attractive to child protection practitioners, at least initially. However, much of the literature outlined above points to potential problems that practitioners may face when using a tool based on risk assessment. For example, the inability of the tools to predict, with any accuracy, the risk of future harm to individual children may, in practice, lead to decisions that conflict with the more intuitive decision making of experienced practitioners. Practitioners may also become concerned about the way that risk assessment focuses attention on certain factors about a family at the expense of others, and how this emphasis affects the working relationship between practitioners and families may also affect attitudes towards use of the tools. Experience of using the tools may highlight these and other (hitherto unforseen) problems and so affect how practitioners use risk assessment tools.

The use of tools in child protection

As mentioned above, concern about how decisions are made in practice has led to the development of tools and frameworks and this trend is aligned to the promotion of ‘evidence-based practice’ (Webb, 2001) and the emergence of risk assessment.
There has been increasing interest in how such ‘evidence’ is applied in practice in response to the growing awareness that this is not a straightforward and unproblematic process (Sheppard et al., 2000). This has profound implications for the use of risk assessment tools in child protection practice. There is, however, a lack of research that focuses on how assessment tools and frameworks are used by practitioners. In this section a review is presented of commentary about how tools are used by both organisations and individuals and research that hints at some of the ways that tools may be used, in particular in ways that may not be intended by their designers.

Organisations may have a number of uses for assessment tools and frameworks that go beyond assisting practitioners to make decisions. These uses may be better described as ‘intended uses’ or aims because, as explained below, there may differences between these and how practitioners actually use them. The intended outcomes of implementing SDM in Queensland specifically are explored further in Chapter Three, but the overall aims in implementing one part of the SDM framework are well expressed by Hetherington (1999) in relation to South Australia. In justifying South Australia’s decision to adopt part of the SDM system, Hetherington (1999) cites Cichinelli (1990), p. 125:

Whatever the state of the art, there is little doubt that formal assessment frameworks:

- Operationalize good casework practice
- Provide a consistent basis for classification of cases into risk-related groups and thus facilitate prioritization
- Can effectively serve as a basis of worker training
- Can provide more readily accessible information in the case record
Cichinelli (1990) argues that assessment tools and frameworks can be implemented by organisations to serve a number of purposes but Rycus and Hughes (2003) disagree. They question how one tool can serve a variety of administrative, political and systemic functions that “have little to do with making accurate protective decisions for children” (p. 27).

As discussed further in Chapter Two in relation to Queensland, a key concern of some child protection agencies is to increase consistency in the way that decisions are made and so offer a more equitable service to families. This is one of the main rationales used to support the introduction of risk assessment tools (Munro, 2002). According to Munro (2002): “Results so far provide good support for the claim that instruments improve consistency between workers” (p. 77). What underlies this (and Cichinelli’s) claim, though, is the assumption that practitioners use tools as they were intended by their designers, which may not be the case. Depending on how such research is conducted, it may just appear that practitioners are using the tools as intended (a point which is discussed further in relation to the findings of this research). An example of research that suggests that practitioners may use tools in ways that are in opposition to their intended use is that of Lyle and Graham’s (2000) research about the use of the Illinois CANTS-17B risk-assessment tool. While Lyle and Graham’s research was focussed on the outcomes rather than process of using this particular tool, they discovered that staff deliberately inflated initial scores of cases in order to increase the eligibility of families for services. Munro (2002) cites a study by Fluke et al. (1993) which showed that half the staff used a risk assessment tool only after they had reached a decision about a case and this finding is reflected in studies conducted by English and Pecora (1994) and Cicchinelli and Keller (1990). English and Pecora (1994) also note that practitioners used risk assessment tools to document rather than guide their decision making. These examples illustrate that there may be a variety of ways that practitioners use tools that may not coincide with the ways that were intended by the designers of the tools.

Even when practitioners use tools as they were intended to be used, under relatively controlled conditions, there is evidence to suggest that this does not necessarily
promote consistency in decision making. Kang and Poertner (2006) recruited 41 practitioners and asked them to apply the Illinois Structured Decision Support Protocol to three different case examples, in order to test inter-rater reliability. The Illinois Structured Decision Support Protocol is quite separate from SDM, though is similar in that the part of it used in Kang and Poertner’s research aims to assist practitioners to “determine if the child was at short-term risk of maltreatment and needed an emergency safety plan” (p. 681). The tool helps to identify and summarise risk factors using software to assist in the practitioner’s decision making. They found that inter-rater reliability was ‘weak’ (Kappa = .29) and suggest a number of improvements, which include the following: “if the final decisions were made by the computer program based upon the information presented by the worker, judgements might be more consistent” (p. 687).

An important factor which affects how practitioners use decision making tools might also be how easy or difficult they are to use. Rycus and Hughes (2003) and Munro (2002) argue that the use of actuarial tools is also a complex task that practitioners may not be adequately trained to do: “Much of the training has been likened to teaching airline pilots how to complete a pre-flight checklist before taking off, but without ever having taught them navigation, meteorology, or even the essentials of flying a plane (Rycus & Hughes, 2003, p. 25). But as both Rycus and Hughes (2003) and Munro (2002) point out, there are essential skills that practitioners need before they are ready to use a risk assessment tool, such as the skills to collect the information required about a child and family to input into a risk assessment tool. As an example, Rycus and Hughes (2003) highlight the skills required to identify the indicators of illicit drug use, particularly when parents might be trying to deny or hide it. The importance of the process of implementing tools in an organisation to how practitioners may subsequently use tools has also been emphasized (Gambrill & Shlonsky, 2000; English & Pecora, 1994). Brandon et al’s (2006) evaluation of the implementation of the Common Assessment Framework in the UK, for example, highlights that attention needs to be paid to the anxiety generated in practitioners by the fear of change and a lack of confidence in using new tools. Gambrill & Shlonsky also note that risk assessment tools may contain vague definitions of abuse and
neglect and the factors associated with their prediction that require considerable interpretation by practitioners, thereby making them more difficult to use.

Munro (2002) suggests another reason why “many of the frameworks and decision aids available at present are only half-heartedly used, if at all, by practitioners, who complain that they conflict with their current ways of working”. She argues that the problem may lie with the guidelines that are issued with tools and which may be treated as absolute rules rather than as a guide. The designers of tools may argue that they never intended for the tools to replace professional discretion, but this would be to deny conditions in the workplace where there has been has rise in managerialism and a diminishing of autonomy for professionals. As Munro explains: “The more managerialism gains control, the stronger the shift towards defensive practice and general procedures and rules that are insensitive to the needs of individual families. The professional role will be increasingly reduced to that of bureaucrat with no scope for expert appraisal and tailored responses” (2002, p. 166). Hence there might be resistance to the adoption of tools by practitioners who perceive that their role, as professionals, is diminished by them. Resistance may be expressed in response to perceptions about the tools also serving organisational purposes (as mentioned above) particularly when those purposes are perceived as serving a managerialist agenda. Attitudes towards the use of tools may be aligned to Jordan and Jordan’s (2000) observation that “(w)hat [social work] does not need is the dreary, mechanistic, systematic, technocratic approach that puts clients into categories, and produces a ready-made package according to a pseudo-scientific classification of their deficits (p. 205)”.

Munro’s (2002) comments need be considered in the context of the United Kingdom where child protection practice is very much the domain of professionally qualified social workers. As such, it is reasonable to draw inferences and theorise about professional autonomy and discretion in decision making. In a setting which is dominated by one professional group, professional concern about such matters would be expected to surface as an important influence on how tools and frameworks are used. However, such an analysis may not be applicable to the context of child protection practice in Queensland. While local authorities in the
United Kingdom only employ qualified social workers, the same is not true in any state in Australia. In Queensland, a range of qualifications is acceptable for employment as a Child Safety Officer, such as degrees in Human Services, Psychology and Criminology. During the fieldwork for this research, a consultation project was commenced to consider broadening the range of degrees acceptable for employment as a Child Safety Officer beyond social sciences degrees (see AASW, 2008). As shown in Chapter Four, qualified social workers were a small minority among staff in the CSSCs visited for this research. I was not able to obtain data to ascertain whether this was generally the case across the Department of Child Safety as the Human Resources Division does not maintain records about the qualifications of its workforce.

Practitioners’ use of tools and frameworks may not necessarily be negative in the form of resistance or outright rejection as they may find more positive and creative ways to use them. Holland’s (1999) research about how practitioners in the United Kingdom used the Protecting Children: A Guide for Social Workers Undertaking a Comprehensive Assessment (DoH, 1988) (or ‘Orange Book’, as it became known) to conduct assessments of families provides an example. Holland found that all of the participants in her research used the ‘Orange Book’ to complete their assessments. Some reported that the ‘discourse of scientific observation’ promoted in the ‘Orange Book’ was useful to them, particularly when justifying decisions in formal settings such as court. Others reported though that they had to use another form of reasoning, that of ‘reflective evaluation’ and go beyond analytic reasoning to complete their assessment. Hence there was an additional process that had to be invoked in order for them to reach the point of being able to make recommendations about what should happen for a child. This reflects Munro’s (2002) position discussed above that analytic reasoning cannot be relied on alone when making decisions and that it must be combined with intuitive reasoning (which is aligned to what Holland refers to as ‘reflective evaluation’). Holland expresses concern that the promotion of tools and frameworks and the increasing routinisation of decision making promoted by their use will undermine the importance of reflective evaluation. Further, that it will lead to the belief that the tasks of assessment and decision making can be completed by those with qualifications other than social work and
possibly with no qualifications at all. With reference to Payne (1995), Holland points out that this has already happened with respect to community care assessments in the UK.

Millar and Corby (2006) raise the question of whether the introduction of the Framework for the Assessment of Children in Need and their Families (DoH, 2000) embodies “an ethos of bureaucratic regulation with stultifying effects on social work” (abstract). Their research, however, suggests that the Framework can, from the perspective of children and parents, provide the basis for a ‘therapeutic encounter’. Part of the reason for this is that they point to the way that the Framework facilitated communication between practitioners and families and how it acted to reduce the power differentials between professionals and clients. They argue that, in applying some well-judged restraint on professional activity, forms and formats have a contribution to make to practice with children and families. This contribution was not apparent, though, in all the cases they studied as the successful use of the Framework was also reliant on the “contribution made by social work expertise (including skill in the flexible use of the assessment form)” (p. 898).

Summary

There has been little research that has focussed on how assessment frameworks and tools are used in child protection. The research that has been conducted and observations within the literature both point to areas for further research to be conducted. For example, practitioners may not use assessment frameworks and tools in the way that their designers intend and they may be used by organisations for purposes that have little to do with decision making about individual children and families. At an individual level, practitioners may resist using them by only completing them as superficial administrative requirements or the may rely on them up to a point, but then need to go beyond them to complete an assessment. There may be a variety of reasons why practitioners resist using a particular tool, which may be because of their complexity or because of a perceived loss of professional autonomy. Practitioners may use tools and frameworks in creative ways that lead, for
example, to positive (and possibly unforeseen) outcomes for the process of communication between professionals and families.

As discussed further in Chapter Three, the research that has been conducted about SDM has focussed on its effects at an organisational level in terms of outcomes and there has been no research that focuses on the process of using the SDM tools. Whether the research to date about SDM demonstrates that it is achieving organisational goals or not, the question stills remains about why this might be so. In focussing on how practitioners in Queensland used the SDM tools, this research makes a significant contribution to answering questions about why the implementation of tools like SDM may be having certain effects at an organisational level.

Ideologies and child protection

As explained further in Chapter Four, this research drew from ethnomethodological and ethnographic approaches to research, both of which require that the researcher become a ‘member’ (ten Have, 2002) of the group of people researched and attempt to “saturate herself/himself in the culture and world of those researched” (Humphries, 2008, p. 134). Further, that the researcher not only describe but also interpret the world of the people researched (Humphries, 2008). Traditional ethnographic studies have been criticised for ignoring the wider social context of the particular subculture being studied (Humphries, 2008). There has been debate about ethnographic studies that focus on the activities of the people researched, without considering the context for their actions (Hall, Slembrouck & Sarangi, 2006; Holstein & Gubrium, 2005).

In this research the concept of ideology was used to interpret the context for practice in Queensland. Sinclair (2005) describes how ideology, citing Therborn (1980), can be used as a “conceptual and analytical tool to explore a range of prevailing ideological discourses that have an effect on systemic child protection practice” (p.
Sinclair defines ideology as “systems of ideas, values and beliefs” (p. 228). In the following sub-sections how the concept of ideology has been used in research and commentary about child protection at different levels, from practitioners to policy makers and organisations, is described.

Ideology and Practitioners

At the level of individual practitioners, Spratt and Houston (1999) describe how various ideologies compete with each other, “like voices within the social worker’s head, all seeking to persuade, to cajole, to direct, a particular response” (p. 318). Identifying these ideologies can assist in understanding the decisions that practitioners make with respect to individual children and families (Gillingham & Bromfield, 2008).

The concept of ‘ideologies’ operating in child welfare practice is not new and was first theorised by Carter (1974). Carter’s (1974) conceptualisation of what she refers to as ‘systems of belief’ about the nature of the problem of child abuse arise from her concern that different professional groups have different beliefs about the causes of child abuse and responses to it and that while these ‘systems of belief’ may overlap, they may also be in conflict at times. She identifies three ‘systems of belief’, the first being ‘penal’, emanating from a legal theoretical framework, which holds that when violent parents commit criminal acts, they should be answerable to society, The ‘medical’ ‘system of belief’, emanating from a scientific theoretical framework, is concerned with the diagnosis and treatment of abuse. The third, the ‘social welfare’ ‘system of belief’, emanating from a humanistic theoretical framework, is concerned with the human facets of child abuse, locating its cause in the pathologies of individuals and/or the structures of society. Carter’s (1974) conclusion is that, at the expense of the technical response of the scientific-medical approach and the rationalism of the legal-penal outlook, humanitarianism should be maximised in the response to families. This is significant in that, over 30 years years ago and in the wake of the inquiry into the death of Maria Colwell, what can be considered as technical or rational (or instrumentalist) approach to the problem of child abuse was
critiqued, in favour of an approach that emanates from an understanding of human beings that is not based in a positivist epistemology.

The notion of ideologies operating in child protection was later developed by Parton (1985), who redefined Carter’s notion of ‘social welfare’ as ‘humanistic’. Spratt and Houston (1999) identify three more ideologies which may be operating in child protection: retributive/blame, bureaucratic and technocratic.

‘Retributive/blame’ ideology arises from what Spratt and Houston (1999) identify as the ‘fear factor’ in child protection practice and its concern is twofold. On one hand it is concerned with the social construction of blame for the perceived lack of protection afforded by services to children who have died at the hands of their carers. On the other, it is also concerned with those who have been harmed through what is perceived to be over-intervention by child protection services. The construction and application of this ideology can be traced through the series of inquiries into child deaths in the United Kingdom (Parton, 1991; Reder et al., 1993) and Australia (Mendes, 2001; Goddard & Liddell, 1995) in particular through the way that such inquiries have been reported by the print media. As mentioned above, Kemshall (2002) identifies how, in the context of the ‘risk society’, social problems become redefined as the mistakes of individuals and it is through this mechanism that governments are able to avoid risk by displacing responsibility.

Spratt and Houston’s (1999) definition of blame ideology concerns the actions and culpability of practitioners in child protection rather than that of parents and carers in relation to child maltreatment. This definition has been extended to include parents and carers, to describe the process by which child protection practitioners seem compelled to apportion blame for harm to children when making decisions about substantiating alleged child maltreatment (Gillingham & Bromfield, 2008). This particular research demonstrates how the need to blame a parent or carer for an alleged act (of commission or omission) leading to harm to a child can be an influence on how decisions are made by practitioners.
While ideologies operate in the minds of practitioners, they also operate at an organisational (Smith, 1991; de Montigny, 1995) and policy level. Spratt and Houston’s (1999) second and third definitions of ideology could be described as operating more at an organisational level and are discussed below.

**Ideology at an organisational and policy level**

With respect to ‘bureaucratic ideology’, Spratt and Houston (1999) propose that any examination of an organisation that provides child protection services will reveal the “hallmarks of rampant bureaucracy” (p. 317). Bureaucratic ideology in an organisation manifests in two significant ways, the first being a highly stratified line of accountability and the second by the use of case management systems, such as child protection procedures, case conferences, child protection registers and case management reviews. Spratt and Houston (1999) trace the genesis of such bureaucratic systems back to the inquiry that followed the death of Maria Colwell. The subsequent process of the ‘bureaucratisation’ of social work in the field of child protection is well documented by Howe (1992). The identification of increasing levels of bureaucracy within organisations as an ideology, rather than just a process, is significant in that it belies the belief that highly structured and regulated organisations are the most efficient way of delivering services. This belief in the inherent efficiency of bureaucracy first surfaces in Weber’s analyses of modern organisations. Jones and May (1992) describe how Weber conceptualised modern organisations, organised along bureaucratic lines, as the most efficient, and perhaps even the only way, that the complex needs of an increasingly industrialised society could be met. While it cannot be denied that providing child protection services across a large geographical area requires a high level of organisation, there does come a point at which the structures and processes it incorporates become antithetical to the practice of social work (Howe, 1992).
‘Technocratic ideology’, as identified by Spratt and Houston (1999) is particularly pertinent to this research. Spratt and Houston describe how child protection has been “influenced heavily by a technocratic ideology in the sense that there is a common belief that ‘technical fixing’ of the problem is the way to proceed” (p. 318). This belief in technical fixing has led to the development of risk analysis methodologies (Brearly, 1982) such as SDM. Spratt and Houston (1999) argue that bureaucratic and technocratic ideologies are the vehicles by which ‘instrumental reason’ has colonised social work practice. They acknowledge that a key source that contributes to the development of this new ideology is the work of Ricardo Blaug (1995), who, drawing from Jurgen Habermas’ Critical Theory, provides an explanation as to why instrumental reason has colonised social work with reference to the increasing bureaucratisation of practice.

Blaug (1995) argues that social work is ideologically under attack and that the increasingly bureaucratised manner in which social workers are expected to provide services is at odds with providing good services, and, in particular, caring for people. Further, that while there is no disagreement about the effects of increasing bureaucratisation on the practice and organisation of social work, this consensus breaks down when the sources of the phenomenon are considered. Explanations for the increasing bureaucratisation of social work agree that it performs a particular function, but “(T)hey fall short, however, when they are unable to state precisely why it is that bureaucratization (and not something else) floods in to satisfy their chosen function” (Blaug, 1995, p. 424, emphasis in original). Blaug (1995) articulates an explanation for this ‘flood’ with reference to Habermas’ Critical theory.

According to Blaug (1995), Habermas (1984) argues that bureaucracy, as a way of organising human activity, is based on a particular set of theoretical assumptions which amount to a specific view of the nature of reason, which he terms ‘instrumentalism’. Habermas considers bureaucratic forms of organisation to be the organisational counterpart of instrumental reason (instrumentalism) and that, in an increasingly rational society, they are the inevitable end product. But, “(I)t is at once
its greatest achievement and its greatest nightmare” (Blaug, 1995, p. 425). Blaug (1995) explains how instrumentalism has made its greatest achievements in terms of the application of science to practical concerns and in areas of production efficiency and describes the temptation to conceive human reason along purely instrumental lines: “(w)hen confronted with problems in the realm of human affairs, we instinctively reach for instrumentalism, partly because of its success in areas of knowledge where things are stable, measurable and separable, and partly because we have come to see instrumentalism as being the only kind of human reason” (p. 455). This explains why, when problems emerge in the provision of human services, such as child protection, the instinctive response is to apply instrumentalism with the predictable outcome of increased bureaucracy as a form of organisation. The application of instrumentalism also, as Spratt and Houston (1999) argue, leads to the development of tools and frameworks as a further manifestation of bureaucratic and technocratic ideology.

Blaug (1995) concedes that some level of instrumentalism and bureaucracy is required in human services organisations in order to provide services to large numbers of people, often spread over large geographical areas, but it is the extent to which instrumentalism has colonised practice with which he disagrees. With regard to the development of bureaucratic procedures for practitioners, he argues that they can never replace the practical judgement of practitioners and “lend themselves less to helping bad social workers than to hindering good ones” (p. 428). Drawing from Habermas, he outlines an alternative form of reason which he believes should be dominant in social work, that is, communicative reason and goes on to propose a ‘Theory of Discourse Ethics’ to explain how communicative reason can be used as an alternative ideology to both resist instrumentalism and further an ideology which is more in line with social work ethics and practices. Spratt and Houston (1999) also develop an ‘alternative ideology’ which they describe as a “Critical Social Work Ideology” (p. 319).

The particular pertinence to this research of the perspectives about ideologies offered by, in particular, Spratt and Houston (1999) and Blaug (1995) is that they
provide an explanation as to why and how, in the development of child protection services, both bureaucratic and technocratic solutions to perceived problems have been sought. Specifically, the response to research that casts doubt on the ability of practitioners to make appropriate decisions has been to develop tools and frameworks as the most appropriate solution (as discussed above). This theme resonates through the next Chapter, which focuses on the development of child protection services in Queensland, leading to the adoption of the SDM tools. Secondly, these authors argue that in applying instrumentalism (and consequently bureaucratic and technocratic ideologies) and developing tools and frameworks the needs of both practitioners and clients are not best met, indeed that we are taking a ‘wrong turn’. If this is the case, the question, for this research, is how such a ‘wrong turn’ would manifest in the way that practitioners use SDM in their practice.

Another form of ideology which currently shapes the way that welfare services are organised and delivered is managerialism (Jones & May, 1992; Harris, 2003). This is pertinent to understanding the re-organisation of child protection services in Queensland. Lonne and Thompson (1999), in their analysis of the findings of the CMC Inquiry, propose that there were, prior to the reforms, two distinct ideologies operating within the department: a managerialist one and a professional one and they question whether the opportunity provided by reform has been taken to redress the imbalance between the two. Harris (2003), with reference to social welfare provision in the UK, describes how social work’s ideology and management are increasingly being derived from an overarching ‘business’ discourse, of which managerialism is a component. This has happened as a result of a series of political choices, from the 1970’s, that aimed to reduce the role of the state in the economy (economic rationalism). As Harris argues: “the culture of capitalism has colonised the public sector as business thinking and practices have crossed the public-private sector divide and been transplanted into activities such as social work” (p. 5). This colonisation has also occurred in the provision of social welfare in Australia (Jones & May, 1992; Gardner, 2006). As Jones and May explain, '[m]anagerialism needs to be understood as a management ideology and as a set of management techniques” (p. 386). The aim of managerialism is to increase both effectiveness and efficiency in the provision of services through the introduction of ‘quasi markets’ and
management strategies and this has introduced a new focus to the way that services are both conceptualised and delivered (Harris, 2003). It has also introduced a new language to the management of social welfare agencies, including ‘targets’ and ‘performance indicators’ (Jones & May, 1992).

As Harris (2003) explains, managerialism has changed the role of frontline practitioners in human services organisations. Before managerialism, practitioners, as ‘bureau-professionals’, had considerable autonomy to define their activities in relation to clients. What services to provide, how they would be provided and to whom were decisions over which frontline practitioners had considerable discretion. Managerialism, in contrast, borrows from principles of ‘scientific management’, and places the responsibility for planning and monitoring the delivery of services with managers rather than practitioners. Consequently, managers need to be able to monitor and measure the activities of frontline practitioners. In order for managers to achieve this level of control, complex areas of practice have to be broken down into discrete and sequential sets of tasks. Harris (2003) demonstrates how this has been achieved with reference to the implementation of Information and Communication Technology (ICT) systems to monitor and control the activities of social workers in adult care services in the UK. His analysis can be applied both to the implementation of a new ICT system in the Department of Child Safety in Queensland and to the effects of implementing the SDM tools on the activities of practitioners (as discussed further in Chapter Two).

Ideology operates not only in how we formulate solutions to problems, but also in how we conceptualise the ‘problem’ we are seeking to address. Pelton (2008) argues that the level of discussion about child protection services needs to rise above the level of “obsessing over statistics, research and terminology” (p. 52) as “our failure to address the basic needs of all individuals and families has little to do with research, and much to do with ideology, cognitive constructs of inclusion and exclusion and our conceptions of justice” (p. 52). Understanding how ideologies, at this level, are defined and operate was one of the keys to interpreting the data.
collected during the fieldwork for this research, both at the time (as explained in Chapter Five) and subsequently.

Pelton (2008), referring to the USA, discusses how, in the 1990s, there was a ‘backlash’ against strategies within child protection to promote family preservation, which was linked to a prevailing politically conservative ideology. He describes how, even in the professional community of child welfare, “the mantra of ‘child safety’ was beginning to replace, or at least overshadow, that of ‘family preservation’ ” (p. 41). With reference to this research, the immediate resonance of this comment was that the child protection agency in Queensland (newly created in 2004), was named the Department of Child Safety. While the choice of name for the department initially struck me as unusual, I was curious as to whether this was the next development in nomenclature and whether it also denoted a particular ideology of and focus for practice with children and families. As Pelton explains, given that the concept of ‘child safety’ emerged in opposition to ‘family preservation’, it equates with removing children from their parents rather than striving to keep families together. As an ideology (or ‘mantra’), Pelton aligns ‘child safety’ to beliefs about ‘bad’ parents not deserving support to look after their children.

In her review of developments in child protection services in Queensland since 1999, Tilbury (2005) speculates about whether the reforms that have been made will avoid the “pitfalls of the pendulum swing between child rescue and family support” (p. 16). Tilbury’s analysis is discussed further in Chapter Two.

Historical studies of child protection services also point to the fact that the ideologies that create the context for practice also change over time. They change as societal attitudes towards children and families change and the and as ideas about what is considered harmful to children change. The response to child maltreatment in terms of the role of the state in intervening in the lives of children and families also changes over time (Parton, 1991; 1996). Ferguson (2004), in his historical account of the activities of the National Society for the Protection of Children in the UK, traces the development of “the ideology that it is possible to prevent children suffering from
abuse, neglect and especially death; that professionals not only can, but should protect children in time” (p. 3, emphasis in original). Scott and Swain (2002), in their account of the development of services for maltreated children in Victoria since the 1890s, refer to two distinct waves of the ‘child rescue movement’. Each wave was underpinned by different sets of beliefs, or ideologies that shaped responses to the problem. The first wave, at the end of the 18th Century, was characterised by beliefs that parents had a moral responsibility to care for their children and ways were sought to compel them to face up to their responsibility. The second wave was informed by social and psychological, rather than moral, approaches to understanding problems, and led to approaches to support, rather than compel, parents to look after their children.

Identifying the various ideologies that underlie how child maltreatment is defined and how it should be dealt with provides insight into the context for child protection practice in an organisation (see Chapter Five). However it cannot be assumed that they are necessarily predictive of particular approaches to the use of tools and frameworks. From the discussion above, approaches to practice that involve the use of tools may be developed from underlying managerialist and technocratic ideologies, but this might be quite separate from other forms of ideologies that underlie how child maltreatment is conceptualised. For example, it cannot be assumed that in an organisation that espouses an ideology that foregrounds ‘family support’ rather than ‘child rescue’ that a ‘social work’ ideology underlies actual practice. As shown in the discussions above, while practice in the UK has moved more toward ‘family support’ rather than risk assessment (Corby, 2006), the introduction of the Framework for the Assessment of Children in Need and their Families shows that there is still a pervasive belief in a technocratic approach (with its roots firmly in faith in instrumental reason. A new ‘tool’ has been developed and implemented to achieve the ideological shift from practice focussed on risk assessment to practice that deals more holistically with the needs of children. The ‘colonisation’ of social work by instrumental reason that Blaug (1995) laments has continued despite a shift in ideologies about how we should protect children and meet their needs.
Summary

The literature reviewed in this section demonstrates how ideologies as “systems of ideas, values and beliefs” (Sinclair, 2005, p. 228) can be a useful conceptual tool to assist in understanding and interpreting child protection practice, from the level of individuals to that of policy makers. On a micro level, ideologies can be a useful to assist with understanding the factors influencing the decision making of individuals, and, in this research, how they use a tool such as SDM. At a macro level, they are useful for understanding the context for practice and, in particular in this research, how and why the implementation of a tool like SDM is considered to be the best way to enhance practice.

Key concepts

In this Chapter, I have identified concepts developed by various theorists in the four areas under discussion. The following table summarizes the key concepts used by these theorists which relate to decision making in child protection and the use of tools, which will be referred to throughout this thesis.
Table One: *Key concepts*

<table>
<thead>
<tr>
<th>Paradigm (from Humphries, 2008)</th>
<th>Author Form of reasoning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postpositivist</td>
<td>Munro (2002; 2008) Intuitive reasoning</td>
</tr>
<tr>
<td>Phenomenological</td>
<td>Holland (1999) Discourse of reflective evaluation</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Practice Development</td>
</tr>
<tr>
<td></td>
<td>Reflective practice Tools to assist decision making</td>
</tr>
</tbody>
</table>

At first glance, the concepts discussed by Blaug (1995), Munro (2002; 2008) and Holland (1999) fall neatly on either side of what Humphries (2008) summarises as the paradigm debate in research. Each side of this debate represents different ontological, epistemological, methodological and teleological perspectives, which, in theory, are incommensurable. Each side also points to different strategies to improve practice, for example, the development of ‘tools’ to assist decision making, or the promotion of reflective practice. In the practice of delivering human services, though, each of the authors above argue that that these ‘seeming incommensurables’ (Marcus, 1994) can, and indeed should be juxtaposed. As Munro (2002; 2008) explains, intuitive and analytic forms of reasoning exist on the ends of a continuum and both are required (and used) by child protection practitioners. Holland (1999) explains how practitioners used both ‘discourses’ in their decision making, each
having their own purpose. Blaug (1995) argues for approaches to practice that are based in communicative reason, but concedes that a certain level of instrumental reason needs to be applied to organise the provision of services. The common thread to these arguments is that it is the combination or balance between each of the approaches that is crucial and that neither (on its own) is sufficient. Similar approaches to child protection practice that aim to combine constructivist and realist perspectives by re-emphasising approaches to practice derived from constructivist perspectives have also been developed (Parton & O'Byrne, 2000; D'Cruz, Gillingham & Melendez, 2007; D'Cruz, Gillingham & Melendez, 2009).

As Blaug (1995) and Spratt and Houston (1999) argue, the inappropriate privileging of one approach to organising services over the other has been caused and sustained by the ‘ideologies’ that underpin policy, practice and organisational culture. The following table summarizes the forms of ideology identified in this Chapter.
### Table Two: Forms of ideology

<table>
<thead>
<tr>
<th>Author</th>
<th>Forms of ideology</th>
<th>Operational Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carter (1974)</td>
<td>Penal</td>
<td>Individual</td>
</tr>
<tr>
<td></td>
<td>Medical</td>
<td>Individual</td>
</tr>
<tr>
<td></td>
<td>Social welfare</td>
<td>Individual</td>
</tr>
<tr>
<td>Parton (1985)</td>
<td>Humanistic</td>
<td>Individual</td>
</tr>
<tr>
<td>Spratt &amp; Houston (1999)</td>
<td>Retributive/blame</td>
<td>Individual/organisational</td>
</tr>
<tr>
<td></td>
<td>Bureaucratic</td>
<td>Organisational/policy</td>
</tr>
<tr>
<td></td>
<td>Technocratic</td>
<td>Organisational/policy</td>
</tr>
<tr>
<td>Jones &amp; May (1992)</td>
<td>Managerialism</td>
<td>Organisational</td>
</tr>
<tr>
<td>Harris (2003)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gardner (2006)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tilbury (2005)</td>
<td>Child rescue/family support</td>
<td>Organisational/policy/individual</td>
</tr>
<tr>
<td>Smith (1991)</td>
<td>Organisational</td>
<td>Organisational/policy</td>
</tr>
<tr>
<td>de Montigny (1995)</td>
<td>Organisational</td>
<td>Organisational/policy</td>
</tr>
</tbody>
</table>

Throughout this research, the concept of ideologies has been useful to understand and interpret data gained from observation, interviews and the case files. From my own research (Gillingham & Bromfield, 2008) and that of Spratt and Houston (1999), Blaug (1995) and de Montigny (1995) the idea emerges that ‘ideologies’ need to be
identified and that, frequently, they are implicit rather than explicit influences on practice. As such, they are part of what Garfinkel (1967) refers to as the unstated conditions of any activity, the identification of which, in relation to the use of SDM, is the main aim of this research.

**Chapter summary**

In this Chapter, four domains of theory and research have been reviewed: decision making; risk assessment; the use of tools and frameworks to guide decision making; and ideologies in child protection. Research about decision making has highlighted concerns about how practitioners make decisions but also potentially provides some insight into how practitioners may use tools in their practice. How this research has led to the development of tools and frameworks to assist with this process has been explored in relation to the ideologies that underlie child protection practice and policy. Many of the tools that have been developed have been based on various forms of risk assessment in an attempt to incorporate future predictions of harm to children into decision making. Much of the research conducted about the use of risk assessment has been focused on outcomes as at a systems level (particularly in relation to SDM, see Chapter Three). But some of the research about risk assessment, and the resulting critique, also point to problems with the use of risk assessment to guide decision making, in particular the problem of ensuring that tools are used by practitioners and organisations in the ways that they were intended by their designers. But, while it may be reasonable to infer from the research to date that there may be differences between the ways that practitioners use tools and frameworks and the way they are intended to be used, there has been no research that has focused on how practitioners use them. As explained in Chapter Three, there is no research about how practitioners use the SDM tools. This is the gap in the literature that this research has been designed to make some contribution to filling, specifically in relation to the SDM tools, and more generally in relation to other assessment frameworks.
The section on the ideologies that operate at both individual and organisational levels in child protection highlighted a range of influences on how tools might be used by both individuals and organisations. Ideologies at a practitioner level can influence how decisions are made about children and families. At an organisational level, ideologies create the context for practice, which may include the mandate for practitioners to use tools and frameworks. Awareness of how these ideologies operate was, as later Chapters will show, important to understanding and interpreting the findings of this research.

In the next Chapter, the recent history of the development of child protection services in Queensland is traced and analysed, particularly in relation to how past problems and their solution were conceptualised and how this process led to the adoption and implementation of SDM as a practice framework.
Chapter Two: Child Protection Services in Queensland and the Department of Child Safety

Introduction

SDM, the focus of this research, was implemented in the Department of Child Safety in Queensland in 2006 and was one facet of a number of significant changes to child protection practice, policy and organisation in Queensland that have occurred since 1999. The first section of the Chapter outlines these changes to provide some context for this research and focuses on how the Department came to implement SDM. The second section provides analysis and comment on the changes in relation to contemporary themes in academic literature about child protection practice and policy and specific commentary about the reorganisation of services in Queensland. The last section draws on statistics about the operation of child protection in Queensland to provide further information about the context of the research.

Organisational change in Queensland from 1999 to present day

The period from 1999 to 2005 has been described as a “tumultuous time” (Tilbury, 2005) for child protection services in Queensland. As Tilbury (2005) explains, changes arose as the result of two independent legal enquiries, new legislation, three restructures, three changes of leadership and significant budget increases. The following account draws mainly from the Commission of Inquiry into Abuse of Children in Queensland Institutions Report (1999)(Forde, 1999), the Crime and Misconduct Commission Report (CMC, 2004) and A Blueprint for implementing the recommendations of the January 2004 Crime and Misconduct Commission Report (2004) (Blueprint, 2004). These reports will be used to trace the problems that were identified in the services provided for children and the policy responses formulated to remedy to the identified problems.
The first legal inquiry (known as the Forde Inquiry) tabled its report in parliament in June 1999 (Forde, 1999). The Inquiry dealt with instances of the abuse and neglect of children going back to the early 20th Century, but was also concerned about residential care for children in Queensland more recently. Its findings were that many children had been maltreated in residential services and that it was likely that such maltreatment might occur again. The Commission found that children in residential institutions, partly financed by the state but run by religious denominations, had been subjected to emotional, physical, sexual and systems abuse (p. iv). The report defined ‘systems abuse’ as the neglect of children’s basic needs for food, shelter, education and nurturance, in particular as, “failures in the system to monitor and track the needs of individual children, . . “ (p. iv). Systems abuse was also defined in the report as “the implementation of practices that led to children who had not been convicted of offences serving indeterminate periods in an institution primarily for convicted children” (p. v). Perhaps most importantly the report was critical of the long term “lack of commitment by government to provide adequate resources” (p. iv). The Commission made a total of 42 detailed recommendations which covered standards of care for children, protection for children in care (such as advocacy and Official Visitor arrangements), monitoring and review processes, the screening and employment of staff in residential services, compensation for past victims of abuse in residential care, the closure of certain institutions and changes to proposals for new institutions. The Queensland government agreed to implement 41 of the recommendations, the only one with which it disagreed concerned the site of a new correctional facility for young people.

Significantly, Recommendation 4 (p. 118) was that the Queensland government increase the budget of the (then) Department of Families, Youth and Community Care by $103 million to meet the national average per capita welfare spending to focus on the prevention of child abuse and to assist families ‘at risk’. Of pertinence to this research was the identification of ‘systems abuse’ as a form of abuse. While some individuals were blamed for certain acts of abuse against children, the report explained the continuation of abuses against children over a sustained period of time with reference to organisational culture (the system).
In 2000, the *Child Protection Act 1999* was proclaimed, replacing legislation that had been in place since 1965. As Tilbury (2005) comments, the legislation was introduced as the previous Act was considered “inconsistent with both the current knowledge base about child protection and changing community values and expectations about the role of the State in protecting children from maltreatment” (p. 10). The new Act responded to concerns that previous intervention by the Department had had little oversight. The role of the courts in decision making about children was increased to make interventions into the lives of children and families by the Department more publicly accountable (Tilbury, 2005).

In 2003, the Crime and Misconduct Commission conducted an inquiry into the abuse of children in the care of the state. The inquiry was initiated after a series of articles appeared in the *Courier-Mail* newspaper, starting on 18th June 2003, in which it was alleged that children had been maltreated while in the care of the state and placed with foster parents. Specifically, a woman alleged that, when she was a child and was in state care, she was subjected to sustained physical and sexual abuse by foster carers and other adults invited into their home and that she knew of other children in the same situation who had been similarly maltreated (CMC, 2004).

The investigation carried out by the CMC went beyond considering only the services received by children in state care to encompass the entire child protection process. The final report by the CMC (CMC, 2004) was very critical of how services had been provided to children at risk of, or suffering, maltreatment. It described how the then Department of Families was perceived by stakeholders as being in a “state of crisis and incapable of responding adequately to child protection issues” (CMC, 2004, p. xi) and went on to clarify that this perception was borne out by the findings of the Commission’s investigations. The Commission found that the only conclusion it could reach was that the child protection system had “failed Queensland children in many important respects” as a result of “longstanding problems of great substance” (CMC, 2004, p. xi). The Commission clarified that the problems that it had found with the
child protection system did not derive from atypical or isolated cases of bad practice that represented bad decision making by individual departmental officers. Its general recommendation was that “fundamental structural and organisational reform” (CMC, 2004, p. xii) was required, specifically that a new “Department of Child Safety” be created with the sole function of protecting children. In 2004, child protection functions were separated from the then Department of Families and the Department of Child Safety was created (Tilbury, 2005).

The development of child protection services

The CMC made 110 recommendations which are grouped under six separate headings in an appendix to the report: The Future for Queensland Children, The Department of Child Safety, Multi-agency Relationships and Mandatory Reporting, Foster Care (46 of the 110 recommendations are included in this section), and Indigenous Children and Legislative Change. Of particular significance to this research are the recommendations made in relation to the creation of the new Department of Child Safety, as mentioned above, the recruitment and training of new staff and the way that child protection practice should be organised and conducted. Specific recommendations that relate to these themes are that the number of workers employed in direct practice should be increased by 160 ( Recommendation Number 5. 1, p. 339) and that this number should be increased annually in line with workload increases (Recommendation Number 5. 2, p. 339). Further, that there should be dedicated officers to deal with intake and assessment (in line with the Commission’s belief that these functions are best carried out by specialist workers) (Recommendation Number 5. 10, p. 340) and that the investigation of child maltreatment and casework should, as far as possible, be carried out by separate workers (Recommendation Number 5. 12, p. 340). In recognition that a number of families subject to “low-level notifications” require ongoing support, the creation of an additional forty staff positions, to be known as “Family Support Officers” was recommended (Recommendation Number 5. 16, p. 340). In terms of how practice should be conducted, it is worth quoting Recommendation Number 7.35 in full because of its significance to the focus of this research: “That there be thorough,
standardised, evidence-based case planning that is consistently applied and focuses on the best interests of the child” (p. 348).

In response to the CMC Report (2004), the state government issued “A Blueprint for implementing the recommendations of the January 2004 Crime and Misconduct Commission Report” in March 2004. This document (Blueprint, 2004) provided detailed information about how the State Government planned to address each recommendation made by the CMC Report (2004) and included estimates of the funding required and plans for implementing organisational change. Of particular pertinence to this research, the Blueprint (2004) made several references to the observation by the CMC Report (2004) that it was systemic failure that led to the dysfunction of the previous department rather than individual staff. Blame for this dysfunction was apportioned to the organisation for failing to “equip officers at virtually every level with the information or skills and resources to make the right decisions in the best interests of Queensland’s at risk children. . .” (p. 7). Information, skills and resources were equated with practice procedures in the Blueprint (2004), which it stressed were inadequate and needed to be improved (p. 18). The Blueprint (2004) also acknowledged that there was a wide variation in the practice procedures used to support the frontline delivery of services which led to wide variations in rates of notifications and substantiations of alleged abuse across the state (p. 17). A lack of practice procedures was also implicated in the high rates of staff attrition as “the appeal of doing frontline work. . . was often lost in an environment of . . . a lack of professional tools to guide decision making. . .” (p. 21). The Blueprint (2004) identified the key characteristics of a more positive organisational culture as the adherence to “best practice standards of therapeutic intervention and specialised services, including a commitment to . . . evidence based, transparent and accountable decision making” (p. 21). Improving practice standards included the development of a Practice Manual (p. 25) and of a “consistent risk assessment framework and methodology” (p. 24). A central task then became to “identify and establish a suite of professional practices and decision tools to help regulate, standardise and record the frontline decisions taken by Child Safety Officers” (p. 25), with the department “currently assessing options available commercially or from other Child Protection Agencies in other jurisdictions” (p. 25).
In March 2004 the Department of Child Safety commissioned a review of available risk assessment tools by staff at Griffith University (Stewart & Thompson, 2004). The purpose of the review was to “evaluate the evidence base for the selection of risk, safety, and needs/strengths tools and to make recommendations about which of these tools might best meet Queensland’s unique needs and current circumstances” (p.2). The tools evaluated by Stewart and Thompson were: Children’s Research Centre (CRC) Structured Decision Making (SDM) System, The Victorian Risk Framework (VRF), Risk assessment tool proposed by ICMS Vendor One, Risk assessment tool proposed by ICMS Vendor Two, Washington Risk Assessment Matrix (WRAM), and the Illinois Child Abuse and Neglect Tracking System (CANTS 17B). The methods used for the evaluation involved reviewing research already conducted and published either publicly or within government departments to address questions about the reliability and validity of various tools and assessment frameworks. While Stewart and Thompson (2004) found that SDM appeared to have the strongest evidence base in relation to reliability and validity, they also note that none of the research that had been conducted about SDM was completely independent of its designers and marketers, the CRC. Their recommendation to the Department of Child Safety was to choose SDM over the other options as “implementing the SDM system in its entirety would be consistent with the blueprint for implementing the CMC’s recommendations, which stated that “the selection decision will be driven by…practice framework consistency [and] the integration of one tool with the other” (Blueprint, 2004, p.25)” (Stewart and Thompson, 2004, p. 5).

The Department of Child Safety purchased the full suite of SDM tools from the Children’s Research Centre (Wisconsin) in December 2004 and they were implemented across the Department throughout 2006 and 2007. More broadly, it is worth noting that all 110 recommendations of the CMC Report (2004) had been implemented by 22 March 2007 (DCS, 2007), prior to the beginning of the fieldwork for this research.
The development of family support services

As stated above, child protection functions were split from the Department of Families in 2004 with the creation of the Department of Child Safety. What was left of the Department of Families became the Department of Communities, in line with the CMC Report (2004) Recommendation 5.14:

that the Department of Families (or some other agency separate from the Department of Child Safety) retain responsibility for delivering prevention and early intervention services, including support services for all children, and for programs targeting communities or families identified as vulnerable.

The responsibility for the provision of family support services stayed with the newly created Department of Communities, which, as the Blueprint (2004) makes clear is a purchaser of family support services (from the non-government sector) rather than a service provider. Locating family support and child protection functions in separate government departments is acknowledged as potentially problematic in the Blueprint (2004) and the need for careful management of the ‘interface’ between the two departments is noted. This separation is criticised by Tilbury (2005) as not based on the best evidence from around the world about the development of a service continuum which aims to achieve a balance between forensically based child protection services and family support services.

Tilbury (2005) presents evidence that the redevelopment of services for children in Queensland was far more focused on the development of child protection than family support services. This is illustrated by figures about the investments made in each. In 2004/05, $15 million was allocated to the non-government sector to provide a range of family support services. In 2003/04, the total child protection budget was $159 million, and by 2005/06, this had grown to $395 million. Tilbury (2005) notes that while funding to the non-government sector was increased, compared to the investments made during this time in child protection, the increases were minor.
The consequences of the lack of attention paid to the development of family support services are that “[t]he family support sector is currently not well positioned as a vehicle for substantial change as it continues to be small in size and influence, with a narrow range of low intensity interventions likely to be of limited use to families with chronic problems” (Tilbury, 2005, p. 15). The key point that emerges from Tilbury’s (2005) analysis is that family support services are a very small part of the overall picture in service provision for children and families in Queensland. Given the dominance of child protection services, the likelihood of families requiring support becoming involved with child protection services increases. The consequences of separating family support and child protection services between two government departments and of developing one significantly more than the other are discussed further in subsequent Chapters (particularly Chapter Five) as they emerge in the findings of this research.

An analysis of the changes to child protection services in Queensland

The overview of the recent development of children’s protective services in Queensland in many ways reflects the development of services in other jurisdictions. The theme of change and development of services in response to a ‘crisis’, such as the publicising of the death of a child or the abuse of children in the care of the state is a familiar theme in child protection literature. Parton (1991), for example, chronicles the development of children’s protective services in the United Kingdom with reference to a series of child deaths (Jasmine Beckford, Tyra Henry and Kimberley Carlisle) and subsequent public inquiries. Scott and Swain (2002) and Mendes (2000) outline the development of services in Victoria following the death of Daniel Valerio. The role of the media in publicising the failures of children’s protective services and in informing and shaping public opinion has been emphasised, both in Australia (Goddard & Liddell, 1995; Mendes, 2001) and the United Kingdom (Reder et al., 1993). This has frequently involved the use of sensationalist and provocative headlines (Reder et al., 1993). The headlines of the Courier-Mail in Queensland during June 2003, and its continuing commentary on the activities of the Department (see Chapter Five) support this observation.
The child death inquiry reports of the 1980’s in the United Kingdom have been characterised as attempts to apportion blame to individuals (Parton, 1991; Reder, Duncan and Gray, 1993; Rustin, 2004). Before the report of the inquiry conducted by Lord Laming into the death of Victoria Climbie (Laming, 2003), inquiries tended to downplay systemic issues such as organisational culture, resourcing and policy inadequacies and senior management failures (Lonne & Thomson, 2005). The CMC Report (2004), while acknowledging the good intentions of and difficulties faced by the workers in Queensland, also acknowledged the deficiencies in their knowledge, training and skills but posited these deficiencies as a systemic problem. This echoes the finding of the Care Standards Tribunal of Lisa Arthurworrey (the social worker involved in the case of Victoria Climbie) that while she was a ‘straightforward and caring individual’, the government needed to take responsibility for ensuring that social workers are ‘better trained, better resourced and better supervised’ (Jerrom, 2005). However, the CMC Inquiry has also been criticised for not apportioning blame to individuals and of being unbalanced in its focus on systemic issues, allowing successive political and organisational teams to escape the public gaze (Lonne & Thomson, 2005).

The conceptualisation of the problems in child protection as systemic rather than the result of the fallibility of individual practitioners by the CMC Report (2004) could be considered as similar to the approach advocated by Munro (2005). But, whether the focus of inquiry is on the fallibility of the ‘system’ or individuals, the outcome might be quite similar. The outcomes of inquiries into child deaths in the United Kingdom that did not take a systemic approach have led to what has been described as an “essentially bureaucratic model of organization” (Rustin, 2004, p. 15), with an increasing proceduralisation of practice (Howe, 1992). The CMC Report (2004) echoes this in its recommendations for the development of practice standards and a practice manual, as does the Blueprint (2004) in its acceptance of the need for decision making tools to regulate and standardise practice with children and families.
So far, only two articles have been published that provide any analysis or commentary on the changes in child protection in Queensland, Lonne and Thompson (2005) and Tilbury (2005). The following is a descriptive outline of these articles which identifies the main themes of these analyses.

Lonne and Thomson (2005) acknowledge that, in response to the CMC Report (2004), the Blueprint (2004) applied a ‘systems’ framework to respond to what is identified as a systems problem, but their analysis suggests that the changes that flow from this application are not sufficient, in themselves, to ensure improvement in child protection practice. Lonne and Thomson’s (2005) main criticism of the CMC Report (2004) is that it does not address the ideological underpinnings of the child protection policies and practice in Queensland. They suggest that the opportunity provided by the CMC inquiry to “turn around the worst features of a managerialist approach to one of child protection and welfare” (p. 97) was missed in the subsequent creation of the new Department of Child Safety. They suggest that “better management and organisational systems, more resources, clearer policy and procedures, enhanced training and a professional case management system” (Lonne and Thomson, 2005, p. 89, emphasis added) will not be sufficient for the new Department of Child Safety to move on from the problems that previously beset child protection services in Queensland. From their thematic analysis of the CMC Inquiry data, Lonne and Thomson (2005) identify a particular problem with the previous “inability of managerialist ideologies to respond to, influence or inspire practitioners to embrace necessary systemic and practice reforms” (p. 89). In essence, Lonne and Thomson (2005) argue that the ideologies that underpin child protection practice in Queensland needed to change. They identify within the CMC Report (2004) the theme that frontline workers and managers did not share the same values framework and ‘vision’ of child protection practice and suggest that there were two distinct ideologies operating within the previous department. One of these ideologies was a managerialist one that “communicated and practiced in terms of political and management discourses” (p. 92), the other “a professional one that operated in a practice focused way, and was fearful of, but resisted, management power and authority” (p. 92).
Lonne and Thompson (2005) argue that in order to address the problem of the conflicting ideologies about providing child protection services that existed in the former Department of Families, there needed to be a "revaluation of a professional, over a managerialist, discourse" (p. 96) and a "renewed commitment to social work values and ethical practice as the foundation for reform" (p. 94). They define social work's 'mission' as "helping people to change and confront structural forces that impede change, which will ultimately assist children and young people". This is missing from the Blueprint (2004) and the subsequent strategies for the recruitment of new staff. They also call for the recruitment of "(h)igh quality staff, with university education that is both broad in its ability to produce critical and contextualised thinking commensurate with professionalism, and specific enough to induct them with child welfare skills to successfully undertake the complex roles and work" (p. 95). In short, Lonne and Thomson (2005) propose that "(i)f we argue for social work values to frame child protection practice, we must, by definition, argue for a renewed focus on child and family welfare" (p. 95). (p. 95). However, they do not argue that qualified social workers should be targeted for recruitment by the new Department.

Tilbury (2005) assesses the changes in child protection in Queensland with reference to what she describes as the current debate in child protection services about the balance between 'child rescue' and 'family support'. This debate centres around the argument that, amid the rising numbers of notifications, substantiations and re-substantiations in child protection services in the developed world, the concentration of resources on the investigation of alleged maltreatment has not served maltreated children well (Tilbury, 2003). This concentration has undermined the development of a more comprehensive approach to meeting the needs of children (which includes 'family support' services) (Tilbury, 2003). As mentioned above, with respect to the recent development of services for children in Queensland, Tilbury (2005) concludes that the balance has shifted toward 'child rescue' rather than 'family support'.
However Tilbury (2005) is mindful that it is very early days in the redevelopment of child protection services in Queensland and that detailed strategies for implementing the changes recommended by the Forde Inquiry and the CMC Report (2004) will take considerable time to develop and implement. She comments that neither of the Inquiries, in their recommendations, provided a comprehensive direction for the development of child protection services that were based on current evidence about best practice: “evidence was interpreted within a legal framework, rather than as findings from research about services of interventions most likely to achieve the desired result” (Tilbury, 2005, p. 15). While Tilbury’s (2005) analysis of the framework as ‘legal’ differs from the ‘systems’ approach identified by Lonne and Thomson (2005), the conclusion that the authors draw is similar in that the recommendations do not address all of the problems with the child protection system in Queensland. It also appears that the consequences of a legalistic approach and a systemic approach to both conceptualising and addressing the problems in the child protection, in terms of increasing proceduralisation and the regulation of practice, are the same. As Howe (1992) argues, in relation to child abuse inquiries in the UK, “it is not surprising that Inquiries, which themselves were conducted along rational, investigative and systemic lines, should recommend the use of firmer administrative and technological procedures in child abuse work” (p. 499).

As discussed in Chapter One, ideology can be useful conceptual tool in the analysis of policy and practice. From my analysis of the CMC Report (2004) and the Blueprint (2004) and those of Lonne and Thompson (2005) and Tilbury (2005), there were four dominant forms of ideology that blended together to affect how child protection services in Queensland were reorganised. Bureaucratic ideology led to the conclusion that, in order to rationalise service provision, practice would need to be proceduralised through the development of a practice manual. Technocratic ideology led to the conclusion that risk assessment and decision making could be rationalised through the implementation of a risk assessment tool. Both of these ideologies underpin one of the main recommendations of the Blueprint (2004), which is the implementation of a “suite of professional practices and decision tools to help regulate, standardise and record the frontline decisions taken by Child Safety Officers” (p. 25). An explanation as to why these particular ideologies may have set
The agenda for change is provided by Blaug’s (1995), who proposes that, in response to a need to fix a problem, we instinctively reach for ‘instrumental reason’, which invokes certain ideologies that then frame both how we conceptualise and respond to the problem.

The third form of ideology that underpinned the redevelopment of child protection services in Queensland was managerialism, as mentioned in Chapter One. Effectiveness and efficiency are the key aims of a managerialist approach to the provision of human services (Harris, 2003; Jones & May, 1992). The implementation of the Practice Manual, the ICMS and the SDM tools can be considered as strategies to achieve these aims. As will be discussed in Chapter Three, the SDM suite of tools contains specific tools to facilitate the management of services, through the monitoring of the activities of frontline practitioners. As discussed in Chapter One, part of Harris’ (2003) analysis demonstrates how managerialist approaches, in their drive for effectiveness and efficiency, reduce the autonomy and discretion of frontline practitioners and break down complex areas of practice to series of prescribed tasks. In child protection, a managerialist approach reconceptualises the role of the practitioner to that of investigator and ‘gatherer of evidence’ and the analysis of this ‘evidence’ is no longer left to the professional discretion of the worker (Howe, 1992). As the description of the SDM tools in Chapter Three shows, the tools prescribe particular tasks for practitioners, in terms of what, how and when decisions are made in a child protection case.

The fourth form of ideology that emerges from the analysis is ‘child rescue’ ideology (as defined in Chapter One with reference to Pelton, 2008). As Corby (2006) notes, child protection services in the UK, through what is referred to as the ‘refocussing debate’, have shifted their focus from the needs of children for protection to a broader consideration of their needs, with protection (or safety) being but one part of these. Services in the USA have, in contrast, continued to develop risk assessment tools (Corby, 2006). As mentioned in Chapter One, it has been argued that child protection services in the USA are driven by an ideology of ‘child rescue’ (Pelton, 2008). Closer to home, child protection services in Victoria have also undergone a
similar transformation to services in the UK. In response to rising numbers of
notifications, substantiations and resubstantiations, the Department of Human
Services in Victoria has invested heavily in creating family support services in non-
government agencies to assist parents to care for their children and thereby avoid
coming to the attention of the child protection service (see DHS 2002 & 2008). It
appears that the reorganisation of child protection services in Queensland has been
more affected by developments in the USA rather than the UK and Victoria.

There may be other factors which tipped the balance more toward ‘child rescue’ than
‘family support’ in the redevelopment of child protection services in Queensland. The
media, as mentioned above, played an important role in publicising the problems that
beset the child protection service in Queensland (and continues to do so, see
Chapter Five). As has been shown in other studies, intense media reporting can set
the agenda for the development of policy in child protection (see Mendes, 2000).
Media reporting not only provides a mandate for policy makers to be seen to be
doing something, but can also influence them to choose what might be considered
as ‘tougher’ measures, or, as Mendes (2000) suggests, remedies that tend more
toward social conservatism than social justice. It could also be argued that the
findings presented in the CMC Report (2004) were so damning of child protection
practice that they provided a mandate for policy makers to adopt a ‘tough’ approach.
The initial problem that was publicised by the media was the sexual and physical
abuse of children in the care of the Department. Unlike other unfortunate situations
which implicate child protection services as blameworthy for not having prevented a
parent or carer from harming a child, the children in Queensland were abused by
people considered (at least by the public) as part of the Department. These children
were supposed to be in a ‘safe’ place, but, in reality, were suffering possibly worse
abuse than if they had remained in the care of their parents. The creation of a new
‘Department of Child Safety’, with increased numbers of staff, newly developed
practice procedures, a new electronic data system and tools to assist decision
making might be considered evidence that politicians and policy makers were not
only adopting a ‘tough’ or ‘rational’ approach but were also taking action.
An assessment of the outcomes of the reorganisation

Information from the Department

During 2008, after the fieldwork had been completed, I attempted to find up-to-date statistics relating to the activities of the Department. The most current report from the AIHW (AIHW, 2008) contained no relevant information about Queensland after 2005/06, with the explanation that the move to a new data collection system had prevented the Department from providing it. I contacted the Department and was informed that the Department had not been able to supply data to the AIHW (and could not accede to my request) because none was available, the reason being that the ICMS (Integrated Case Management System) reporting functions had ceased to function. It was hoped that new systems would be available for testing in April 2008 and fully operational by the end of the year.

When I accessed the Child Safety Annual Performance Report 2006-07, I found that data had been included for 2006/07, but there was clarification about the data in this report contained on page 4:

It is important to note that the 2006-07 figures presented in this report are interim as they relate to data collected from the version of ICMS [Integrated Case Management System] released in March 2007. Figures will be revised in early 2008 based on the August 2007 version of ICMS and released via the ‘Our Performance’ section of the Department's internal website.

The updated information has not been made available on the Departmental website and so there is no final data available that covers the period since the SDM tools were introduced across the Department. As yet there is no data available for the 2007/08 period.
The 2006/07 Report does contain overall statistics dating back to 2002/03, which provide some insights, more broadly, about what has happened since reorganisation. Table Three provides a summary of these statistics.

Table Three: Summary Statistics (reproduced from DCS, 2008, p. 7)

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Intakes</td>
<td>40,202</td>
<td>44,631</td>
<td>53,503</td>
<td>62,496</td>
<td>64,266</td>
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<tr>
<td>Child concern reports</td>
<td>NA</td>
<td>NA</td>
<td>3,711</td>
<td>28,884</td>
<td>35,686</td>
</tr>
<tr>
<td>Notifications</td>
<td>31,068</td>
<td>35,023</td>
<td>40,829</td>
<td>33,612</td>
<td>28,580</td>
</tr>
<tr>
<td>Children notified</td>
<td>22,027</td>
<td>25,009</td>
<td>29,633</td>
<td>25,687</td>
<td>24,360</td>
</tr>
<tr>
<td>Substantiations</td>
<td>12,203</td>
<td>17,473</td>
<td>17,307</td>
<td>13,184</td>
<td>8,441</td>
</tr>
<tr>
<td>Children subject to substantiations</td>
<td>9,032</td>
<td>12,741</td>
<td>12,985</td>
<td>10,177</td>
<td>7,402</td>
</tr>
<tr>
<td>Children subject to protective orders</td>
<td>4,107</td>
<td>4,950</td>
<td>5,857</td>
<td>6,446</td>
<td>6,156</td>
</tr>
<tr>
<td>Child protection orders</td>
<td>4,058</td>
<td>4,837</td>
<td>5,751</td>
<td>6,323</td>
<td>6,061</td>
</tr>
<tr>
<td>Court assessment orders</td>
<td>49</td>
<td>113</td>
<td>106</td>
<td>123</td>
<td>95</td>
</tr>
<tr>
<td>Children living away from home</td>
<td>3,787</td>
<td>4,413</td>
<td>5,657</td>
<td>6,654</td>
<td>6,510</td>
</tr>
</tbody>
</table>

Notes:
* 2006–07 data are interim and will be revised in 2008.

Interpreting the trends in the data contained in Table Two that relate to demand at the intake and investigation stages of the child protection process is complicated by the changes between the years in how data has been collected and classified (as
explained in the Report). For example, from March 2005, the department changed its policy about how notifications would be counted. Only those contacts which required an investigative response rather than just advice or referral would be counted. The sharp increase in the number of intake responses from 2004/5 to 2005/06 may be partly due to Queensland police changing their operational procedures to include notifying the Department of all children involved in domestic violence incidents from February 2005.

The data in relation to the numbers of children subject to child protection orders and the numbers of children living away from home are comparable across the years and the trends more easily discernable. From 2002/3 to 2005/6, the number of children subject to child protection orders rose by 57% and the number of children living away from home rose by 76%. Up to 2005/2006, the trend was clearly that the Department was becoming statutorily involved with more children each year and increasing numbers of children were removed from the care of their parents.

Of pertinence to this research there are two references to the SDM tools contained in the 2006/07 Report. Firstly, from page 9:

The number of notifications recorded since 2004–05 has since moderated due to a combination of practice and recording changes:
• The introduction of Structured Decision Making (SDM) tools in 2005–06 has assisted the department to improve consistency in assessment and target resources to those children and young people most at risk.

Despite the difficulties noted in the Report about making comparisons across the years mentioned, the claim is clearly made that the SDM tools have helped the
Department to “improve consistency in assessment and target resources”. Claims about the moderating effects of the introduction of the SDM tools are also made in relation to the numbers of substantiations (p. 13):

The number of substantiations recorded since 2004–05 has since declined. This decrease in substantiations is likely to be due to a number of factors, including:

• the decrease in notifications also recorded since 2004–05

• the introduction of Structured Decision Making (SDM) tools in 2005–06. SDM has had a moderating effect on the number of substantiations by assisting to improve consistency in assessment and through targeting resources to those families most at risk, helping to prevent further substantiations for those clients.

The main criticism that can be levelled at these claims is that they are made in relation to incomplete data (as mentioned above). The data for 2006/07 is only complete up to March 2007 and does not include April, May and June 2007. Therefore it is to be expected that the numbers of notifications and substantiations would be fewer for 2006/07 than 2005/06. This is more likely to be the explanation for the drop in numbers than the ‘moderating effect’ of SDM. What is significant about the claims is that they demonstrate the importance of the SDM tools to the ‘official’ version of practice (Buckley, 2003). In particular, they convey a message that the implementation of the SDM tools is achieving what was intended and that the resources expended on it have been justified. The same cannot be said about the ICMS, which has failed in meeting its most basic legislative function of providing accurate data to the AIHW.
Information from outside the Department

Finalised statistics that provide some insight about the court activity of the Department, since the implementation of the SDM tools were available from the Queensland Magistrates Court Annual Reports from 2005-06 and 2006-07. The statistics are limited in that the reports do not provide information about types of order and the totals of applications (made to the court) and orders (granted by the court) both contain extensions, revocations, variations and interim orders. A comparison between the statistics provided by both of the reports shows the following. Overall, across the state, the total number of applications for child protection orders dropped slightly from 2005-06 to 2006-07, from 6174 to 5991 (2.96%). The total number of orders made also dropped, much more significantly, from 11 404 to 8 781 (23%).

The reports also contain information about individual courts. In Brisbane (which includes three of the CSSCs visited for this research), the total number of applications rose by 3.63% but the total numbers of orders made dropped by 16.75%. The total figures in relation to applications to the court perhaps obscure what was happening at individual courts across the state. In some courts, applications rose by as much as 126% from 2005-06 to 2006-07 and in others dropped by as much as 66%. There is no indication in the later report that these increases were due to a change in arrangements or a reorganisation of courts, but there are differences in the names of the courts listed in the two reports, which suggests that there may have been some reorganisation of jurisdictions that affected the figures. Without specific information about these changes, it is difficult to draw any conclusions from the data and the timeframe of the data is too short to make any inferences about trends or the effects of the introduction of SDM. Perhaps the most interesting finding from these statistics is that, in courts that encompass two of the CSSCs visited for this research, the total numbers of applications and orders made rose significantly between 2005-06 and 2006-07. The requirement for anonymity precludes providing precise information about the increases, but both were over 50%. These increases support the observations made by participants (in Chapter Five) that there appears to have been an increase in the numbers of children
removed from their parents, though it appears from the reports that this is not uniform across the state.

Chapter summary

In this Chapter, a description and analysis of the developments in child protection policy and practice in Queensland since 1999, which led to the creation of the Department of Child Safety and the implementation of SDM has been provided. While the reorganisation of child protection services was a major opportunity to redevelop services according to models of best practice globally, comparison with other jurisdictions suggests that a choice was made to develop services along what might be considered as less rather than more progressive lines. As will be shown in the next Chapter, SDM is not new and there have been jurisdictions in the USA and Australia that have tried to implement it but have, for a variety of reasons, encountered problems and even stopped using the tools. An analysis of the developments in child protection in Queensland using the concept of ideologies as forces which shape and direct change has shown how the adoption of a tool such as SDM was an outcome of the way that the problems were conceptualised. Specifically it has shown how the problems in child protection practice in Queensland prior to 1999 were conceptualised, at least in part, as organisational and ‘systemic’ and how the resolution of these problems relied on a blend of ‘managerialist’, ‘bureaucratic’ and ‘technocratic’ responses in formulating the necessary changes to improve services. It has also been argued that the reorganisation was influenced more strongly by ‘child rescue’ ideology than ‘family support’ ideology.

In the next chapter, information and research about the SDM tools is presented and how they have been integrated into the Department’s Practice Manual is described.
Chapter Three: Structured Decision Making and the Department of Child Safety Practice Manual

Introduction

As stated in the previous Chapter, the implementation of the SDM tools in the Department of Child Safety began in 2006. This implementation coincided with the introduction of the Department’s Practice Manual and the ICMS (Integrated Computer Management System). This Chapter is divided into two sections. The first section is descriptive and provides information about the SDM approach to child protection and the tools it provides to agencies, with reference to both documents produced by the Children’s Research Centre (CRC) and the Department of Child Safety Practice Manual. This section concludes with an analysis of the convergence between the claims made about SDM by the CRC and the themes that emerge from the CMC Report (2004) and the Blueprint (2004). In the second section, an overview is provided of existing research and commentary about the use of the SDM tools.

1. SDM – an overview

This section draws mainly from the CRC document ‘The Improvement of Child Protective Services with SDM: the CRC Model’ (CRC, 1999), which is available for download from the CRC website. The document is a brochure, designed to promote SDM and while the document is useful as a description of the various components of SDM, it does not provide any analysis or critique. This was the only document available at the time that SDM was implemented in Queensland and preparations for this research were being made. After the fieldwork had been completed the CRC posted a later version of this document (CRC, 2008) on their website. The following account is based on the earlier document as that was current at the time of the fieldwork. The new document does not present any new material of relevance to this research.
SDM is described as a suite of practice tools designed to assist the decision making of professionals in child protection services. It was developed by The Children’s Research Center (CRC) in Wisconsin, USA. The CRC was established as a division of the National Council on Crime and Delinquency in 1993 to help federal, state and local welfare agencies reduce child abuse and neglect by developing case management systems and conducting research aimed at improving service delivery to children and families (preface to CRC, 1999).

The first SDM project was in Alaska (in the late 1980’s) and this was followed by Michigan, Oklahoma, Rhode Island and Wisconsin in the early 1990’s. In the late 1990’s, similar projects were carried out in Indiana, Georgia, and New Mexico, all of which implemented SDM models. From 1999, the list expanded to include California, Minnesota, Ohio, Washington and Louisiana with Colorado and South Australia implementing some of the aspects of the system (preface to CRC, 1999).

In recognition of the rising demand for child protection services and apparent crisis it has caused, the CRC (1999) points to the need for “more efficient, consistent and valid decision making in children’s protective services” (p. 1). In particular: “[a]gencies overwhelmed by heavy workloads need to be able to consistently and accurately determine which cases should be investigated, which children need to be removed, and which families require the most intensive services “ (CRC, 1999, p. 1, emphasis in original). SDM therefore aims to address how decisions are made in terms of prioritising need and directing resources to families by the use of tools (based on actuarial forms of risk assessment) to measure and codify levels of risk. Tools have been developed to assist with decision making at various critical points throughout the life of a case, from intake through to decisions about reunification and permanency planning. However, as Shlonksy and Wagner (2005) explain, while these tools might indicate that an agency needs to manage unacceptable levels of risk to children, they need to be combined with a consensus based tool to assist in identifying what services should be offered to a family. For this purpose, SDM provides the Parental Strengths and Needs Assessment and the Child Strengths and Needs Assessment tools.
The four principles and objectives

As described by the CRC (1999, p. 3), SDM is based on four principles:

First, decisions can be significantly improved when structured appropriately: that is, specific criteria must be considered for every case by every worker through highly structured assessment procedures.

The second principle stipulates that priorities given to cases must correspond directly to the results of the assessment process. Expectations of staff must be clearly defined and practice standards must be readily measurable.

The third principle is that virtually everything an agency does – from providing services to an individual case to budgeting for treatment resources – is a response to the assessment process.

Fourth, a single, rigidly defined model cannot meet the needs of every agency.

The fourth principle is expanded upon with the explanation that, while each system for a particular area or jurisdiction is based on the same principles, it is then adapted to local practices and mandates through the input of local managers and staff, resulting in a “site – specific system which is “owned” by the agency and builds upon its strengths as a service organization” (CRC, 1999, p. 3).
The objectives of SDM are stated as:

- To introduce structure to critical decision points in the child welfare system.
- To increase the consistency and validity of decision making
- To target resources to families most at risk.
- To improve the effectiveness of Child Protective Services (CRC, 1999, p. 4)

A clear distinction is made between the concepts of ‘safety’ and ‘risk’ in SDM: “Safety refers to imminent danger to the child and the steps required to provide immediate, short term protection. Risk, on the other hand represents the likelihood that the caretaker will re-abuse or re-neglect the child in the future” (CRC, 1999, p. 9, emphases in original).

Specifically, SDM contains ten components, which can be summarised as follows (see Fig 3. p. 5, CRC, 1999):

1. *Response Priority* - this is used when a case is referred to a child protection agency and assists with making a decision about whether it is accepted as a notification and, if so, how quickly an investigation should begin. In the Department of Child Safety this tool is split into two parts. Firstly, Child Safety Officers are required to use the Screening Tool to decide whether a referral is accepted and then use the Response Priority Tool to decide how quickly a case is investigated. More detail about this is contained in the section below on the Department of Child Safety Practice Manual.¹

2. *Safety Assessment* – this is used at the onset of an investigation, prior to the removal of a child from his/her parents/caregivers, to identify whether there is any immediate threat of harm and what protective factors may exist.²

¹ This is one of the four tools focused on in this research.
² Ibid.
3. *Risk Assessment* – this is completed at the end of the investigation and is used to assess the long-term likelihood of re-abuse and neglect. On the basis of this assessment, a case may be closed if there is no risk to the child, or it may be opened for further intervention. If the case is opened for further intervention, this tool assists with the allocation of a ‘level of service’ decision according to the level of risk (for example, high, medium, or low). ³

4. *Family Strengths and Needs Assessment* – this is to be completed by the end of an investigation and is used to identify the services required by a family and drive the caseplan.

5. *Child Strengths and Needs Assessment* - this is to be completed by the end of an investigation and (again) is used to identify the services required by a family and drive the caseplan.

6. *Classification and Service Standards* – this is completed after the risk and needs assessments of the child and family have been completed and is used to differentiate particular levels of service for cases that will remain active.

7. *Risk/Needs Reassessment* – this is to be competed every 3 to 6 months to measure progress, adjust level of service, amend the caseplan and make decisions about case closure.

8. *Reunification Assessment* – This is to be completed when considering the reunification of a child in out-of-home care with his/her parents. It is used to reassess risk and safety and compliance with the caseplan and visitation.

9. *Workload Management* – this is used continually to assess the numbers of staff needed in an agency and assist with workload allocation.

³ This is one of the four tools focused on in this research
10. Management Information - this is used continually to monitor quality assurance, planning, evaluation and budgeting.

Assessing future risk

Within SDM, the Risk Assessment instrument is an actuarial model that incorporates a range of family characteristics which the CRC (1999) claims have been demonstrated to have a “strong correlation with subsequent child abuse/neglect referrals” (p. 11). The CRC claim that: “Risk assessment can help frontline staff make better decisions. Research has consistently demonstrated that simple actuarial tools can assess risk more accurately than even a well-trained clinical staff person” (CRC, 1999, p. 14).

It is claimed by the CRC (1999), with reference to Baird, Wagner, Healey and Johnson (1999), that this particular risk instrument is transferable between jurisdictions and that it makes it possible to assess risk with a “high degree of accuracy” (CRC, 1999, p. 11). The tool is used to classify families into risk groups that have “high, medium or low probabilities of continuing to abuse or neglect their children” (CRC, 1999, p. 11). High risk families have a 50% or higher risk of again abusing or neglecting their children and low risk families have a 5% or lower risk of abusing their children. Data from a CRC study in California (which is referenced as ‘California, 1998’, but does not appear the reference list) are used to demonstrate the efficacy of the risk assessment tool in classifying families as low, medium or high risk in relation to higher rates of renotification (up to three times higher) for high risk families as compared to low risk families. Subsequent substantiation rates for high risk cases are also higher.

Proponents of SDM stress, however, that the application of the risk assessment tools should not be considered as predictive of whether a child will be harmed in the future, as: “results of the risk assessment should not be considered a prediction of
future behavior but only as a classification: they place a family in a group of families that share certain characteristics and have a known outcome rate" (Freitag & Wordes, 2001, p. 79). The purpose of such classification is to assist with the targeting of resources and it is claimed that the SDM tools can achieve this even in agencies that employ inexperienced workers with minimal training and have high staff turnover (CRC, 1999).

Given that the tools may not capture all that is relevant in a particular case, the forms contain a prompt for workers to consider overriding the assessment generated by the tool if it appears to them that the circumstances of the case place a child at a higher level of risk (Freitag & Wordes, 2001). Acknowledging that different family dynamics may be present between abuse and neglect, there are also different scales of characteristics to assess the risk of abuse and neglect (CRC, 1999).

Assessment of Family Needs and Strengths

This tool is described as another important feature of the SDM system and is, as a companion to the Risk Assessment, used to “systematically identify critical family issues and resources and help plan effective service interventions” (CRC, 1999, p. 15). Unlike the risk assessment, which is an actuarial model, the Family Needs and Strengths Assessment is a consensus based model, developed in consultation with practitioners in Wisconsin, but has been developed with different emphases in different jurisdictions.

Both the Risk Assessment and the Family Needs and Strengths Assessment form the basis of re-assessments which are usually scheduled every 90 days for the time that a case is open. If necessary, the risk level (low, medium or high) can be adjusted in response to the re-assessment. The documentation is described as fairly brief and designed to replace longer (and more time consuming) caseplan reports. The importance of assigning a risk level, and adjusting it accordingly, is explained in the next section, with reference to ‘Service Standards’.
Establishing Service Standards for Cases at each Risk Level

In line with the objective of targeting resources to the families considered to be at highest risk of re-abuse or re-neglect, the SDM system proposes the use of “differential service standards, whereby the mandated frequency of contact between the worker and the family is tied to the family’s level of risk” (CRC, 1999, p. 17). The example of service standards developed in Michigan is provided (as typical), in which the number of contacts between a worker and a family is prescribed by the ‘service level’ the family has been assessed at. The ‘Minimum standards’ for a ‘Low’ service level family require that there be one face-to-face contact between worker and client each month plus one collateral contact by the worker on behalf of the client. ‘Moderate’ service level requires twice as much involvement, ‘High’ three times and ‘Intensive’ four times as much.

SDM for Children in Out-of-Home Care

The SDM system also contains a tool to guide decision making about reunification of children in care with their parents or permanency planning for children assessed as having to stay in state care. It consists of four assessment components (quoting from CRC, 1999, p. 18):

- “A structured risk reassessment;
- A structured evaluation of parental compliance with visitation schedules;
- A reunification safety assessment; and,
- Structured guidelines for changing the permanency planning goal”.

These four separate assessments are considered jointly to guide decisions about whether children should be returned to the care of their parents and incorporate criteria which are reflective of policies and regulations pertinent to particular jurisdictions.
The Management Components of the SDM Model

There are two ‘management components’ of the SDM system, which are “designed specifically to facilitate management and administration of the child welfare agency” (CRC, 1999, p. 20). One tool deals with workload measurement, which is promoted as a way of translating caseload into time requirements and consequent staffing needs. The model assumes that cases require a certain number hours of work each month, depending on what level of risk (or service level) they have been assigned. Knowing the monthly time requirement means that the total workload demand can be calculated, providing a “rational, empirical basis” (CRC, 1999, p. 20) for planning workloads, staffing requirements and budgeting.

The second ‘management component’ is ‘Management Information Reports’ which provide data for planning, monitoring and evaluation. The premise offered is that “the information needed to make good decisions at the individual case level (e.g., structured assessments of risk and service needs) is the same information needed – in aggregate form – by agency supervisors, analysts and administrators” (CRC, 1999, p. 21).

SDM and the Department of Child Safety Practice Manual

As recommended by both the CRC Report (2004) and the Blueprint (2004), the newly formed Department of Child Safety developed a Practice Manual to guide the work of Child Safety Officers. As described in Chapter Five, all CSOs, Team Leaders, Senior Practitioners and Managers have a copy of the Practice Manual and one is on the shelf beside each work station. The Practice Manual has been updated and added to eight times since its introduction in 2005. The version used at the time of the data collection for this research was updated in June 2007. The Practice Manual is currently 825 pages long, excluding the ‘Practice Papers’ which provide information about particular aspects of practice, such as dealing with domestic violence. The purpose of the manual is stated in the introduction (Page 20) as:
The Child Safety Practice Manual is one of a set of ‘authority documents’ that collectively make up the policy and procedural documentation of the Department of Child Safety. The purpose of the practice manual is to facilitate standardised practice across the state. In addition, the practice manual:

- informs ‘frontline’ child protection practice;
- outlines the roles and responsibilities of departmental staff in the delivery of statutory child protection services; and
- advises staff of their statutory obligations to promote the safety and well-being of Queensland children and young people, specifically those at risk of harm.

The Practice Manual goes beyond providing a list of procedures for staff to follow as it provides information and advice to staff about how to do their job at every stage. It appears to be designed to guide and instruct staff who may have no previous knowledge or experience of working in child protection. The theme of the need for consistency in decision making is continued in the Practice Manual, as explained on page 2-3, Chapter 1:

The use of the following structured decision making tools during the intake phase provides consistency in responding to the information received.

- the screening criteria tool: a structured decision-making tool that guides the decision about whether or not the information received meets the departmental threshold for a notification; and
- the response priority tool: a structured decision making tool that guides the decision about the required timeframe for the commencement of an investigation and assessment.
Consistency of response by the department is dependant upon the CSO having a thorough knowledge and understanding of the definitions of the screening criteria and the response priority tools. In particular, the CSO needs to consider the cultural context for Aboriginal and Torres Strait Islander children when completing the tools.

This theme is also continued with reference to the tools used in the ‘investigation and assessment phase’ in Chapter 2 (page 56):

The purpose of the family risk evaluation tool is to achieve a level of consistency and reduce the subjectivity that can occur as part of risk assessment decision-making.

This doctoral research project focused on cases that had been accepted by Child Safety Service Centres (CSSCs) as notifications (up to the conclusion of the ‘investigation and assessment stage’) and a selection of cases that had not been accepted and classified as ‘child concern reports’. Consequently the focus within this research was on the SDM ‘Screening Criteria’ (referred to by practitioners as the ‘Screening tool’), ‘Response Priority Assessment’ (the Response Priority tool’), ‘Safety Assessment’ and ‘Family Risk Evaluation tool’ (‘FRET’).

The following is a descriptive summary of the intake and investigation stage of a case referred to the Department of Child Safety which focuses on how the SDM tools are to be used, drawn from the Practice Manual. Chapters 1 and 2 of the Practice Manual, which cover ‘Intake’ and ‘Investigation and Assessment’ processes, the foci of this research, are 60 and 94 pages long respectively and so, in comparison, the following account is brief. Certain words and terms have been placed in single quotation marks as they are drawn directly from the Practice Manual and their use and meaning is particular to the document itself. Placing these terms in quotation marks is necessary to ensure that the meaning and context of these terms are not misinterpreted.
marks serves to highlight these terms for later consideration as part of the ‘argot’, from an ethnomethodological perspective, of child protection practice in Queensland.

**The Screening tool**

At the point of first referral to a child protection agency, SDM provides a tool to assist in the decision about whether a case should be accepted for investigation, closed or referred to another agency (the ‘Screening tool’). The requirement in the *Practice Manual* is that this decision be made within 24 hours. Only cases that are accepted for investigation are referred to as ‘notifications’. Referrals about concerns for children in state care are referred to as ‘Matters of Concern’ and invoke the use of a different set of procedures that intake workers must follow. If a referral is not recorded as a notification, the intake worker records it as a ‘Child Concern Report’ (CCR). A referral is only accepted as a notification if the intake worker is able to tick one of the boxes in the Screening tool. Once completed, the Screening Criteria tool is submitted to the team leader for approval within five working days. The Screening tool from Chapter 1 (page 27) of the *Practice Manual* is reproduced in Appendix 1.

**Response Priority tool**

Having accepted a referral as a notification through the application of the Screening tool, intake workers are then required to use the ‘Response Priority tool’. Each question in the Response Priority tool requires a yes/no answer and leads to the categorisation of the notification in terms of 'response timeframe', which may be 24 hours, five or ten days. If more than one timeframe is indicated by the application of the tool, then the quicker response is the one that should prevail. There are also the options for ‘policy’ and ‘discretionary override’ to allow the consideration of information that is not prompted by the tool, allowing the response time to be shorter or longer. At the completion of the Screening tool and the Response Priority tools, both are then forwarded to the Team Leader for approval within 24 hours.
The Response Priority tool is embedded in the ICMS and requires staff to tick boxes. On completion of the forms, the ICMS automatically produces the response priority of 24 hours, 5 days or ten days.

**Safety Assessment tool**

The ‘Safety Assessment’ tool is used during the investigation to identify “specific and immediate harm indicators that may place a child in danger” (section 2.11) and to decide whether a child can remain at home or needs to be placed elsewhere. The tool contains four sections, the first being ‘Immediate Harm Indicators’, which contains thirteen questions about factors believed to pose an ‘imminent threat of harm’ to a child. This section is to be considered during the first contact with the family. The second section concerns ‘Safety Interventions’ and is to be applied if one or more ‘immediate harm indicators’ were identified in the first section. It lists a range of interventions ranging from the least intrusive through to placement interventions that separate a child from his/her family. The third section is the ‘Safety Decision’, which documents the decision based on the information from the first two sections. In this section, a child can be considered as ‘safe’, ‘conditionally safe’ or ‘unsafe’. ‘Safe’ is applied when there are no ‘immediate harm indicators’. ‘Conditionally safe’ is applied when there are one or more immediate harm indicators present and non-custody interventions have been planned or implemented. A ‘Safety Plan’ is then completed with the family. ‘Unsafe’ is applied when one or more ‘immediate harm indicators’ are present and placement away from the family is the only ‘safety intervention’ possible to ensure safety. The fourth section is concerned with the preparation of a ‘Safety Plan’ (for children assessed as ‘conditionally safe’), which is a written agreement between the department and the family, signed by all the people involved in its implementation. The plan documents the ‘specific time-limited non-custody interventions’ which have been agreed to ‘by all parties’ and records who is responsible for monitoring compliance with the ‘Safety Plan’ and the ‘anticipated completion date’. The Safety Assessment tool, from Chapter 2 (page 42) of the *Practice Manual* is reproduced in Appendix 2.
Family Risk Evaluation tool

At the completion of every investigation, the ‘Family Risk Evaluation tool’ (FRET) is completed, to determine the risk level on the basis of scored items contained in the tool. The score from the Family Risk Evaluation tool is automatically calculated by the ICMS and a risk level of ‘very high’, ‘high’, ‘moderate’ or ‘low’ assigned. There are four possible outcomes of an investigation: the case may be ‘substantiated – child in need of protection’, ‘substantiated – child not in need of protection’, ‘unsubstantiated – child not in need of protection’ and ‘no investigation and assessment outcome’. ‘Substantiated’ is defined as the Child Safety Officer assessing that a child has been harmed or is ‘at risk of harm’. For cases that are assessed as ‘substantiated – child in need of protection’, the outcome of the FRET is expected to be ‘high’ or ‘very high’. For cases that are assessed as ‘substantiated – child not in need of protection’, the outcome of the FRET is expected to be ‘moderate’ or ‘low’. However, for this outcome “there must be clear information recorded to support the parent’s ability and willingness to protect the child, not just statements to this effect” (Section 2.17). The assessment of ‘no investigation and assessment outcome’ is expected to be rare and can only be recorded when factors relating to the family have prevented the completion of the investigation, rather than factors that relate to the organisation, for example, workload pressures. The FRET, from Chapter 2 (pages 61-62) of the Practice Manual is reproduced in Appendix 3.

Ongoing Intervention

Ongoing intervention by the Department of Child Safety will occur for the following outcomes: ‘substantiated – child in need of protection’ or where cases scored ‘high’ or ‘very high’ on the Family Risk Evaluation tool. An intervention may be ‘opened’ with parental consent or with a ‘child protection order’.

Where a family has scored ‘very high’ or ‘high’ on the Family Risk Evaluation tool, but an outcome of ‘substantiated – child not in need of protection’ or ‘unsubstantiated – child not in need of protection’ has been recorded, the case will be opened and Child Safety Officers will ‘work with the family to address the risk factors identified’.
Where a parent refuses such ‘ongoing intervention’, attempts should be made to link the family with other government agencies and community support services. Only in cases where the outcome has been recorded as ‘substantiated – child in need of protection’ will the department intervene against the parents’ wishes.

Commentary

Reading the CRC documents about SDM provides a useful overview of the tools and the principles that underlie them. Reading the *Practice Manual* shows how the tools structure the way that practitioners within the Department are expected to make sense of and order the lives of the children and families with whom they come into contact (de Montigny, 2005). As reflected in later Chapters, some of the language used within the tools is open to considerable interpretation by individuals and teams. For example, what constitutes ‘bizarre disciplinary measures’ (Response Priority tool) or ‘escalating patterns’ of various behaviours (Screening tool and Response Priority tool) or ‘terrorising’ (Screening tool) will differ, depending on who is asked to define the terms. The tools also assume that certain information is available to complete them, particularly the Screening tool and the Response Priority tool, information which may not be available because the only source of information, at the time the tool is supposed to be used, is the notifier. A particular organisational ideology (de Montigny, 1995) that appears to underpin the application of the tools is the need to supply yes/no answers to the questions. From my own experience, many of the answers to such questions, at any stage of dealing with a child protection case, might only ever reach a certainty level of ‘maybe’ or need to be framed by so many conditions that certainty in providing a ‘yes or no’ answer would be very difficult. As de Montigny (1995) points out, this need to arrange the lives of clients according to ‘organisational ideology’ is not always easy for practitioners to achieve. As later Chapters will show, these points emerged, more or less strongly, in the interviews with practitioners conducted for this research.

The way that the SDM tools have been integrated into the *Practice Manual* is similar to the way in which they have been integrated into the Integrated Computer
Management System (ICMS). Aas (2004) discusses how information technology is used to convert (subjective) knowledge into (objective) information by the process of making it recordable and transmissible. The points she raises certainly apply to the ICMS in Queensland. Given that the SDM tools are embedded in the ICMS, they are also an important way in which the ‘knowledge’ that a CSO has about a child and family is converted into ‘information’ recorded on ICMS, to be used as a ‘resource’ (see Parton, 2008). These points are discussed further in Chapter Eight in relation to the findings of this research about the case files created by CSOs.

The Convergence of Themes

As noted above, the CRC document is clearly designed as promotional material for SDM and it contains a number of rhetorical claims about the efficacy of its use. These claims are of particular interest as they resonate very closely with some of the themes that emerged from the CMC Report (2002) and the Blueprint (2004) explored in Chapter Two.

According to the CRC document, SDM “brings structure and consistency to each decision point in the child welfare system through the use of assessment tools that are objective, comprehensive and easy to use” (p. 6). This sentence contains a number of claims which resonate with the themes identified in the CRC Report (2004) in Chapter Two. Perhaps most significantly, there is the claim that SDM brings structure and consistency to child protection practice. An important theme in both the CRC Report (2004) and the Blueprint (2004) is that there was a lack of consistency in both the way that decisions were made in relation to children and families and the ways that services were provided. The assessment tools are also claimed to be ‘objective’, which promotes the idea that human agency is minimised in the process of decision making, which is significant when the original reason for the CMC inquiry is considered, that is, the abuse of children in foster care. The objectivity of the tools is claimed to ensure that ‘critical case characteristics’ are not overlooked. In the CRC document it is made clear that the tools do not actually make the decisions for staff, who are still required to exercise professional judgment, rather
they help to “structure decisions by bringing objective information to bear on (these) critical questions” (p. 6).

The relative ease of use of the tools is also promoted as particularly important for agencies where there is high staff turnover, high workloads and large numbers of inexperienced staff. This also significant in terms of the findings of the CMC Report (2004) (and subsequently acknowledged in the Blueprint (2004)) which found that there was high turnover of staff and offices where there were high rates of staff vacancies. This is also significant in terms of the recommendations of the CMC (2004) that the numbers of staff in the new Department be doubled.

A comparison between the claims made for SDM and the problems with child protection service in Queensland identified in the CMC Report (2004) and subsequently in the Blueprint (2004) shows that there is considerable convergence between them. It almost appears, when reading the brochure, that SDM was designed specifically to meet the needs of the new Department. More broadly, both the claims made for SDM and the analysis of the problems and possible solutions in both reports are, as discussed in Chapter Two, grounded in instrumental reason and propose managerialist, bureaucratic and technocratic solutions. The ideologies that guide the design of SDM and the vision for the new Department espoused in the Blueprint (2004) therefore appear to be in accord.

The claims made by the CRC about the efficacy of SDM are an important consideration in this research in terms of how they might affect the process of how staff use the tools. An important way in which they might do this is to build expectations in the minds of those who have to use the tools, which can amount to unstated conditions (Garfinkel, 1967, see Chapter Four). One specific expectation is that a consistent approach can be adopted when intervening in the lives of children and families, who may come from a diverse range of background and circumstances and be facing many different kinds of problems in their lives. This point is particularly illustrated by claims in both the CRC document and the Department of Child Safety
Practice Manual that SDM is able to promote ‘objectivity’ in decision making about families irrespective of their social or ethnic differences. Such a claim would appear to contradict social work approaches to practice that emphasise the importance of acknowledging and working with diversity (for example, Trevithick (2005)) and the need to achieve ‘cultural competency’ (Maidment & Egan, 2004).

2. Research about SDM

Published research about the use of SDM in various jurisdictions in the USA has been conducted as part of the follow up service to those jurisdictions by the CRC and has aimed to modify and develop the tools so that they are adjusted to local conditions. As noted by Stewart and Thompson (2004) (in Chapter Two), there has been no independent research about SDM published in academic journals: the research that has been published is authored by researchers affiliated with the Children’s Research Center. The following is a summary of these evaluations.

The CRC (1999) provides information about two evaluations of the SDM tools. The first, by Baird, Wagner, Caskey and Neuenfeld (1995) evaluated the impact of SDM on child protection services in Michigan by comparing counties that had implemented SDM with a cohort that had not. They compared 900 families investigated by 13 counties that had implemented SDM with 13 counties that had not and followed these families for 12 months after they had been referred to the child protection agency. The evaluation showed that SDM jurisdictions apparently made more effective decisions about which families to serve post investigation. Even though SDM counties closed a higher percentage of cases immediately upon concluding the investigation, closed cases in SDM counties had fewer subsequent referrals, substantiations, injuries, and placements than did closed cases in non-SDM counties. SDM counties were also more effective at getting targeted services to families with specific identified needs. For example, among all families identified as needing family counselling in SDM counties, about 40 percent actually received family counselling. While this percentage is far below optimal, only 25 percent of families with an identified need for family counselling received it in non-SDM counties. Freitag and Wordes (2001) (who are both identified as employed by the
NCCD, of which the CRC is a part), commenting on the research by Baird et al. (1995) are very positive about the potential of SDM to reduce the levels of child abuse, but they caution that it is not a panacea and will only work if the services it identifies that families require are actually made available.

The other study outlined in the CRC (1999) document is the ‘OCAN Study’, in which staff from the CRC were commissioned by the Office of Child Abuse and Neglect to conduct a comparative evaluation of the reliability and validity of three different risk models (Baird, Wagner, Healy & Johnson, 1999 – a version of this report was also published as Baird et al., 2000). In the first stage of the evaluation, three risk assessment models were compared to test reliability: the Washington Risk Assessment Matrix and the California Family Assessment Factor Analysis (a derivative of the Illinois CANTS model) both of which are consensus based models, and the Michigan Family Risk Assessment, an actuarial based SDM tool.

The evaluation demonstrated that the reliability of the SDM tool was “significantly higher than the level of reliability attained by the “expert” or “consensus-based” approaches to risk assessment” (p. 24). The kappa is not given for any of the instruments in the CRC (1999), but the following comment is made: “A statistical test used to measure reliability (Cohen’s Kappa) indicated that the Michigan scale was reliable, while the Washington and California scales were not” (p. 25). In the report by Baird et al. (1999) the kappas are given as 0.562, 0.180 and 0.184, respectively. The authors state that while researchers might disagree about what might be considered an adequate kappa, “a kappa above .5 to .6 is generally deemed acceptable” (p. 18).

The second stage of the OCAN study evaluated the validity of the three risk assessment models using the rate of renotification of families assessed as low, medium and high risk. The assumption underlying this evaluation was that families classified with a risk level of ‘high’ should have a renotification rate that is three to four times greater than those classified with a risk level of low. The conclusion of the
study is: “[c]learly the Michigan system did a superior job identifying families with low, medium and high proclivities for maltreating children” (CRC, 1999, p. 25). There is no additional research offered in the later version of the CRC brochure (CRC, 2008) that is pertinent to this research. In the 2008 document, the above evaluations and research are repeated, with the addition of a second study in Michigan that focussed on the outcomes of the use of the SDM tools designed to assist with the reunification of children with their families.

The following examples of evaluations are mentioned in the CRC (2008), but were accessed from the CRC website before the fieldwork for this research began. Johnson (2004) used data from California to assess the accuracy of the California Family Risk Assessment, which is completed at the end of investigations and used to assign a risk level to determine whether the case should be opened for the provision of services. The conclusion of this study was that Family Risk Assessment was highly accurate and did not need to be adjusted. In particular the tool was useful in reducing the rate of re-substantiations of abuse and neglect. A further example of research conducted by the Children’s Research Center to revalidate a risk assessment tool they had developed is the evaluation conducted by Johnson, Wagner, and Wiebush (2000) in South Australia. As a result of their evaluation, which found that the risk assessment worked well, they proposed changes such as fewer items in the instrument to make it easier for practitioners to use and a revision of some of the factors to be considered in relation to child and family characteristics.

The available research about the SDM tools, as outlined above, is conveyed with a tone of optimism about how they might make a positive contribution to practice. Indeed, the results of the various evaluations suggest that where the tools have been implemented, they have been successful in terms of the goals of promoting consistency in decision making and targeting the children most in need of the resources of child protection agencies. The research by Baird et al. (1999) also suggests that the SDM tools are better than other tools, particularly in terms of reliability and validity, though it is questionable whether a kappa of 0.562, is acceptable when making decisions about vulnerable children. But it must be borne in
mind that these evaluations and the research by Baird et al. (1999) were conducted by staff at the CRC, albeit, in the case of the OCAN study, overseen by “an independent Advisory Board of national experts” (CRC, 1999, p. 24) and that the research, as presented in the CRC brochure (CRC, 1999) has been selected to promote rather than provide a critical evaluation of the tools.

As argued in Chapter One, the outcomes of the evaluations mentioned above also rest on the assumption that practitioners used the tools as they were intended to be used. In Baird et al.’s (1999) first study concerning the reliability of the tools, it can be assumed that the participants did use the tools as intended, under research conditions, but this still offers no insight into how practitioners, under practice conditions, use the tools. As discussed below, there is some evidence emerging that it cannot be assumed that use of the tools in practice is straightforward.

There is growing body of literature that discusses the need for careful implementation of SDM using specifically constructed training for practitioners at different levels. Each year the CRC holds a conference and in 2007 the theme was implementation strategies (the link to this and the abstracts has now disappeared from the CRC website). Within this literature the need for training of workers at different levels of the organisation is emphasised, as is the need for implementation to be grounded in theory about organisational change (DePanifilis, 1996). However the assumption in such literature is that the use of SDM by practitioners is unproblematic after successful implementation. The CRC also publishes ‘SDM News’ (a newsletter which is available on the website) every three or four months, but this contains no useful insights to guide this research as, again, it is designed to promote the use of SDM by providing positive accounts of its use in various jurisdictions.

Information from public documents, rather than research published in journals or by the CRC itself, indicates that the use of the SDM tools in practice is not straightforward. An example of this is a report by Claire McCaskill, State Auditor of
Missouri in her 2004 report entitled, *Performance Audit: Follow-up of Child Abuse and Neglect Reporting and Response System* (McCaskill, 2004). According to the report, in 2000, it had been recommended by the State Auditor that SDM be implemented in the child protection service in Missouri. While the 2004 report confirms that this recommendation was followed, it notes that caseworkers “inconsistent use or documented SDM tools designed to determine risk levels or whether to open a case for services. DSS had not adequately monitored caseworkers’ use of these tools or provided caseworkers any subsequent SDM follow-up training” (p. 6). The audit also found that “(t)he facts of the case did not support the risk assessment for 10 percent (7 of 70) of applicable incidents reviewed” (p. 7) and that “16 percent (11 of 70) of the applicable case status decisions were not supported by case facts and risk levels assessed” (p. 7). In short, the Auditor’s report does not question the efficacy of implementing SDM but blames a lack of training for the workers and monitoring by the department for the problems it encountered with how SDM was used. Its findings suggest that the use of SDM does not automatically promote high levels of consistency in decision making, as claimed by the CRC. It can also be inferred that human agency in the use of the tools is perhaps more important than suggested by the CRC.

A further example of how practitioners might use SDM tools is provided in a policy brief issued by the Association for Children of New Jersey (ACNJ, 2004). The brief aims to provide some description of how the SDM tools were used in New Jersey and also engages with research/commentary from other states that have implemented SDM. While much of the brief is concerned with the impact of SDM at a systems level, some of the points made by the briefing are pertinent to this research.

The brief explains that the state of New Jersey decided not to use the initial screening tool in SDM as it was not considered to be sufficiently detailed in its direction. They did start to use the ‘Response Priority tool’ but found that it resulted in too many responses being assessed as ‘immediate’ and so its use was discontinued. In terms of the experiences of other states in the use of SDM, the briefing quotes Mary Dibble, from the Wisconsin State Division of Children and
Family Services. According to Ms. Dibble, Wisconsin only uses SDM in four counties and only as an aid to the initial assessment made by practitioners. It was decided that SDM had failed to provide the depth of assessment necessary to help abused children and their families. Ms. Dibble is quoted as follows: “We couldn’t bank on it being valid and we were looking at a model that actually assisted our workers in spending time with the family, not doing a quick screen.” (p. 2). Ms. Dibble is quoted as summing up SDM as “a fairly superficial statistic based model. It has no theory of why abuse/neglect occurred and why people change. For CPS [Child protection Services] to be successful, you absolutely have to have that” (p. 2).

The briefing also mentions a major impact of the use of SDM in California where there was a dramatic increase in the number of ‘unfounded reports’ of child abuse and neglect. In other words, there was an increase in the number of investigations as compared to substantiations. However, this experience was not uniform across all the counties of California and there were considerable inconsistencies.

On the experience of the use of SDM in Michigan, the briefing quotes Ted Forrest, manager of Michigan’s Children’s Protective Services Program: “Caseworkers often see the process (of using SDM tools) as another piece of paper, another redundant way to document what they find” (p. 4). The briefing also proposes that the Michigan child protection statistics show that individual counties apply the SDM tools very differently (as in California). Referring to Ted Forrest, the inconsistencies are related to the fact that, even eight years after the implementation of SDM, some practitioners still resist using the tools and fail to understand the intent of the system. Describing the implementation of SDM as a continual struggle, he is quoted as commenting that “(t)here has been a reluctance. Caseworkers feel like it’s taking away their skills and ability to make a decision. In some areas, it’s almost become a culture where that feeling is passed on to new workers” (p. 4). He also states that some practitioners also ‘manipulate’ the results of assessments so that ‘low priority’ families receive services rather than get screened out. In order to try to address the inconsistencies in the way that SDM has been applied, Forrest goes on to explain how they have
formed a task force made up of both proponents and opponents of SDM within the
department to examine the system.

In summary, there has been no independent evaluation of the SDM tools in any
jurisdiction. The evaluations conducted by researchers employed by the CRC
generally demonstrate that SDM achieves its promoted goals, particularly when
changes are made to make the tools more responsive to local conditions. Some of
these claims appear to be refuted by the commentaries described above and it
appears that some states have either limited or ceased their use of the SDM tools.
There has been no research that focussed on how practitioners use the SDM tools,
but the anecdotal evidence stated above suggests that its use is not straightforward
and can be problematic. In focussing on how practitioners in Queensland use the
SDM tools, this is the area of knowledge to which this research aims to make a
contribution.

Chapter summary

The first section of this Chapter provided an overview of the rationale provided by the
CRC for the development and use of the SDM tools and their integration into the
Department of Child Safety Practice Manual. It provides an account of the ‘official’
version of practice (Buckley, 2003), that is, how the SDM tools are supposed to be
used. This overview demonstrates how the use of technocratic ideology and the
appeal to instrumental reason (as discussed in previous Chapters) is justified within
a particular approach to conceptualising and dealing with child abuse and neglect.
This section concluded with the observation that the claims made for the
implementation of SDM converge closely with the problems with child protection
services in Queensland, and their solutions, identified by the CMC Report (2004). In
the second section, a review of the current published research about SDM revealed
that there has been no independent research about the SDM tools and none that
focuses on how practitioners might use them. Anecdotal accounts from some of the
jurisdictions where the SDM tools have been implemented suggest that use of the
tools is not straightforward. These accounts can be considered as starting to
articulate the ‘unofficial’ version of practice (Buckley, 2003) with regard to the use of the SDM tools. It is to this is the gap in existing knowledge that this research aims to make some contribution.

This research adopted an ethnomethodological perspective in order to focus on how Child Safety Officers use the SDM tools in their practice with children and families. A key point that arises from ethnomethodological studies of work and which is particularly pertinent to this Chapter is that the formal rules that are used to guide work practices are inadequate for describing what practitioners actually do in complex and problematic situations (Smith, 1991). Consequently, the Department of Child Safety Practice Manual can only be considered as one influence (to a greater or lesser extent) on the practice of Child Safety Officers, but it is significant in that formal rules and procedures are invoked by practitioners as rhetorical and accounting devices in dealing with others (Maynard & Clayman, 1991), particularly in child protection services (Hall, Slemrouck, & Sarangi, 2006). One of the main purposes of this Chapter has been to describe how the Practice Manual prescribes the use of the SDM tools in practice, as a set of formal rules, in order to establish a starting point for discovering what practitioners actually do – the ‘unofficial version’ (Buckley, 2003).

In the next Chapter, the ethnomethodological perspective and how it informed the design of this research is explained and the methods used to conduct it are described.
Chapter Four: Research Design – Methodology and Methods

Introduction - Research Design

In this Chapter, both the methodology, in terms of the theoretical approach to the research, and the methods used to conduct the research are described. This account of the design of the research has been guided by Blaikie’s (1993, p. 7) definition of methodology as being:

... an analysis of how research should proceed. ... It includes discussions of how theories are generated and tested – what kind of logic is used, what criteria they have to satisfy, what theories look like and how particular theoretical perspectives can be related to particular research problems.

In the first section of the Chapter, the theoretical approach to the research is described in detail. In the second section, the sources of data and methods for data collection, recording and analysis are described. This is followed by an analysis of the ethical challenges that were involved in conducting this research. The Chapter concludes with a consideration of some of the limitations of the research design and potential problems that conducting the research posed, particularly my own positioning in relation to the topic and those associated with conducting an ethnographical study.

Theoretical approach to the research

Theoretically, the approach to data collection and analysis was guided by ethnomethodological approaches to research, that “seek to treat practical activities, practical circumstances and practical sociological reasoning as topics of empirical study, and by paying to the most commonplace activities of daily life the attention usually accorded extraordinary events, seek to learn about them as phenomena in their own right” (Garfinkel, 1967).

As de Montigny (2007) explains, ethnomethodology, as an approach to thinking about social work practice, is useful because it encourages workers, and I would
argue, social work researchers, to explore what might be considered “disjunctures between their everyday experiences of practice and ideologically constructed worlds of professional knowledge” (p. 112). The focus of a study informed by an ethnomethodological approach in social work research is on what practitioners actually do, the “sequential production of what it is that practitioners of esoteric competencies distinctively and in detail do” (Katz, 2001), p. 333), rather than what they are assumed or supposed to do.

Ethnomethodological studies have shown how practitioners do not necessarily use the rules or abstractions that we assume they do when they decide how to act in problematic situations (Smith, 1991). As demonstrated in Chapter Two, previous research about decision making in child protection has shown how decision making processes are influenced by a range of factors, with formal procedures being only one of these. Further, it was proposed in Chapter Three that some research in child protection practice about the use of risk assessment has shown how tools and assessment frameworks are not necessarily used by practitioners in the ways intended by their designers. This disjuncture between what rules, procedures and practice tools prescribe as ‘good practice’ and what practitioners actually do is particularly pertinent to this research. As Maynard and Clayman (1991) argue, the formal rules and procedures that are designed to guide practice have been shown to be inadequate for capturing or describing the detailed work that is necessary in order to perform a work role competently. How practitioners use rules and procedures is important, though, as they are invoked as rhetorical and accounting devices in dealing with others and completing tasks (Maynard and Clayman, 1991). Noting the limitations of rules and procedures as descriptors of what practitioners actually do focuses attention on how, as Garfinkel (1986) explains, practitioners create and maintain a sense of social order to accomplish tasks, and on how they do this in interaction with others (de Montigny, 2007).

Recognising that there may be a disjuncture between what the formal procedures and rules prescribe as practice and what practitioners actually do is central to this research. This disjuncture has been identified by previous research that has sought to describe and analyse practice in child protection. A recent example is the research into the practices of social workers in the Republic of Ireland by Buckley (2003) in
which she proposes that there is the official version of practice, as prescribed by the procedures, and the unofficial version generated by the observations from her research. A key difference between the context for this research and Buckley's research, though, is that practice in the Republic of Ireland, particularly in the jurisdiction where the research was conducted, was directed and prescribed by far fewer procedures and rules as it is in Queensland. Another example is the research by Holland (1999) (mentioned in Chapter One) in which she identified that some practitioners using the “Orange Book” to conduct assessments of families found it insufficient in itself to complete their decision making, and they had to invoke ‘professional judgement’ in order to make the required recommendations.

Given that rules and procedures are inadequate for describing practice, their use requires that practitioners use tacit knowledge, which is additional to the formal rules. As Garfinkel (1967) proposes, the process of applying rules in any form of social action requires intuitive knowledge, or unstated conditions, which develops over time and in interaction with others. It is also a situated or ‘indexical’ phenomenon. These unstated conditions assist ‘actors’ in making sense of and applying the rules in any social action, or, as ten Have (2002) explains, in solving the problem of the gulf between the abstract and general on the one hand - the rules, in this case SDM - and the concrete and situational on the other - in this case the lives of children and families referred to the Department of Child Safety. Articulating these unstated conditions is the key to articulating the ‘unofficial’ version of practice. Miller (1997) refers to these unstated conditions as the interpretive methods and procedures that people use to make sense of their experience and constitute social realities. The focus of an ethnomethodological study then becomes identifying the methods and procedures that people use in a specific context.

However, the choice of methods and procedures that workers can draw from in any particular context is not exhaustive as certain methods and procedures may be privileged over others (Miller, 1997; Miller, Dingwall, & Murphy, 2004). In the context of this research, SDM can be considered as privileged as its use by practitioners is mandated by the Department of Child Safety. However, from an ethnomethodological perspective, SDM, as a set of rules and procedures designed to guide practice, is unlikely to be the only set used by practitioners and they may
invoke a range of other unstated conditions in their practice and decision-making. Also, given the abstract and general form of the SDM tools, they may also need to invoke unstated conditions to apply the tools to the ‘real world’ and specific situations of their clients.

In summary, an ethnomethodological perspective, in proposing that there may be a disjuncture between official and unofficial versions of practice and that practitioners use unstated conditions or additional, unofficial rules and procedures, provides a particular focus for this research. The question of how practitioners use SDM can be recast and expanded as:

1. What are the unstated conditions that practitioners invoke to use SDM in their practice with children and families?
2. What other unstated conditions, not associated with SDM, do practitioners invoke to use SDM in their practice with children and families?

The exploration of these questions in this research assisted with the broader aims of this research which were to address a gap in the literature about how child protection practitioners use tools in their practice and to contribute to debates about the future development of tools to enhance practice.

Focussing on what practitioners actually do and the unstated conditions they invoke when using the SDM tools required research methods that captured the experience and work of the Child Safety Officers, their team leaders and managers. The strategy adopted in this research resembles a particular strategy in ethnomethodological studies identified as “the one that most resembles traditional ethnographic fieldwork. . . [which] consists of closely observing situated activities in their natural settings and discussing them with the seasoned practitioners, in order to study the competences involved in the routine performance of these activities” (ten Have, 2002, p. 7). Consequently, the research design drew from ethnographic approaches to social research, both micro-ethnography, focussing on “the face-to-face interactions of members of the group or institution under investigation” (Berg, 2001), p. 136) and macro-ethnography which considers the context of these interactions. The overarching concern of both approaches is “assessing everyday community life
from the perspectives of the participants. . . (f)rom detailed examinations of people and their social discourse and the various outcomes of their actions, underlying principles and concepts can be identified” (Berg, 2001, p. 136).

Data was collected from three main sources: observation of what it is that Child Safety Officers do in their practice with children and families, interviews with staff to provide information about how they made sense of their practice using SDM and the case files created by staff. The rationale for choosing multiple sources of data extended beyond the need for triangulation and was drawn partly from the work of Argyris and Schon (1996), particularly their conceptualisation of ‘espoused theory’ and ‘theory-in-use’. Argyris and Schon argue that what practitioners say they do (‘espoused theory’) may be at variance with what they actually do (‘theory-in-use’) (see also Kellehear, 1993). Further, that ‘theory-in-use’ is implicit and can only be constructed by a researcher through observation of the interactions between individual members of an organisation. Garfinkel (1967) also proposes that the participants in any social action may not be consciously aware what unstated conditions they apply to make sense of any set of rules, except, perhaps, when they do not share the same set of unstated conditions or one participant breaches them. Hence data was collected about what Child Safety Officers do, what they say they do, and what they record they do. During data analysis, these three sources of data were continually juxtaposed and compared, in order to uncover the disjunctures between the official and unofficial versions of practice and develop theory about how practitioners use SDM. In the next section, the techniques used for data collection are described in more detail.

**Methods**

An overview of the methods used in this research is as follows:

- Analysis of documents pertaining to the context of child protection services in Queensland.
- Observation of the decision making activities of Child Safety Officers.
- Interviews with Child Safety Officers, Supervisors and Managers in six different Child Safety Service Centres in rural and metropolitan Queensland.
• Auditing of a selection of case files of children notified to the Department of Child Safety from the same Child Safety Service Centres.

Specific details of these methods are as follows and arranged into three sections: ‘sources of data’, ‘data collection and recording’, and ‘data analysis and interpretation’.

**Sources of data**

**Documents**

Government and Children’s Research Centre documents were analysed to explore the context (historical and current) for the research and development of child protection services in Queensland. As demonstrated in Chapter Two, these documents were an important source of data in terms of understanding how the Department of Child Safety represents itself and its future organisation, particularly as part of a broader ethnographic examination of work practices (in this case, the use of SDM) and professional cultures (Atkinson & Coffey, 2004). These texts were considered not as a true and accurate reflection of some aspect of the external world, but as representations of the world according to discursive rules and themes that predominated in the social and political contexts in which they were produced (Prior, 1997). They were also considered as ‘active’ in terms of their structuring effect on the accounts of or prescriptions for practice they offer (Watson, 1997). They included:


Sites
Child Safety Service Centres as the sites for the research were selected in consultation with senior managers at the Department of Child Safety. Sites were chosen both within the metropolitan area of Brisbane and outside in areas that might be considered rural rather than remote. The final choice of sites reflected the willingness of the staff of particular Child Safety Service Centres to allow access and their relative proximity to Brisbane, given that the research was only partially supported financially by the University of Melbourne. I spent ten working days at four of the sites, six working days at another and eight at another. The fieldwork was divided into three periods of up to a month each, with five weeks in between both the first and second period and the second and third.

During this time, I attended and observed team and office meetings and case consultation meetings. I also observed as many other activities as possible, such as, applications before the Children’s Court. One purpose of this was to orient myself to the organisational culture of the Department of Child Safety and the subcultures of the individual sites (D’Cruz, 2004). Other opportunities, beyond the specific sites, were also sought, such as contact with the Training Unit and attendance at the Department of Child Safety conference in November 2006.
Interviewees

Prior to visiting each site, I contacted the manager to remind them about my visit and ask them to distribute the Plain language Statement to staff in the Intake, Investigation and Assessment team (IA team) and the Intervention with Parental Consent Team (IPA team). At some of the sites, I was able to present an outline of the research at staff meetings and invite staff to be interviewed, at others, I was introduced to staff when I arrived and recruitment involved following up on the introductions. Participation in the interviews was voluntary and all potential participants were informed of the aims and procedures of the research by a Plain Language Statement. Verbal consent was sought at the beginning of each interview rather than written consent (see ethical considerations below). Sampling was purposive and opportunistic, with the main criterion being that the interviewees were active in the occupational roles mentioned above.

Case Files

At each of the six sites, files were selected for auditing. This approach to data collection is aligned to Epstein’s (2001) analogy of ‘data mining’ in which researchers use the clinical data that is already available in case files in social work settings. Epstein describes a process that involves ‘surveying’ the information that is available to find the ‘pay dirt’, and putting the ‘ore’ through stages of ‘refinement’. He also explains how such an approach, while time consuming, is unobtrusive and can yield unexpected information and raise questions for exploration with practitioners. But, while the files were considered ‘active’ texts in terms of their structuring effects on the activities of Child Safety Officers and clients of the Department (Watson, 1997), they were not considered as a transparent representation of organisational routines or decision making processes (Atkinson and Coffey, 1997). They were considered as a distinctively documentary version of reality, with particular conventions that guide their production and presentation (Atkinson & Coffey, 1997). As Garfinkel (1967a) cautions, the information contained in an agency’s files may be confined to the attempts of practitioners to portray their practice as being in accord with the prevailing rules of practice, part of which might be how practitioners use files to justify and plan further action (Prior, 2004). However, how the practitioners attempt to align their practice with the prevailing rules, was, in itself, pertinent to the task of
articulating practitioners’ unstated conditions of practice. Hall, Slembrouck and Sarangi (2006) add another process to how records are created in social work, whereby information about clients is not only ‘recorded’ but also ‘recoded’ to meet the requirements of agency schema. De Montigny (2007) describes this process of how the ordinary and everyday events of people’s lives are lifted out of context and reorganised according to organisational and professional matrices in case files as ‘indexicality’. A particular feature of this process in child protection is that the experiences of children have to be tested against and fitted into legal categories for defining abuse and neglect (Hall et al., 2006). In Queensland they also have to be recoded to fit with the schema, or matrix, contained in SDM. Child Safety Officers have to recode experiences and situations in terms of, for example, ‘immediate harm indicators’, ‘imminent threat of harm’ and ‘high risk’ (see Chapter Three). This is different from other forms of social work case files in which practitioners construct narratives in the form of case notes in that the imperative to categorise clients using the SDM is more explicit.

Another key factor for consideration in studying the SDM forms used in specific cases is that as case records, they go beyond what might normally be considered as a ‘passive’ version of events, constructed for an as yet unknown audience, and used possibly to justify social workers’ versions of events and their decisions and actions (Hall, Slembrouck, & Sarangi, 2006). The forms used at various decision making points actually prescribe what should happen in a case, for example, whether a case is accepted for investigation and, if so, when this investigation should occur, whether a child needs to be placed away from parents or whether further intervention needs to take place. Consequently the process of how the experiences of children are recoded (or categorised) to fit into the schema contained in the SDM forms becomes even more important.

The research focussed on cases that had been accepted for investigation just prior to, or during the time that I was at each site. The reason for this was that it allowed the observations of practice to be linked to the accounts of that same practice in the client files (Hammersley & Atkinson, 1995). It also provided opportunities to engage interviewees in discussion about real and current situations in their practice. At the Intake stage at each site, a number of files were selected that had not been
accepted as notifications for investigation but had been categorised as Child Concern Reports (CCR). During the first round of data collection, selecting files was facilitated by the Integrated Case Management System (ICMS), a recently introduced computer-based data management system. Having been granted a high level of access, I was able to generate lists of cases for each site that had recently been accepted for notifications or screened out as CCR’s. Unfortunately, this function ‘broke down’ and was not available at the last four sites and I was reliant on Team Leaders to provide me with lists. This was not problematic as they already kept lists of cases and outcomes (some in electronic form and some in paper form), which they were happy for me to have access to. One restriction was that, despite the emphasis within the Department on timely and thorough record keeping (explored further in Chapter Seven), case records and the SDM tools were frequently completed well after the action or decision about action had occurred. Also, all records had to be approved by the Team Leader and I was not able to access documents until they had been approved, which added further delay to being able to access them.

Data collection and recording

Interviews
The interviews were semi-structured and used open-ended questions to explore how interviewees use SDM in their practice and their reflections on its utility. Interviewees were asked to ground these reflections with reference to current case examples as much as possible. An interview schedule is included below. Data from the interviews was recorded by taking notes of the responses of the participants, taking care to capture their exact words. In order to ensure that I had captured the meaning of what participants were saying, I read back their statements from my notes and asked them to add or amend as appropriate. This approach to data recording, known as ‘member checking’ (Rubin & Babbie, 2005) was adopted in accordance with principles from ‘grounded theory’, concerned with the point that “(t)he central meanings attached to objects or relations should reflect the beliefs that the insiders hold about these” (Kellehear, 1993, p. 38). Further that “(v)alidity here begins with the convergence of the researcher and the subject’s ideas about the subject’s view
of the world” (op cit). The notes from interviews were typed up as soon as possible after the interview, mostly straight after and all on the same day. An alternative approach would have been to tape record the interviews and transcribe them, however, the approach for this research had the advantage that the meanings that I ascribed to the words of the interviewees were (at least initially) checked with them. While such validity could have been attained by getting participants to check, add to and amend transcripts once they had been typed up, I was concerned about maintaining the privacy of the participants (see later section on ethical considerations). While the participants were encouraged to contact me after the research if they wished to add or change anything, I undertook not to contact them again. I was also concerned that audio recording the interviews might also affect how candid CSOs might be in their comments about SDM, as they might be concerned about what could happen if the recordings fell into the wrong hands. Personal information was also collected about the interviewees, such as age, gender, experience in the welfare sector and professional qualifications.

Interview schedule

The interviews were conducted according to the following schedule:

First phase – introduction to the research, discussion about consent. Recording of personal details: age, gender, qualifications, experience in social work/welfare/child protection.

Second phase – open discussion re SDM – how are you finding using SDM? How do you use SDM in your practice with children and families?

Third phase – specific questions (if not previously covered in open discussion): At what points in a case do you find SDM most/least useful (provide examples)? What difficulties have you found in using SDM? What are the best/worst features of SDM? If you could tell the Department what you think of SDM (good and bad), what would you tell them? Specific questions about case examples.

Fourth phase – joint recording of statements in response to above questions and key points from Second Phase open discussion.
Fifth phase – ending the interview, invitation to contact researcher to add comments at a later date, reassurance that researcher will not contact participant.

In total, I interviewed 46 members of staff, including Managers, Senior Practitioners, Team Leaders and Child Safety Officers. Their ages ranged from 20 years to mid fifties, and their length of experience in child protection practice from a number of weeks to 30 years. Most had degrees in Human Services or Psychology and only 11 were qualified as professional social workers (see Chapter Five for further details about qualifications and experience). Most of the participants were female. Some participants has worked in other states of Australia and other countries such as the UK and USA. Many had worked in other CSSCs.

Recruitment of participants was not problematic as staff were generally keen to share their views about SDM and their practice more generally. Occasionally appointments to be interviewed were broken because staff were busy, but were re-arranged for a later time. In one Centre, a change of Team Leader and staff going on leave led to a lack of participants after the first week. Observing practice had also raised some issues for senior staff and so I made the decision to leave the centre early. It was also clear that the staff in the Centre were under considerable pressure and I considered that my continued presence may have added to that pressure.

Case file audits

As mentioned above, I undertook audits of recent and active cases. Cases were summarised, including information about the child, the family, the alleged abuse and the outcome of investigations and excerpts taken from files and copied to the field diary (and anonymised). Both narratively constructed casenotes and the SDM forms were examined. These summaries were also used to prompt discussions with Child Safety Officers and to get them to discuss real rather than hypothetical cases that they would also be familiar with. While a template for recording such information could have been developed, this would have involved developing and imposing ideas about what the researcher thought should be contained in the files. Such an exercise might, as Garfinkel (1967) warns, have resulted in an unfavourable assessment of the kinds of information contained in files, as compared to the
researcher’s ideas of what they should contain. The focus in this research was not on the potential shortcomings of the client files, but rather on the processes and unstated conditions by which they were produced, particularly with reference to the rules and procedures of SDM.

The SDM forms used at each stage of decision making in a case were particularly scrutinised. The focus of this scrutiny was on how the forms were used to direct decisions and actions and the extent to which it was apparent that they had done so. In Chapter Three it was mentioned that an audit of files in a particular jurisdiction in the USA which had implemented SDM that workers had not consistently filled in forms and/or had not filed them in correctly. While the Practice Manual is very prescriptive about when and how the SDM forms should be filled in, from an ethnomethodological perspective, it is inadequate for explaining or predicting what Child Safety Officers actually do. While I was careful not to impose my own expectations of what the files should contain, inevitably some assessment was made about whether the forms had been be filled in and acted upon as prescribed in the Practice Manual. This was particularly so when it was clear that there was a disjuncture between how the forms were actually used and how the Practice Manual prescribed they should. The focus then became on why there should be such a disjuncture.

In total, I audited 51 case files, some of which were only a CCR containing the list of concerns expressed by someone who had contacted the Department and perhaps a rationale as to why the case had been screened out. Some case files were very long in that they contained histories of previous Departmental involvement. Reading these histories was particularly important to understanding how subsequent decisions were made. As explained further in Chapter Eight, how the SDM tools were used to justify removing children immediately in case that had, only a few weeks before, been ‘screened out’ as a CCR, was particularly informative.

One limitation to the process of auditing files was that I was not able to access SDM forms and case summaries on active cases where these documents had not been electronically approved by the Team Leader. Team Leaders only tended to approve documents when they were required to do so, such as when the case was being
closed or transferred to another team. So, while I focussed on cases that were being dealt with at the time of the Fieldwork, it was previous involvements with the Department in the case files that provided more examples of how the SDM forms had been completed and actions justified.

Observation

The focus in observing Child Safety Officers in their daily practice was on how and to what extent they used SDM. An important aspect of this was the language they used to describe the cases they were working with as SDM contains particular key words and phrases (see Chapter Five). Observations were also made about the extent to which Child Safety Officers allowed their practice to be driven by the need to fill out the forms from SDM, in terms of what questions they asked, who they posed questions to and how they dealt with competing or even contradictory versions of events. Linking these observations to the files was also part of this process in terms of how the information they collected was 'recoded' into a form compatible with the schema of the SDM forms.

In all of the sites, I was able to observe COSs conducting interviews with parents and children. The limitation was that almost all investigations were conducted by two COSs, and many of them with police (some of whom also seemed to prefer working in pairs), so already there might be three of four 'officials' involved in an interview. Having a researcher as well as four professionals was clearly one person too many. On one occasion, I chose to withdraw from an interview with a mother who required an interpreter as I assessed that my presence might add to her confusion and distress.

A particular problem with observation as a method of data collection is that, on its own, it is limited to observable phenomena and cannot provide insights into how participants feel or what they are thinking. As Darlington and Scott (2002) comment, “[o]bservation alone cannot tell us why people do the things they do or what the particular activity means to them. . .” (p. 75). The interviews did help to clarify some of my observations, but I also found that participants were keen to discuss and reflect on the situations they had allowed me to observe. Most of the interviews with
children and parents that I observed involved travelling some distance by car. During these journeys, practitioners were keen to discuss their practice with me.

All data collected during the three periods of fieldwork, through observation, interviews and file auditing were recorded in Field Diaries. A separate Field Diary was created for each period of fieldwork and, in total, they comprise 74,101 words. Towards the end of the third period of fieldwork, my impression was that data saturation was being achieved, in that continuing analysis of previous Fieldwork Diaries while still collecting data, revealed that data collection was no longer providing new insights. The relative sizes of each of the three diaries also reflect the process of data saturation (36,662, 19,281 and 18,158 words respectively).

Following the advice of Hammersley and Atkinson (1995), entries were made in each of diaries as soon as possible after the observation had been made and aimed to capture, as far as possible, the actual words and phrases that Department of Child Safety staff used to describe their experience of using SDM. As discussed above, the interviews were recorded by taking notes that were then typed up into the Field Diary. The statements made by participants were recorded in the third rather than first person and this is reflected in their presentation as quotes in subsequent Chapters of this thesis.

**Data analysis/interpretation**

In order to identify the unstated conditions of using SDM in practice, the three sources of data (observation, file audit and interviews) were compared with each other. One aim of the analysis was to identify the differences between what Child Safety Officers appeared to do (through observation), what they reported they did (in the case files) and what they said they did (in interviews). Drawing from a ‘grounded theory’ approach (Strauss & Corbin, 1990), these three sources of data were analysed to identify themes as data collection proceeded and these themes were used to focus and guide further data collection (theoretical sampling). As themes were identified, they were compared with new data and refined and expanded, or even discarded.
As mentioned above, the aim of collecting data at Child Safety Service Centres from three sources was not to use ‘triangulation’ as a way of achieving ‘rigor’ (Rubin and Babbie, 2005). It was not expected that there would be consistency between the different sources of data or that they should corroborate, support or refute each other. Each source of data was considered as a different perspective on the same phenomena and it was the disjunctures between these perspectives that were of particular interest. Reflecting on these disjunctures was an important part of the process of building theory about the unstated conditions of using SDM.

However, as the research proceeded, it became clear that it was in some of the interviews with Child Safety Officers, in their candid accounts of how and to what extent they used the SDM tools, that fragments of the unstated conditions of their use were initially verbalised. This was particularly so in the accounts of how they reinterpreted the daily lives of children and families into language that met the requirements of the SDM forms (the process of ‘recoding’ or indexicality referred to above). It was these accounts, which might, in some cases, be considered to be the ‘unofficial version’ of practice, that led me to observe and note certain actions and conversations more attentively, and lent more focus to the case file audit. As described further in Chapters Six and Seven, collecting these accounts by asking participants to reflect on their practice was also the process by which, in an ethnomethodological sense, the unstated conditions of SDM use became ‘stated conditions’.

As mentioned above, data analysis was an ongoing process as data were collected and this was a conscious attempt to identify and pursue themes as they emerged in the data collection process. During the fieldwork periods, at quiet times and during the evenings, I read through the Field Diaries and recorded my reflections and impressions. Significantly, though, much of this reflective process led to questions being raised rather than themes being identified. These questions, or rather the pursuit of their possible answers, guided the research as data collection proceeded.

In between field trips, the Field Diaries were loaded into NVivo 7 and this was used to code the data from the interviews into various categories (known as nodes in
NVivo 7). In keeping with a grounded theory approach, categories were allowed to emerge from the data and they were created as I read through the data. Some of the data was coded into more than one category. After finishing the first Field Diary, the various categories were explored. Some were combined with others as, on reflection, they were variations on a theme. Conversely some were expanded and coded again as I found that they contained more than one theme. Through this process of identifying themes and coding the data, further questions and directions for enquiry emerged. A particular example of this was the realisation, after the first round of data collection, that the knowledge and values of the workers making the decisions was an important determinant in how the tools were used. This led me to investigate this further during the second and third rounds of data collection. After the second and third rounds of data collection, the diaries were again coded using NVivo 7 but each time a ‘new project’ was created so that pre-existing categories could not be used. Consequently new categories had to be created and were compared to previous categories after the process had been completed.

While in Queensland, I was not able to use NVivo 7 as it required more RAM than was available on my laptop. However, I was able to save the categories created within NVivo 7 as Word documents so that I could reflect on previous data collection rounds.

After data collection had been completed, the coded data from the three projects was analysed in accordance with principles drawn from qualitative research, whereby the researcher aims to identify patterns and contradictions in the data and interpret subjective meanings generated by the participants (Everitt, Hardiker, Littlewood & Mullender, 1992; Strauss & Corbin, 1990). Data from the three rounds of collection were compared and combined which led to the creation of new categories, the expansion of others and a refinement of the naming of categories.

Writing the Chapters that present and analyse the interview data was also another stage in the analysis of the data as new themes emerged during the process of
constructing the chapters. Subthemes in the data emerged as statements made by participants were again scrutinised and quotes from the Field Diaries were arranged within the text. As mentioned in Chapter Six, the process of using quotes taken from interviews and notes in the Field Diary (and of coding the Field Diaries) risked misconstruing the meaning of the words used by participants by decontextualising them. A particular example of this was that many participants made positive comments about the SDM tools at the beginning of their interviews that they later went on to contradict. In order to reduce this risk, I located the quotes in the Field Diary to check that I was not misconstruing their meaning in the context of the interview. An example of this contradiction was as follows:

SDM is a step toward consistency and that is great. It provides really good guidance to people who are new to the Department and child protection, particularly about what constitutes risk.

Different offices tend to use the tools differently.

Hardly ever get a 5 day response – either 24hr or 10 days.

Sometimes hard to fit children’s lives into the tools and defns. (Interview 28)

The reason why participants tended to contradict themselves lies in the process of the interview. Participants may have been more reserved about their opinions about the SDM tools and descriptions of how they used them at the beginning of interviews, but as the interview proceeded and they relaxed, they became more direct.

Case file data were also analysed as excerpts from the files were collected and added to the Field Diaries. Notes were made in the Field Diaries about what particular excerpts might demonstrate about the use of the SDM tools and the process of decision making about cases. After data collection had been completed, the case file data were separated from the interview data to be analysed. NVivo 7
was not used to analyse the case file data. The data were analysed by reading the case file excerpts and my notes from the Field Diaries over and over to identify what they could contribute in answering the key question of how the SDM tools were being used. Again, writing Chapter Eight, which focuses on the case files, was another level of analysis, during which new themes were identified and existing ones refined.

**Review of data analysis**

Each stage of the data analysis process was discussed extensively with my supervisor and parts of the Field Diaries were reviewed. Opportunities for peer review by, for example, asking another student or member of the academic staff to code a sample of data were discussed. This was not considered to be appropriate because of the ethnographical nature of the research. As discussed further in the next Chapter, the processes of analysing and interpreting the data were grounded in my observations and experience of the context for child protection practice in the Department.

**Ethical Considerations**

Permission from the Department of Child Safety to conduct the research ‘in principle’ was sought during the second half of 2006 and granted as the research was considered to be aligned to the research agenda of the Department (Ethics ID: 0608060, see Appendix 4). Clearance to conduct the research was granted by University of Melbourne Behavioural and Social Sciences Human Ethics Sub-Committee in December 2006. Following this Full permission from the Department to conduct the research was granted in March 2007. In the following subsections the particular ethical challenges of this research are explored, with reference to the principles for social work research contained in the AASW Code of Ethics (2002).
Informed Consent and Voluntary Participation
The AASW Code of Ethics (2002, p. 20) states:

Section 4.5.2. In addition to the general provisions of the Code, social workers engaged in research will undertake specific ethical responsibilities.

g) Ensure that informed consent to participation has been obtained from either the potential participants or their representatives. In addition, children and others whose ability to provide consent is compromised for any reason, should be offered the opportunity to express their assent or objection to research procedures and their views should be given due regard.

h) Consent must be given voluntarily, without coercion or inferred disadvantage for refusal to co-operate. Participants should be informed that they may withdraw from a programme at any time, taking into account stated conditions of entry and closure, and without compromising any treatment being received from a service.

Participation by the staff of the Department of Child Safety in the research was required in two different ways, for the periods of observation and individual interviews. For the purpose of observation, it was made clear to the staff at each site, as soon as possible after arrival that I wanted to observe as much of their day-to-day practice activity as possible, but also that this observation would not occur without their consent. This was explained at staff meetings and by the distribution of a Plain Language Statement. The Plain Language Statement also explained how staff at the various sites could become involved in the research through interviews. Again it was made clear that participation was voluntary. Verbal rather than written consent was sought as there were particular concerns about anonymity and confidentiality (see below).

A potential problem with the voluntary nature of participation in the research was the coercion of participants by their employer to take part in the research. Clearly, in order to gain access to the Child Safety Service Centres, the permission of the Department of Child Safety had to be sought and I was dependent on a member of the Department’s research branch to approach the chosen centres to request and arrange access. Whether coercion through administrative/ hierarchical power was exercised in these approaches to ‘direct’ that particular offices participate in the
research can only be speculated upon and was certainly beyond my control. Similarly within the sites, and despite my efforts as mentioned above, there may have been expectations placed upon staff that they would (or would not) co-operate with me.

A particular dilemma is alluded to in the literature (for example, Rubin and Babbie, 2005) about observation as a method for data collection, which arises when a participant, in the course of a conversation with the researcher, makes a statement that is particularly pertinent to the research. Such a statement may even be made outside the time of the observation, such as after work hours in a social setting. The researcher may want to record this statement and ask the participant to elaborate on the point that has been made. The dilemma concerns whether it would be ethical for the researcher to use such a statement as data, given that it was made outside the parameters of the research setting (that is, observation or interview). It is encapsulated in the AASW Code of Ethics (2002) as ensuring that participants are aware that information they give to the researcher will only be used for purposes that they are aware of. During this research, when this dilemma arose, I asked the (potential) participant whether the observation or statement they had made could be recorded and used for the purposes of the research. In all cases, consent to do this was given by the participant. In some informal discussions, some staff offered opinions about the Department and SDM which they insisted be included in the research.

Anonymity and Confidentiality
The AASW Code of Ethics (2002, p. 20) states:

Section 4.5.2. In addition to the general provisions of the Code, social workers engaged in research will undertake specific ethical responsibilities.

f) Ascertain that due care has been taken to protect the privacy and dignity of research participants.

j) Seek to ensure the anonymity and/or confidentiality of research participants and data and will discuss them only in limited circumstances for professional purposes. Any identifying information obtained from or about the research participants during the research process will be treated as confidential.
A particular concern in this research was protecting the confidentiality and anonymity of the observed participants and interview participants. This was important as I wanted to be able to provide participants with the opportunity to be candid, but, given that they were mandated to use the SDM tools by their employer, their contributions had to be anonymous, lest their honesty invite disciplinary measures against them. Hence names of participants were not recorded. Personal information about the participants in the interviews was recorded as I was interested in whether certain factors, for example, professional qualifications and experience, affected how Child Safety Officers used SDM in their practice. While there were some inferences to be drawn from comparing personal characteristics, these were only tentative given the limitations of using only a small sample. The smallness of the sample also made it very difficult to disguise individuals when relating findings to personal characteristics.

A challenge to anonymity and confidentiality that was beyond my control was that people talk. Most of the staff were keen to know what other offices were doing and were sometimes surprised that I would not disclose to them which offices I would be visiting. However, most understood the need for confidentiality and anonymity when it had been explained to them. Mobility between CSSCs was quite high and while I did not encounter any Departmental officer at more than one site, some participants mentioned that they had worked at other CSSCs that I had visited, the inference I took was that they knew that I had visited that particular centre.

Because of the compromises to my ability to keep the identity of the centres visited confidential, I have chosen not to develop profiles of each office and then develop comparisons, lest they be identified by senior staff and the comparisons used to direct criticism to particular centres. I discussed this decision with senior staff in more than one centre and they were relieved that I would not be, however anonymously, developing CSSC profiles. This was particularly important for one CSSC, at which staff said they liked to do things ‘a bit differently’ to how Head Office might want them done and for another where the opinion was that the CSSC already had to put up
with enough pressure from senior management at Zonal level, particularly about compliance with using the SDM tools.

Anonymity and confidentiality were also important considerations with regard to the clients of the Department of Child Safety, both in terms of the file auditing and the observations of practice. In order to be able to gain access to the sites and client files, I had to become an Honourary Child Safety Officer and so was bound by the Code of Ethics for Public Servants in Queensland in relation to the use and privacy of client information.

The Potential for Harm
The AASW Code of Ethics (2002, p. 20) states:

Section 4.5.2. In addition to the general provisions of the Code, social workers engaged in research will undertake specific ethical responsibilities.

c) Place the interests of research participants above the social worker’s personal interests or the interests of the research project.

i) Strive to protect research participants from unwarranted physical, mental or emotional discomfort, distress, harm, danger or deprivation.

While anonymity and confidentiality were important issues to be considered to prevent harm to the participants in this research, there were other concerns. One was the appropriateness of me observing particular parts of practice, for example, a sensitive interview with a victim of abuse. I was concerned that my presence did not inhibit or otherwise adversely affect Child Safety Officers in carrying out their work. Consequently I explained that, if there were parts of their practice that they did not consider it was appropriate for me to observe, particularly for reasons relating to clients, then the staff only had to inform me that observation was not appropriate. No explanation for the decision would be sought by me.

Another issue was raised by the University of Melbourne Behavioural and Social Sciences Human Ethics Sub-Committee and related to what I would do if I observed ‘bad’ practice which would lead to a child being harmed or at placed at greater risk of being harmed. While I wanted to remain an observer, rather than participant, my
response was that I would intervene in such a circumstance, either at the time, if required, or later by discussing the situation with the Child Safety Officer and/or their manager.

It was sometimes very difficult to be a passive observer when I did go on visits to families with COSs. On one occasion, I was invited to attend as ‘second worker’ and take the notes, which I declined to do. Because participants were aware of my experience in child protection practice, I was asked for my opinion about the cases that I observed. I was also invited to observe ‘case consults’ with Team Leaders and Senior Practitioners and asked to provide an opinion.

There was only one occasion when I stepped outside the role of observer to remedy what might have led to ‘bad practice’ and went beyond providing advice. On one particular visit I had to intervene in two ways; firstly to calm a distraught mother who was reacting to being accused of punching her newborn baby. The COSs and police appeared to be making the situation worse by arguing that it was their job to put these allegations to her. Secondly, they made no attempt to check that the baby was uninjured, other than to glance at her. Having calmed the mother down, I was able to persuade her to let me hold the baby (and to confirm that there was no sign of injury to her face and most of the rest of her body).

Limitations of the Research Design

While the limitations of this research will be discussed more fully in the final Chapter, in this section the potential problems and limitations of the research design are reflected upon, with reference to the pertinent themes within the literature about qualitative research, particularly ethnographic research involving fieldwork. The potential problems and limitations mentioned in this section were carefully considered at the time of preparing to conduct the fieldwork in Queensland.

Subjectivity, the positioning of the researcher and researcher bias

D’Cruz and Jones (2004) draw, in particular, from the work of Riessman (1994) to emphasise the importance of acknowledging the ‘positioning’ or subjectivity of the researcher in relation to their chosen research. Rather than considering that
subjectivity is a problem, D’Cruz and Jones take the position that the subjectivity of
the researcher needs to be acknowledged because it provides a rationale not only
for the way that the research may be conducted but also the area for research and
the framing of the research question. The subjectivity of the researcher is also a
crucial consideration in a qualitative research design, particularly when data
collection consists, in most part, of the researcher’s observations in the field and
interpretations of case files (Morris, 2006). The researcher is, as Padgett (2004)
argues, the “instrument of discovery” (p. 276).

In the introduction to the thesis, I described my practice experience in social work
and child protection in particular and explained how I came to be interested in
researching how SDM is used by practitioners in Queensland. In this section, I will
focus on what effects my previous experience and practice interests might have had
on the research design and on how the process of preparing to do the research also
changed my positioning.

Initially, I was sceptical about the efficacy of implementing SDM in Queensland.
Having witnessed the introduction and continued use of the Victorian Risk
Framework in child protection practice in Victoria from 1999 onwards, my opinion of
such frameworks was quite critical, at both a theoretical (see Gillingham, 2006) and
practical level. I have witnessed how the Victorian Risk Framework was used in
various and partial ways by practitioners but also how it contributed to sometimes
meaningless, sometimes harmful categorisation (Hall et al., 2006) of children and
families. I also became concerned that its use seemed to change the nature of the
relationship between practitioners and families (Parton, 1998), though there were
other factors which contributed to this trend. My engagement with literature and
research about decision making and risk assessment perhaps also served to
reinforce a negative attitude toward the use of prescriptive frameworks in social work
practice, particularly since so much of the critique resonated with my own
experience. At the same time, though, I was also developing an understanding of the
purpose of critique, as a way of contributing to change.
At the time of designing the research and preparing to undertake the fieldwork, my positioning was also affected by the view of Professor Eileen Munro of the London School of Economics in a personal communication that what we need to develop are tools to assist decision making that enhance the abilities and skills of workers, rather than hinder them. This observation linked to my growing awareness of the ability of research to contribute to positive change and to the realisation that understanding how practitioners use SDM in their practice might assist in developing ways that it can be used to enhance practice. That is, research focussing on how practitioners use the SDM tools might show creative, rather than just restrictive, ways that the tools can be used. And so, my orientation toward the implementation of SDM had moved on from a critical stance that might predispose me to notice only the negative uses of SDM to a more optimistic view that might predispose me to seek out the positive uses too. The possibility that finding out how SDM is actually used by practitioners might contribute to positive change was also enhanced by a deepening understanding of ethnomethodological approaches to research.

In summary, my positioning in relation to the research, at the time of entering the field was not dispassionate, nor could I claim to be objective or, in an ethnomethodological sense, ‘disinterested’. My positioning was, however, more balanced in that my disposition toward SDM was not entirely negative; it was critical but also optimistic. From this position, I was more able to ‘notice’ rather than just ‘see’ (Hall et al., 2006) the various, from positive to negative, ways that Child Safety Officers used SDM. This process is explained further in the introduction to the next Chapter.

The purpose of reflecting on my positioning in relation to the research was that it increased awareness of the possibility of ‘researcher bias’. A specific strategy to maintain this awareness during the process of conducting research at any stage suggested in the literature is the use of reflexivity (D’Cruz & Jones, 2004; (Marlow, 2005; Riessman, 1994). Reflexivity in the practice of social research has been proposed as a way of articulating, and therefore acknowledging and scrutinising, the tacit knowledge of the researcher (Rodwell, 1998). The reflexive researcher is
aware of the assumptions that underlie how they make sense of practice situations (Shepherd, 1998) and in making these assumptions explicit seeks to reduce the effects of bias. Further strategies, particularly ‘negative case analysis’ can also serve to reduce researcher bias and are discussed further in the next section.

Becoming a ‘member’ and ethnomethodological indifference

Both the positioning and potential bias of the researcher, as factors that affect the process of conducting research, are represented in ethnomethodology by the concepts of ‘membership’ and ethnomethodological indifference. Gaining ‘membership’ and access to ‘membership knowledge’ is the process by which a researcher becomes positioned within the research context and learns the knowledge specific to tasks being carried out. It is the process of learning the “competencies involved in being a bone fide member of a collectivity” (ten Have, 2002, p. 6) and includes insight into both the implicit and explicit rules that guide action.

Ethnomethodological indifference, at a general level, refers to early aims of ethnomethodology made by Garfinkel (1967) that one of its distinctions as a discipline should be that it should be indifferent to the aims of other disciplines, particularly in terms of studying everyday activities in order to provide correctives or suggestions for improvements. At the individual level of the researcher, it refers to the process of suspending judgement about the outcomes of activities, in order to concentrate on the process of how they are conducted (de Montigny, 2002). A further development of this process is ‘interpretive practice’ (Holstein and Gubrium, 2005) which aims to develop a fuller account of activities. ‘Interpretive practice’ requires a researcher to shift the focus of their attention between the ‘what’ (the outcomes of a particular activity) and the ‘how’ (the process by which the activity is carried out). How these concepts were applied in the process of this research is described in more detail in the introduction to Chapter Five.
Entering the field - reactivity

Bryman (1988) defines ‘reactivity’ as the “reaction on the part of those being investigated to the investigator and his or her instruments” (p. 17) and as a phenomenon that can be a problem that besets both quantitative and qualitative research. Participants in any research may be influenced in their behaviour or opinions by what they perceive to be the underlying aims of the research. They may also react to the personal characteristics of the researcher, such as age, race or gender. In this research, the participants may have also reacted to my status as an experienced practitioner. Bryman (1988) comments that this phenomenon is generally played down by ethnographers by suggesting that developing familiarity with the participants militates against reactivity. Clearly this phenomenon is linked to the personal biases outlined in the previous section in terms of how the research is presented to the participants. A particular example given by Bryman (1998), which was pertinent to this research, is when the researcher is perceived by the participants to have a particular inclination toward the research topic, which tends to attract people in the organisation who have a similar inclination. Consequently a distorted picture emerges in the research.

Padgett (1998) suggests six strategies for overcoming reactivity, which are also relevant to researcher bias, three of which appeared to be most suitable for this research. ‘Negative case analysis’ involves a conscious effort by the researcher to seek disconfirming or contrary evidence to what appear to be the emerging themes in the data. There was the danger in this research that I would attract participants who were in some way disgruntled about the implementation of SDM and sought to have their view heard. ‘Negative case analysis’ therefore involved seeking out participants (particularly for interviews) who had more positive views about using SDM in their practice. ‘Auditing’ is another strategy and involves keeping careful notes and recording the decisions made by the researcher as the process of research proceeded. This also assisted with the process of reflexivity mentioned in the previous section, as does the third strategy suggested by Padgett (1998), ‘peer debriefing’. This involves discussing how the research is progressing with a third party, in this case I benefited from contact with the PhD supervisor during and between periods of data collection.
On reflection, I did attract participants who felt strongly, both positively and negatively, about the SDM tools. Some participants were also keen to ‘debrief’ about their work and their working conditions and considered the interview as a form of catharsis. Others, though, were genuinely interested in demonstrating how they used the tools, particularly newer COSs who were still learning how to use them. I also sought out COSs who did not offer themselves for interview, a usual response being that they had nothing to say about the tools, except that by the time of the interview after they had had an opportunity to reflect, they did have something to say about the SDM tools.

Chapter summary
This Chapter has described the theoretical approach to the research and the methods used to collect and analyse data. It has also drawn from the literature to reflect on the ethical challenges and the potential problems and limitations of the research design that were pertinent at the time of preparing to conduct the fieldwork. The next Chapter contextualises the use of the SDM tools by presenting the ‘insider view’ of practice within the Department of Child Safety, based on my observations and interviews with participants.
Chapter Five: ‘Insider views’ of the Department of Child Safety

Introduction

In Chapter Two the policy context for practice within the Department of Child Safety was described and explored to provide what amounts to an ‘outsider view’. This Chapter provides an overview of practice from within the Department of Child Safety, from the Child Safety Service Centres (CSSCs) visited by the researcher (the ‘insider view’). This insider view is sourced from the notes taken during the interviews with COSs, Team Leaders, Senior Practitioners and Managers and the observations recorded at the time by the researcher in the field diary. As mentioned in Chapter Four, the quotes are taken from notes about observations and interviews rather than transcripts of recorded interviews, and are presented in the third rather than first person. In particular the disjunctures between the ‘insider view’ and the practice and policy documents, such as The Practice Manual are explored. The account is presented in four general sections that reflect the four main themes identified in the data: entering the Department of Child Safety; the staff of the Department; influences on practice and child rescue and family support. Each section is divided into subsections which focus on sub-themes in the data. The aim in this Chapter is to present the themes as they occurred in the data, as contextual or background data to the focus of the research. The context for practice in the Department was not the focus of the research and some of the themes presented in this Chapter raise questions that require more research to answer fully. Some of these themes are explored further in later Chapters, particularly as they relate to the use of the SDM tools. Before proceeding with this account there are two sections which discuss, firstly, how the account is presented, and secondly, methodological issues concerning how it was generated.

The importance of context

Ethnomethodological studies generally focus on, as described in Chapter Four, the practical means by which members create a sense of order in their activities and have de-emphasised the factors within contexts that affect these practical activities (Maynard, 1989, cited in Holstein & Gubrium, 2005). Hall et al. (2006), for example,
argue that their aim is to “direct attention to observing some of the ways in which professional practice actually takes place”, rather than the context for practice (though they concede that this might be important for other studies). Citing Maynard (1989), Holstein and Gubrium (2005) argue that an approach to research that investigates both the context (in terms of how participants see things) and how participants do things is potentially more informative than an approach that focuses on one or the other. The implication for this research is that understanding the context for practice, as seen through my eyes as an observer and the eyes of the participants is important to understanding how Departmental staff use SDM in their daily work. In this thesis I have chosen to present the context for practice before the describing how the SDM tools are used.

Membership knowledge and ethnomethodological indifference

Before describing my ‘insider view’, I will reflect on how I interpreted and made sense of my observations in order to make more explicit the unstated conditions of this process. In ethnomethodological terms, this is the process of gaining ‘membership knowledge’, or of learning the “competencies involved in being a bone fide member of a collectivity” (ten Have, 2002, p. 6). Competency, in this sense, goes beyond the skills required to be a Child Safety Officer (CSO), and is concerned with the unspoken rules about being a CSO in terms of what they do, how they do it and why. Part of this process is the identification of the ‘ideologies’, as defined in Chapter One, that were operating in the minds of practitioners (Parton, 1997). It was also important to identify my own ideology about child protection practice, or my own ‘positioning’ in relation to the research (Riessman, 1994).

Acknowledging my own ideology about child protection was essential to the process of understanding and making sense of the practice I was observing in the Department. The ideology of child protection that I observed in the department, as explained below, was, at times, very different, and in some ways, oppositional to my own ideology. As a professional social worker for the last twenty years, I strongly believe that good child protection practice should be good social work practice. That
is, practice should be consistent with the ethics and values of professional social work and informed by social work theory and research. Further, that it should be located in a ‘family support’ rather than ’child rescue’ paradigm. Every effort should be made to support and enable parents to care for their children and removal to alternative care should be a last resort. My own positioning acted simultaneously as a temporary impediment and benefit to the data collection process.

Initially, my beliefs about child protection practice predisposed me to be critical of some of the practice I was observing, but as the fieldwork progressed, I realised that making such judgements was hindering my ability to gain ‘membership knowledge’. Holstein and Gubrium (2005) propose an approach to research (‘interpretive practice’) that requires a researcher to shift the focus of their attention between the ‘what’ (in this case the achievement of child protection practice) and the ‘how’ (the process by which practice is achieved). During the early stages of data collection, my focus was on the ‘what’ of child protection practice in Queensland and in order to be able to shift to the ‘how’, I had to develop ethnomethodological ‘indifference’. However, this indifference to the end products of what I was observing was only temporary, as I became more adept at shifting my attention between the ‘what’ and the ‘how’.

Having a different ideology of child protection to that which I observed in the Department was also useful and even essential to the process of identifying forms of ideology as they manifested in the daily activities of the CSSCs I visited. In ethnomethodological terms, it was essential to the process of perceiving the ordinary and everyday activities of COSs as different, as something that is achieved rather than just happens (Garfinkel, 1986). It is similar to the strategy recommended by Schwartz and Jacobs (1979, cited in ten Have, 2002) of the researcher being ‘The Novice’ or ‘The Stranger’ where “one is instructed by a setting’s members to see the world in a way that is natural for them but not for oneself” (ten Have, 2002, p. 7). It also assisted me to deal with what Hall et al. (2006) describe as the dilemma faced by ethnomethodologists who need to identify closely with the world of practitioners in order to analyse their activities, but who, at the same time need to refrain from
making the kind of judgements that world demands. In short, this might amount to accepting and internalising organisational norms, or ‘going native’ in anthropological terms.

A Biased Account?

Some of the views presented in this and subsequent Chapters present negative and critical views about the Department. The thesis might be open to criticism that it is biased and that the researcher set out to find evidence with which to criticise the Department. This was not the case. I actively sought to speak with as many staff as possible and encouraged those who did not appear to be interested to speak with me. More generally I also looked for positives about the Department and its practices and found them. As described in Chapter Four, it was not difficult to find participants to interview as staff were keen to share their views about the Department and SDM. Participants were also very honest and open during the interviews and many thanked me for the opportunity to discuss and reflect on their practice. Many of the interviews took on a cathartic purpose as participants were keen to vent their frustrations with the Department and SDM.

Some of the more critical points about the department raised by my observations and statements by the participants clearly contradict some of the intended aims of the Department as expressed in policy documents. For example, the Department has clear policies about the training of COSs, but many participants talked about a lack of training, particularly about not being able to access the training that was being offered. The discovery in this research of disjunctions between policy and practice should not be construed as unnecessary or biased reporting, but rather as an opportunity to consider why some policies are not achieving their aims.

As a researcher rather than an employee of the Department, I am not concerned with trying to present a ‘balanced’ view, rather with presenting, as honestly and accurately as possible, what I actually found, particularly in terms of the views and
opinions of the participants in this research. As Smith (1991) notes: “No one story overrides; no story is suppressed (though not all stories will be told, and those that are, not all can be cited); it is finding their articulations and assembling them that is the work of analysis” (p. 143). The aim of providing an honest and accurate account is also congruent with the aim of uncovering the ‘unofficial’ version of practice or organisational life (Buckley, 2003).

**Entering the Department of Child Safety and becoming a ‘member’**

**Entering a Child Safety Service Centre**

Every CSSC I visited was very well appointed in terms of the physical conditions: each CSSC had clearly been recently refurbished to the same pattern. Each also had extensive security to protect COSs and reception staff, which included electronic swipe guards, glass partitions between the reception staff and waiting area, high desks between workers and clients in interview rooms and, in some CSSCs, closed circuit television monitoring of all areas. In every waiting area there was also a poster which advised clients that staff of the Department would not tolerate any form of threat made to them, with the slogan ‘expect respect: we do’. Under the slogan, the wording of the poster was:

> The Department of Child Safety does not tolerate the use of abusive language, violence, threats, intimidation or other unacceptable behaviour. Certain actions will be reported to the police.

Inside the CSSCs, each CSO had a desk in a ‘pod’, perhaps sharing with three other staff, separated from the next ‘pod’ by a chest high partition. Team Leaders, Senior Practitioners and Managers occupied their own offices. Each CSSC also had a large lunch room with fridges, a microwave, and dishwasher. One CSSC even had a full stove, with grill and oven, at which some staff cooked their lunch. Clearly much money had been spent by the Department on the physical environment inhabited by their staff in order to keep them comfortable and protected. In some CSSCs staff
also wore blouses that had been embroidered with the Department of Child Safety Logo. These blouses came in a range of colours and striped patterns. I asked a member of staff about these blouses and it was explained to me that employees can buy, very cheaply, uniforms which consist of pants and a blouse. There was no compulsion to purchase the uniforms and, as far as this participant knew, the offer had mainly been taken up by administrative staff. However, I met frontline staff and Team Leaders who were wearing the uniform.

Language practices

Becoming a ‘member’ of the Department required that I learn a new language as the terminology used by staff which was different to other jurisdictions with which I was more familiar. I had been familiar with in other jurisdictions. As data collection proceeded, I became increasingly aware of how the particular use of language affected and represented the approach taken to practice. This observation was informed by research that demonstrates how child protection practice is socially constructed and that language is an integral part of this process (for example D’Cruz, 2004; Hall et al., 2006). The most obvious example was the name of the Department and the consequent use of the concept of ‘child safety’ (as mentioned in Chapter One). As one CSO explained to a child in an interview that I observed “our role is to make sure that kids are safe” (quote from observation of interview with a child). Within the SDM literature (see CRC, 1999), safety is defined as an immediate or short term condition. Safety is not about whether a child will be protected from harm in the future. In short, the focus for practice and the decisions about whether, and even how, to intervene is on what is happening now rather than what might happen in the future. As reflected in some of the statements made by participants (see below), this can result in a narrow focus for practice, one that is not concerned with the more diffused and longer term notion of child welfare or family support.

Team structures and organising work

As mentioned in Chapter Two, the CRC strongly recommended that the various functions of intake, investigation and work with families be separated within CSSCs.
Different CSSCs in this research clearly took the recommendation to mean different things as the ways that teams were organised differed from one CSSC to another. For example, in one CSSC, members of the Intake Team were supervised by the same Team Leader as the Intervention with Parental Agreement Team, with the Investigation and Assessment Team being supervised by another Team Leader. In other CSSCs, the same Team Leader supervised workers from each of the three functions and still in another, the Intervention with Parental Agreement Team was supervised by a separate Team Leader. The effects of organising teams according to specific functions was commented on by one interviewee who felt that workers in the separate teams did not know, or seem to care, what was going on in other teams. Neither were they in touch with the consequences of the decisions they had made about, for example, separating children from families and communities. However, I also observed in one CSSC that workers tended to ‘swap around’ and cover for each other, so they worked in different roles. The same workers were also concerned with providing some continuity to the children and families they had contact with and went to great lengths sometimes to ensure that children were, for example, taken to medical appointments by a worker that they were knew.

Workloads

The CSSCs that I visited varied enormously in terms of how busy they were. Some were very busy and needed more than one intake worker to cope with the volume of work. At the other extreme, another CSSC had only one part time intake worker who could go for days without receiving a phone call. In some CSSCs investigations were continual with COSs going from one investigation to another and in others, investigation workers had several days without any.

During one period of data collection it was the school holidays and staff were taking leave. Arrangements were made for staff to move from one team to another and for some to act up as team leader or manager. However, this arrangement left only two very new COSs in the Investigation and Assessment (IA) Team (where there would normally be four) and staff were extremely concerned about how they would not only
manage the load but deal with some of the cases awaiting investigation given their lack of experience. ‘Acting up’ in the position above was seen as the only strategy to deal with staff vacancies in all of the CSSCs visited and, particularly in the example above, led to the ‘front line’ being severely depleted. It appeared to demonstrate the belief that to have Team Leaders, Senior Practitioners and managers was more important than having frontline workers. It was also explained to me that ‘acting up’ was seen as a staff development strategy.

Working with families and meeting administrative demands

At all the CSSCs, staff spent vast amounts of time at their desks completing their administrative duties and at the busier CSSCs staff were anxious about their ability to keep up with this part of their job. On leaving one CSSC on a Friday evening, a CSO who had been sitting next to me commented that he had spent most of the week typing away at his computer and he needed a break. I asked him (jokingly) whether he had left the CSSC at all and seen any of the 35 children he was responsible for and his response was that he was too busy filling in review forms about the children to make any time to actually visit them.

The emphasis on administrative work was commented on by more than one participant:

Workers [are] obsessed with paperwork and filling in their forms and do not see their job as helping children and families, more to do with servicing the organisation. (Interview 8)

Example of new staff member who, because of training provided by the Department is very focussed on the SDM tools to the exclusion of families. More important to him to have filled in all the forms of ICMS than the child – and this is reinforced by the posters on the walls which emphasise the
importance of recording. Workers think that the files are all they will be judged by if something goes wrong – and to a large extent they are quite right. (Interview 10)

Staff more concerned about ensuring they fill in their computer screens than spending time with families. (Interview 39)

But while this was a concern for some participants, others did not perceive their role as including working with families (casework), but rather as case managers, whose role is to identify ‘issues’ and refer families on to agencies that could help them. One senior member of staff lamented that the SDM tools and the introduction of the Practice Manual had ‘deskilled’ COSs but then added that the staff they were now recruiting, with general degrees rather than professional qualifications, did not have any assessment or intervention skills anyway. One participant, only a few months into the job and having graduated with a general human services degree, provided another perspective on this same theme. She explained that she understood that she was not qualified or skilled to work with families, that it most certainly was not her role and neither was there any expectation by the Department that it should be. For her, proficiency with using the SDM tools to assess children’s safety was her role. This was frequently linked to the opinion of more experienced workers who felt that the introduction of the SDM tools had led to a ‘dumbing down’ of practice.

Organisational Change

As described in Chapter Three, staff in the recently formed Department of Child Safety had been through much organisational change with the implementation of the CMC Report’s (2004) recommendations. While many of the participants interviewed had only joined the organisation after most of the changes had been made, there were a few who had been there prior to 1999. Some said that they had seen all the changes but all that had really changed was the name of the Department and they still have all the same struggles and problems with bureaucracy. One noted that a
major change had been that they were much more accountable for what they did and much time was now spent answering enquiries about cases from within and outside the Department. Another described how practice had become increasingly defensive, and referred to the work of Dingwall et al. (1983) (see Chapter One). For some participants who had worked for the Department prior to the CMC enquiry, the new accountability requirements were, though time consuming, considered to be a positive and necessary move.

Participants were also keen to share their views on the process of change, in which they felt powerless. The strategy adopted by the organisation to promote change and to implement all the CMC Report’s (2004) recommendations was to push change through as fast as possible, without giving staff any time or opportunity to comment. Several participants felt that it was pointless to raise any kind of objection to any of the changes or the process of change:

No point for her in complaining as no-one would listen anyway – people at head office have no idea what it is like in the front line. As long as their stats can be manipulated to tell them what they want to hear, that is all they are interested in, to make themselves look good. (Interview 34)

Throughout the process of change, participants reported that they had never been asked for any feedback about SDM or the Practice Manual. Head Office was described as only being interested in whether the SDM tools and the Practice Manual were being used, with compliance being the key concern rather than utility.

One participant described a particular strategy in the process of change:

One of the problems has been that the new Department has distanced itself from the old Department. Got rid of many experienced people and
replaced them with MBA content free managers (none of whom last very long). Reason for this is that politicians took no responsibility for past mistakes so blamed the Public Service. Everyone had to re-apply for their jobs at senior level and they did not get them. Helped with process of organisational change as did not have to teach old dogs new tricks. (Interview 31)

The scope of the changes was also of concern, with one participant stating:

When they reorganised the Department, they got rid of a lot of good people (some deadwood) but then imported some deadwood from other states. Threw the baby out with the bathwater, and then threw the bath out too. (Interview 27)

At the frontline of practice, a manager commented that most of the qualified social workers had left during the process of change, taking with them much experience and knowledge. Throughout the changes, it was noted that the workload had been steadily increasing and also that the emphasis had been on the development of the ‘front end’ of the child protection service, the intake and investigation stages, though some attention was now shifting to services for children in care.

The staff of the Department

Staff qualifications, experience and turnover

At the start of each interview, I asked each participant about their age, length of experience with the Department (and any other child protection jurisdiction) and their qualifications. I also contacted the Human Resources branch of the Department to request data about the qualifications of staff to assess how representative my sample of participants’ qualifications were in the Department, but was informed that
no records were kept about staff qualifications. In the following two paragraphs this data is described to provide an overview of the participants.

Eleven of the 46 participants were qualified social workers and one was a BSW student on placement. Eighteen participants identified the Bachelor’s degree that qualified them for their role in the Department as ‘psychology’ or ‘behavioural science’, five as ‘social science’/community welfare, four as ‘human services’, four as ‘criminology’ and one as ‘law’. Specific qualifications were not recorded for one participant and another reported that she did not have a degree. Many of these participants commented that their degrees had not helped them in their role in child protection:

- Has just done ICARE training about interviewing children and found this very useful as had not ever done anything like this – degree did not prepare her for actually working with people. (Interview 29)

Five of the participants had completed the Graduate Certificate in Human Services (Child Protection) at the University of Queensland, with the financial support of the Department. They all commented that this had been helpful to their work, particularly in “thinking about what we do”. In view of some the comments by social work qualified participants (see below) about the lack of social work qualified staff in the Department, it is notable that nearly a quarter of the participants were qualified social workers. This was perhaps an example of ‘reactivity’ (Bryman, 1988) as I tended to attract certain kinds of participants rather than others.

In terms of experience in child protection (prior experience in another jurisdiction was counted), six participants had more than ten years, five had between five and nine years, fourteen had between two and four years and 21 had less than one year. As might be expected, those who had more experience were in supervisory positions. In terms of age, seventeen participants were older than 40 years, six between 36 and
40 years, nine between 30 and 35, seven between 25 and 29 and seven were less than 24 years old. The impression I gained, which included staff who chose not to be interviewed (or who were not included in the sample because they worked in stages of the child protection process not covered by this research), was that there were many recently recruited and predominantly young (in their 20’s) staff, particularly in the ‘front line’ dealing with parents and children.

My concerns about the large numbers of inexperienced staff in the ‘front line’ of service delivery were echoed by participants in the research, especially those in supervisory or managerial positions. There was a sense that, in some CSSCs, recruiting any staff had taken over from trying to get the right staff:

Mentioned high turnover of staff but does not feel that is because they are hiring the wrong people, at least not in this office. There is a ‘bums on seats’ mentality in other offices though. (Interview 34)

More experienced staff were concerned that newer staff were convinced that after two years in the Department they should be Team Leaders. Two participants with less than three years experience explained how they had moved CSSCs just so that they could get the opportunity to lead a team.

Some of the younger and/or less experienced participants appeared to lack basic knowledge about the complex problems faced by many of the parents and children they were dealing with. Some of these staff conveyed an attitude that their job was really quite simple and they already had the knowledge and skills to be able to do it. Sometimes this came across as confidence, and occasionally arrogance and was perhaps, in part, a function of the expectation within and outside the organisation that they should be able to solve extremely complex, seemingly intractable problems, while working within a stressful and confronting area of work. Interviews with these participants revealed that such confidence was merely a façade they felt they were
expected to maintain. More positively, beyond this projection some were keen to engage in discussion about the complexities and uncertainties of their job and with new research and ideas about child welfare practice. It appeared that the interviews with the researcher provided a safe space for participants to do this and some also mentioned that such opportunities did not normally exist for them.

While all the COSs I met and interviewed appeared to be very committed to their role in protecting children from harm, what did become clear, at times, was that some staff had not been prepared for the reality of practice which can be challenging, confusing and surprising in contrast to the straightforward, logical and sequential world of SDM and the Practice Manual. A particular example was an interview which I observed in which the CSO leading the investigation had been employed in the Department for less than two weeks and had with no previous experience except for a three-month placement as part of a degree. The CSO struggled to interview the child concerned and received little guidance from her slightly more experienced colleague.

My concern with the expectation that inexperienced (and untrained) staff should be dealing with complex situations was echoed by one participant who was concerned about the lack of training for new staff and commented that:

*They [The Department] tend to abuse staff rather than invest in them – they are expendable and just cannon fodder. (Interview 4)*

Another participant echoed this sentiment:

*Understandable that the department would not want to waste resources investing in these employees – but the other side is that should not have to wait for a year before you get any training. Also backed up by the attitude*
that COSs are expendable – this is very apparent very soon after you join
the department. (Interview 3)

While this might appear to be an extreme view of the position of COSs, it supported
my impression that less experienced staff were expected to undertake duties for
which they were not prepared. The lack of preparation for the role was also apparent
in the following participant’s account of her first weeks as a CSO:

Only ever had two days training in SDM and was not sent to any initial
training – just given 33 cases (in Children on orders team) in first week and
told to read through them and get on with it.

Only survived because there was another woman in the same team in the
same position and they supported each other. Did not really feel that she did
not know what she was doing – just got on with it. (Interview 29)

The high turnover of staff was also frequently mentioned by participants, particularly
those in supervisory positions, though this was considered more a problem in rural
rather than metro CSSCs. Eight of the participants informed me that they either
intended to leave the Department soon or already had made plans to do so. Some
commented that staff who could not get supervisory positions in Brisbane, because
of a lack of perceived competency and/or experience, could find such positions much
more easily in rural CSSCs, and frequently did so:

Department also has the problem of a lack of experience, particularly with
team leaders. Difference between rural and metro, much easier to get higher
positions in the country but he is concerned that workers are attracted by the
power of supervisory positions but they are not ready to take on such a
position. (Interview 45)
Some participants reported that they had initially held positions in rural CSSCs but had aimed to move back to a Brisbane CSSC as soon as they were able. Many of the participants were able to compare practice in different CSSCs as they had moved from one to another, as opportunities arose. Turnover of staff was not therefore just concerned with staff leaving the Department, but moving around within it. As one participant commented:

> Always getting staff to move around from office to office on secondments to cover gaps – means that teams find it very hard to feel settled and people don’t invest in relationships that they know are not going to last. (Interview 4)

**Staff Training**

One strategy the department has adopted to train new COSs is ‘workplace learning’, encapsulated in a document entitled ‘Verification of Competence’. The document lists the competencies required for the duties of a CSO and requires COSs and Team Leaders to fill in boxes on how each competency will be developed and when/how this will measured and what evidence of accomplishment can be provided. Amid discussions in the paragraphs above about compliance with Departmental standards for recording and ‘servicing the department’, a CSO drew my attention to the advice at the bottom of the front page of the competency document:

> While completing your workplace learning you need to know the definition of competence. For our purposes competence is:

> The minimal base knowledge, skills and attitude conveyed in the Child Safety Practice Manual, legislation, practice papers and other departmental documents. *Competence does not relate to how well or
badly something is done but only to whether it is done according to departmental standards.  (bold in original, but italics added).

From this quote, it can be inferred that compliance with Departmental directives is more important within the Department than actual 'good practice'. This strategy was described by one Team Leader in the following way:

The training and competency standards are very superficial and it is worrying to give new workers the feeling that after six months they are competent because they are not. (Interview 5)

One very new staff member commented that she had not found the initial induction training for COSs helpful as it focussed mainly on the procedures and guidelines of the Department:

Major emphasis within induction training on departmental processes rather than knowledge – assumed to have knowledge but she studied nothing about DV and drug use on her course and never pretended she had… (Interview 9)

This participant had taken the initiative to develop her own study plan to cover topics such as domestic violence, drug misuse and sexual abuse but had to do this in her own time (mainly on the train to and from work) with no official support or recognition from the Department.
Attitudes Toward Parents and Children

One participant was concerned about the attitudes of the staff who had been recruited since the Department had been reorganised, in that they:

...are on some kind of power trip in relation to their clients" (Interview 5)

In a few of the discussions between COSs and Team Leaders I witnessed negative and punitive attitudes involving what I perceived to be harsh moral judgements about parents and children. A particular example observed were attitudes towards women who had been subjected to violence by their male partners. While reading a file in preparation for an unannounced first visit, a CSO commented to her colleagues that she could not understand why women stayed in relationships in which they were subjected to violence, that she certainly would not and that there must be something wrong with such women. This was not challenged by any of her colleagues and seemed to be tacitly agreed to. The worker went on to say that such women deserved to have their children removed as that might provide them with the motivation to ‘think again’ about what they might be subjecting their children to (“She needs to wake up to herself”). Clearly, though, the attitude expressed by this worker was not based on any real knowledge or experience of working with women subjected to violence by their partners.

Another example was the attitudes expressed by two COSs about a fourteen year old who had become pregnant (referred to as a “little slut”) which led me to wonder why they had chosen an occupation which would lead them into having contact with young people in such a situation. I also encountered racist statements which demonstrated a distinct lack of knowledge about and sympathy for the difficulties faced by refugees from very different cultures (“They’re in Australia now and they have to learn to do things our way”).
It is important to note that such offensive statements were infrequent events, but it was also significant that they went unchallenged by others. The statements I heard were not exceptionally confronting in that it would not be difficult to find similar views expressed in newspaper editorials and letters pages. What was of concern though was that they were being expressed by people in an occupation which constantly brings them into contact with people who are marginalised in society by circumstances over which they have no control.

The position of social work

The range of opinion about the need for a social work qualification was wide, ranging from one participant (with a degree in psychology) saying that, after two years in child protection practice, she wanted to take some time out to study social work as she needed to know much more about how to assist people to change and meet the challenges in their lives. At the other extreme, another participant was adamant that what they did in child protection was most definitely not social work and that social justice had no place in their activities:

Child protection is a profession in its own right and what they do here definitely is not social work – it is not about social justice.

Not about social justice because they are not here for parents and sometimes they have to do things which might not seem like justice to parents. (Interview 24)

In the same vein, a social work student on placement was disappointed that, during the placement, there had been little opportunity to observe any social work practice. One social worker (who was about to leave the Department) complained that:

Certainly no social work being carried out in this office but why would there be when she is the only social worker here? (Interview 8).
All of the social workers interviewed, to a greater or lesser degree, commented on the diminishing importance of a social work perspective within the Department despite their efforts to promote it. Some also commented that many social workers had left the Department over the past two or three years:

They have lost 5 social workers from this office in the last 12 months or so. (Interview 10)

One commented that she had had enough and could not wait to leave the Department and return to a social work oriented child protection organisation overseas. Another participant was adamant that the Department had deliberately moved away from recruiting social workers and promoting social work as a desirable profession to have in the Department. This participant believed that social workers in the Department have three options:

1. Give up any idea of practice according to a set of ethics and follow the procedures.
2. Work with the procedures to try to adhere to good practice standards and challenge the procedures.
3. Give up and leave (as many have done). (Interview 45)

One participant provided a completely different perspective on the debate about qualifications: she felt that professional knowledge and qualification was not as important as personality as this was the major factor in determining whether a CSO would perform their role well, in particular how a CSO dealt with interpersonal conflict. Another referred to values as being more important:
Don’t need a degree to do this job – more about a set of values than what degree you have – but new strategy to open the doors even wider is not a good idea. (Interview 6)

This particular comment echoes the findings of Healy and Meagher (2007) which focussed on how child protection practitioners and managers perceived the utility of tertiary social work and social science qualification as preparation for child protection practice. They conclude that social work educators, in preparing students to practice in high employment sectors such as child protection, need to “seek a better balance between generic and specialist foci in social work educational programmes” (p. 334). The findings of this research support the idea that a generic social work education is, from the perspective of some practitioners and managers, not considered as the best preparation for statutory child protection practice. The findings of this research also go further and suggest that there is some hostility toward professional social work within the Department, to the extent that many social workers have left the Department.

Organisational structure and team leaders

The Department is structured hierarchically according to Weberian principles of bureaucracy, though according to the following participant, this was not the original intention:

While bureaucracy not necessarily the answer, there was a need for some as there was nothing before and the lack of accountability and structure led to some terrible practices. (Interview 2)
The changes, however, had not led to the desired outcomes:

But, in many ways they have just recreated the structure they had before – was supposed to be flatter but it is not and the further up it you go the more you are having to protect the org rather than children. (Interview 2)

As described in Chapter Three, every decision made and recorded on ICMS has to be ‘approved’ by a Team Leader, and so does every case note. Consequently, the Team Leader plays a crucial role in the decision making about cases and the decisions made in any team strongly reflect the orientation to practice of the Team Leader. As discussed further in the next Chapter, this led to practitioners within teams having to ‘second guess’ the Team Leaders:

Frequently workers at the front end fill in the tools by trying to second guess their team leader as they have to approve it. They are so busy that they cannot afford the time to disagree with the team leader. (Interview 27)

Spends a lot of time trying to work out what the Team Leader actually wants to hear when he writes his casenotes and assessments. (Interview 4)

One of the consequences of Team Leaders having to approve every decision and action (and how it is recorded) is that their role can become one of control and surveillance rather than support, leading to a situation where:

Team leaders [are] policing rather than supporting their teams. (Interview 27)
A need for control over team members was expressed by one Team Leader, who explained to me that she had insisted that the staff in her team use the electronic diary system. The enabled her to control their activities by moving their appointments and inserting entries for meetings.

This surveillance and control over decision making and more generally the activities of frontline practitioners could lead to tensions between practitioners and their team leaders. In the extreme form this was described by one practitioner as follows.

Culture of silence and fear within the Department – relationship between the staff and management like a DV relationship. Management keep piling the expectations and then punish workers when they are not met – make it very clear who is in charge. Also undermine confidence by constantly changing their assessments when it comes to approving them. Punish workers by giving them complex cases and threatening to ‘performance manage’ them. If they fail the attitude test and do not accede to this then they are ‘managed out’ or pressured so much that they ‘crack’ and leave of their own volition. Children and families are considered to be the ‘children’ of the relationship and the workers are held responsible if they mess up – they then get punished. (Interview 4)

Tension sometimes turned into conflict. In one CSSC I witnessed a disagreement between a CSO and her Team Leader, in which the CSO argued that she felt continually undermined by her Team Leader and which led to the resignation of the CSO.

These examples of the relations and conflict between frontline practitioners and Team Leaders are at an extreme end of a continuum. My observation was that most of the Team Leaders were very involved with and supportive of their team members. At the other end of the continuum were Team Leaders who considered their role as
being to support their team members and promote the development of their expertise. As one participant commented, in relation to using the over-rides to the SDM tools:

She is lucky as she has a team leader and managers who understand this and have taught her this – they have also taught her to put faith in her own judgement and skill at assessing and this has prompted her to keep asking questions and reading etc because she realises she has so little experience. (Interview 3)

Excellent Practice

While much of the data about the staff observed and interviewed during the fieldwork leads to a critical view of the department, there were some important exceptions. As shown above, some of the participants interviewed had many years of experience and demonstrated a wealth of knowledge and expertise. Such conversations also showed the commitment of staff not only to children but also to their parents. I was also privileged to observe some excellent practice. One particular interview by a police officer and a CSO with a child was conducted with considerable skill and understanding of the child’s limited communication skills. This was followed by a long interview with the child’s mother which was made more challenging by having to use an interpreter for the deaf. The final outcome was very positive and this was due, in no small part, to the considerable skill, patience and dedication of the CSO and the police officer. I also observed a difficult but excellent interview with a grandmother, after which the CSO was able to articulate how she had used a narrative approach and how this facilitated the task of not only gathering information about a child’s situation but also making sense of that information from the perspective of the interviewee.

Summary

The overall view of the staff of the Department is one of extremes. While there were some very experienced staff there were many more who had little experience and
preparation for the job they were expected to do. This was not unexpected, given the planned and actual growth in the numbers of frontline staff mentioned in Chapter Two. The recruitment of inexperienced staff without professional qualifications is particularly pertinent in light of the claims made by the CRC that the SDM tools are especially useful to jurisdictions which have high staff turnover and a lack of experienced staff (as discussed in Chapter Three). The levels of experience of staff in child protection was also pertinent to the another important claim made by the CRC in relation to SDM promoting consistency of practice, and in how the tools were actually used. Both of these observations are discussed further in Chapter Six, which focuses on how COSs and Team Leaders (in particular) use the SDM tools.

**Influences on practice**

**The ‘Integrated Case Management System’**

Shortly before I started the fieldwork, the Integrated Case Management System (ICMS) had been introduced and staff were struggling to use it. This was not helped by the fragility of the ICMS which would slow down at times and make completing tasks even more onerous. Various parts of the system either did not work or were closed down as time went on (as mentioned in Chapter Four). In one CSSC I sat next to a CSO who had asked for assistance from an ICMS support worker to sort out her cases. This took over two hours and involved much frustration for both parties. On the one hand the CSO had made mistakes that needed to be undone and on the other the support worker struggled to explain what had gone wrong and how it needed to be put right. At the end of the session, it was clear that patience on either side was stretched to the limit. Interestingly, though, no participants questioned the need for a statewide computerised recording system, so there was no debate about or resistance to the use of information technology.

**The Practice Manual**

How staff use and regard the *Practice Manual* was not the focus of this research but it was an important part of the context for practice. By the end of data collection, the
manual had grown to longer than 825 pages and it was clear that the Department was investing significant resources in its development. Every desk had a copy of the Practice Manual and though I rarely saw any practitioner consult one, it was an important influence on practice, as this participant described:

Concerned that people so caught up with the prac handbook – ‘you show me where it says I need to do that…’ Practice being driven by the book and not what is best for children. Continual haggling between offices re case transfers, particularly whether they have followed the procedures or not – won’t accept a case if all not completed (but gave example of a case where an office quibbled over procedures but had ignored fundamental need to respond to several concerns, esp sexual abuse). (Interview 45)

When I asked questions about the manual genuinely seeking knowledge, it appeared that I had a greater knowledge (at least of some sections) than those I was asking. Participants seemed ambivalent about the manual, for example:

Wondered how they did the job before they had SDM and the practice manual (would be nice to have the time to read it though). (Interview 44)

Both make the job very concrete but sometimes wonders where ‘common sense’ is in all of it, sometimes the procedures get in the way and are more important than the child’s interests. (Interview 44)

Another participant alluded to the size of the manual, but also its positive role for new COSs:
Re practice manual – really overloaded now with forms and procedures. Interesting that new workers actually like them at first as it provides some structure for them. (Interview 34)

This was contradicted by a new CSO, who was expected to spend her first two weeks reading the manual, who commented that it made little sense to her. Another participant alluded to the role of the manual in Departmental practice as follows:

Feels that cp should be a social work activity. Would not need such a big practice manual then - more a set of guidelines to help with legal procedures and obligations. (Interview 27)

Others commented that its main use would be to blame practitioners when tragedies occurred in terms of not having followed the procedures.

The SCAN (Suspected Child Abuse and Neglect) system

Another significant factor in the context of practice, which many participants mentioned, was how the SCAN system operated. According to the *Practice Manual*, the SCAN system “through its multi-disciplinary approach, ensures a co-ordinated and effective response by those government Departments with statutory responsibility for child protection and any other agencies providing services that will contribute positively to the proposed intervention” (p.87, Chapter 2). In short, referrals are made to a multidisciplinary committee (within each zone) for discussion and recommendations for action. But there appeared to be a disjuncture between how the SCAN system is supposed to operate and how it actually operated, with participants expressing very strong opinions about it. In general, participants considered that the SCAN system was not only a waste of time, but was damaging. Stories were related to me of Senior Practitioners returning from SCAN meetings in tears and refusing to attend another one. Many saw the SCAN meetings as a forum
where other agencies ‘ganged up’ against the Department and as an opportunity to criticise the Department and its staff.

Discussion with [Participant 45] re SCAN meetings. Frequently consist of other professionals, ie police and paediatrician, telling the Deaprt what to do and dictating how cases should proceed. They have had people come back from the meetings feeling sick and in high states of anxiety over the way that they have been treated. No respect for the fact that the Departmental workers might know what they are doing. Very much a pecking order, with Department at the bottom. (Excerpt from Field Diary)

This theme is reflected in the Child Death Case Review Committee Report 2006-07 (Fraser, 2007) in its observation of “interpersonal conflict among core members, resulting in an unwillingness to collaborate. . “ (page 44). Some felt that dynamics within SCAN meetings were symptomatic of the Department continuing (from before the re-organisation) to adopt a ‘victim role’ with respect to other agencies, resulting in other agencies feeling that they had to tell the Department what to do rather than work with the Department. One participant described the SCAN meetings as a forum where the Department becomes the ‘dumping ground’ for the concerns of other agencies, which do not understand their role in protecting children. Indeed one example that was offered involved a paediatrician ‘ordering’ the Department at a SCAN meeting to investigate a matter that very day. To the staff involved, it was quite clear that the paediatrician was also trying to cover up the deficiencies in his own service by making such strident demands (a child had allegedly been injured by a parent but had attended a hospital appointment after the alleged injury had occurred). But, while the staff at the CSSC concerned complained to each other, they still had to investigate the matter that afternoon.

Another participant described how SCAN operates to over-rule and undermine the decisions of the Department (even when they have used SDM). This participant described a case in which she had conducted an investigation and recommended that the Department take no further action. The original notification had come from
the police and so the case had been back before SCAN for review. In her assessment, the CSO contradicted, in some ways, the account of events as reported by the notifying police officer (the CSO had spoken to a wider range of people about what was happening in the child’s life). Because of this the police representative on SCAN refused to accept the COSs assessment and the recommendation of SCAN was that the CSO re-interview the child and parents. This participant explained that SCAN can only make recommendations to the Department, however these recommendations are usually accepted as ‘orders’ because the senior Departmental staff who attend SCAN feel powerless. The CSO was directed to interview the child and parents again, which she did and she reached the same conclusion in her re-assessment. Of particular concern to this participant was the lack of support she received from her manager and Team Leader and their lack of faith in her decision making and assessment abilities.

The following statement seemed to sum up the attitudes of participants towards SCAN:

Feels that SCAN only there to burden the Department and bully them into removing children – which they resist. Never get anything positive out of SCAN – just another accountability measure. (Interview 23)

Influences from outside – the media

As explained in Chapter Two, the media were instrumental in publicising the problems in the child protection system in Queensland in 2003 and, during the time that the fieldwork for this research was being conducted, this was an important external pressure on practice. During the fieldwork, both the local print media and television networks reported on deaths of children known to the Department and/or health services. In one CSSC, I observed that there was a daily ritual in the team to scan the Courier Mail newspaper for any news about the Department. At another CSSC, a child known to the Department had recently died and it had been reported on by the media. Statements made by staff in general conversation revealed that the media was another pressure on them which shaped how they practiced. Again, this
could be an influence which could lead to various forms of ‘defensive practice’ (Dingwall et al., 1983). Over the Christmas/New Year period there were two cases which were reported by the media and in response the Director-General sent out three emails to all Departmental staff. The first email was concerned with the unauthorised use of information about a Departmental client by the media and the unfairness of naming staff who had already been subjected to disciplinary proceedings. The second email was concerned with the same case and the misinformation that had been reported in the media. In particular it expressed concern about the continued ‘hounding’ of Departmental staff by the media and the focus they have on cases where, with hindsight, the Department would have acted differently. The email also had an attachment, which was a letter to the editor of the Australian newspaper, expressing these concerns. The third email concerned the media reporting of the death of a child known to the Department on New Years Day and it urged staff not to allow their “self worth to be judged by the media”.

Three emails from the Director-General might appear to be excessive, but the ‘attacks’ on the Department were continual and led to the impression that, in Queensland, far more than in other jurisdictions, the problems faced by the Department were very much debated in the public domain. Some staff of the Department no longer seemed to take much notice of the media. In one CSSC, I tried to engage staff in the tearoom about the latest report about the Department, and their response was not only outrightly dismissive, but it appeared the debate had also been had so many times before. This latest report was a good example of the media interest in the Department and appeared on page 12 of the Courier-Mail on Monday 14th January 2008. The headline was: “Abuse files pile up – inaction on child cases exposed”. The article quotes figures obtained from the Department that, as at 31/12/2007: “nearly 2700 cases of suspected child abuse across Queensland have no case worker allocated to investigate and assess alleged maltreatment”. The article finishes with a quote from the State opposition:

Opposition child safety spokeswoman Jann Stuckey said although the decision to send a team of seconded workers to the Cape was welcome, it did not resolve some of the critical issues facing the agency, including high staff turnover and inadequate training.
Influences from outside

During one of the periods of fieldwork, the Department had invited Professor Eileen Munro (London School of Economics) to give a presentation to staff, which I attended with staff from the CSSC. Professor Munro gave a presentation about how intuitive and analytical thinking can be used to enhance practice and towards the end of her presentation, she made the point that, while child protection practitioners might need guidelines, the use of detailed procedural manuals was antithetical to the forms of thinking required in practice. Some of the audience nodded in agreement with this, though the Department had recently released the latest edition of the Practice Manual which had grown to 825 pages. Discussing this with staff on that way back to the CSSC revealed the following. While it appeared to be a positive move that Department was willing to listen to the views of an expert who presented views that were oppositional to its own practice, staff were not optimistic that this would lead to change. They felt that the Department would want to be seen to be seen to be taking the advice of Professor Munro, but would disregard it. However, Professor Munro’s presentation did have some impact within the Department as months later, during subsequent rounds of data collection, some participants mentioned her ideas.

Child rescue and family support

As explained in previous Chapters, using the concept of ideology became central to this research in understanding the beliefs and values that underpinned practice within the Department. This section explores how the ideologies of ‘family support’ and ‘child rescue’ surfaced as themes in the data and provided insights into practice.

Unstated conditions and ‘unannounced visits’

An unspoken rule existed in several of the CSSCs, which only became apparent to me when I went to a CSSC where the rule did not exist. The rule was that initial visits during an investigation were not arranged with parents and there was assumed to be
some benefit in ‘surprising’ them. I checked the Practice Manual and it stated that this was a discretionary point of practice, dependent on an assessment of the circumstances. In practice, this meant that the first that most parents and children knew about any involvement with the Department was two COSs and possibly one or two police officers knocking at their door. This automatically placed parents and children at a disadvantage and, as I observed, led to interviews in which workers had to deal with emotions of, for example, shock, anger and disbelief, before they could start to talk about the ‘allegations’. It also meant that much time was spent making arrangements with police and driving to sometimes distant locations only to find that no one was at home.

The practice of conducting unannounced visits to children and families demonstrated a certain attitude towards parents, referred to in Gillingham & Bromfield (2008) as ‘blame ideology’, and particular beliefs about the role of the Department, which is exemplified in the following observation of an interview with a parent. Firstly it was the language the CSO used to describe the case to me on the way to the interview provided insight into what she considered her role to be and her attitude towards parents. For example, she talked about her ‘plan of attack’ and how she would ‘challenge’ the parent, how the parent would have to ‘prove to her’ that he was ‘genuine’ and how she had lost the benefit of ‘surprise’ because the agency worker had already told the parent what the ‘concerns’ were. When she spoke with the parent, she talked about keeping the children ‘safe’ rather than looking after or caring for them and was quite clear that her job was to monitor the parent’s behaviour and that this would involve ‘unannounced visits’ to check that he was living where he said he would and that the house was clean. This would also mean that if he and the children were not at home at the time of the unannounced visit, the CSO would contact the parent on his mobile phone and expect them to return within the hour. For me, this approach invoked descriptions of child protection as ‘policing’ (Donzelot, 1980) and providing ‘surveillance’ for families (Parton, 1991).

In later discussion, and despite my impression that she had been punitive toward this parent, the CSO explained that she was very supportive of this parent getting his
children back in his care and wanted to give him every chance to succeed. The CSO was able to articulate her role as prescribed by legal mandate and policy in the *Practice Manual* very clearly indeed. But despite her supportive stance, the onus was very much on the parent ‘proving’ his ability to follow the COSs directions, with the CSO monitoring this ability rather than providing support. If the parent needed support or education, then it was very much up to him to take the initiative to access such a service. The CSO was also clear in my discussions with her that her role was not to try to predict how this parent might fail and try to help him avoid adverse situations and consequences. Rather, the Department would only intervene if certain circumstances arose and make another assessment (that is, they would only intervene after an adverse event had occurred for the children and, with the parent having ‘failed to protect’, would most likely remove the children from his care).

Interestingly, the CSO was concerned that perhaps her Team Leader would think she had not been sufficiently ‘confronting’ with the parent.

**Child rescue**

One participant who had worked for the Department for many years commented that, years ago, removing children from families had only been done as a last resort and only rarely were there children about in the CSSC, waiting to be placed. Now, this participant lamented, almost every day there were sibling groups waiting to be placed. Other participants were also concerned about what they described as the lack of emphasis in practice on working with families to keep children with their parents and the lack of consideration of the emotional harm caused to children by removing them:

Focus is very much on safety rather than welfare. (Interview 8)

Focus has gone from helping families to look after their children to assessing risk (in a very surface way – skimming across the surface of the issues). (Interview 39)
Some of my observations of practice concurred with this, a particular example being a court case that I observed. The Department’s application was for an extension of a Temporary Assessment Order and I was able to read the file and all the court documents before observing the hearing. In none of the court documents was there any information about how the Department had provided any support to keep the children with their mother, nor any information about what they wanted to assess during the extension of the order. The CSO was not able to answer my questions about these matters, and during the hearing, which was contested by the mother, these matters were not raised. Meanwhile the three children had been placed with a foster family some distance from the mother, making daily contact impossible. A few days after the hearing, I heard that the eldest boy, aged ten, was ‘escalating his behaviours’ and had ‘broken down his placement’: he was subsequently separated from his siblings. At another CSSC, the magistrate who usually dealt with all of the Department’s applications had been replaced by a new magistrate. The new magistrate was causing problems for the COSs because she insisted on asking questions about what supports had been considered for families and this was perceived by the COSs as being ‘parent’ rather than ‘child’ focused. Again, this illustrates and explains the attitude of some of the participants towards parents and their role in relation to children.

Some participants commented on the amounts of money being spent on foster care, specifically on supporting placements through the provision of money to purchase, for example, day care, laundry services and transport. They questioned whether, if even a proportion of this money could have been used to support the natural parents, removal might not have been necessary. As one participant commented:

> All about social control rather than social care – heaps of money out into foster care so it is not about the money as much as the attitude behind where it should go. Could list numerous cases where they could have spent money on specialist services for families to keep children with their parents but the manager just will not let them do it – not the way the system works at all. (Interview 10).
But while this emphasis on removal rather than support for children and families was a theme throughout all the CSSCs I visited, it differed in intensity from one CSSC to another and from one team to another. In some teams, it was clear that the opposite was true: in one CSSC the intake workers described how they spent much time referring families and notifiers to services outside the Department, thereby avoiding any need for the Department to become involved. These cases were recorded as Child Concern Reports and closed, but the attempts of intake workers to refer families and notifiers to alternative services were not documented. Even for cases that had been investigated, there was evidence that attempts were being made to assist parents to address problems and avoid the need to remove children. In one CSSC it was clear that progression for most families, where it was assessed that the Department needed to continue its involvement, was from investigation to ‘Intervention with Parental Agreement’ (a form of voluntary involvement with the Department where the children remain with their parents). The lament of some of these COSs in this team was that they lacked the resources to work with families in the way that they wanted to:

Don’t actually have much chance to do anything with families – lots of renotifications which eventually lead to children being removed as previous involvement used as evidence of history – in which the Department did absolutely nothing to help a family. (Interview 15)

One participant told me how she would do ‘follow up’ visits to families after she had officially finished investigating a case in order to support them with referrals, but was careful to keep this activity a ‘secret’.

The frustrations of staff with seemingly having no choice but to remove children, due to a lack of resources, is expressed in the following quote:

Long discussion about the removal of two children yesterday from an alcoholic mother with long history. Got to the point where she is drinking
heavily again and being abused by a former partner and the children are not safe.

Removed the children before trying to improve the situation even though she [Team Leader] could see that, with the right resources, they could have worked with the situation and kept the children with their mother. (Interview 10)

The remainder of this excerpt also relates to the points made below about accessing the services that do exist and the perceived role of COSs:

But they had no choice [but to remove the children] because it was only by removing the children that they could get the other agencies to act, ie admit mother to rehab rather than keep her on a waiting list for six weeks. Neither do any of the case workers here have the sorts of skills and knowledge that would mean they could help this mother – so very much a sledgehammer approach. (Interview 10)

While some the quotes above show that some participants were concerned about the removal rates of children from their families, it was the ideology of ‘child safety’ rather than of ‘family preservation’ (Pelton, 2008) or ‘child rescue’ rather than ‘family support’ (Tilbury, 2005) that was dominant in the Department. This was encapsulated in a home made poster on the wall of a Team Leader’s office which read: “they are the innocent victims and for many we are their only hope”. It was also reported to me that a senior executive had addressed an audience more than once and talked about how the Department aimed to ‘save’ children.

My realisation that practice within the Department was based more in a ‘child rescue’ than a ‘family support’ paradigm became crucial to understanding the context for practice. Consequently, when I interviewed participants in the third round of data collection, I specifically asked them about their approach to protecting children identified as unsafe. I also adopted a strategy proposed by Garfinkel (1967) which
involves breaking or challenging unspoken rules in order to find out what they were. This strategy involved challenging participants to articulate why they were making certain decisions or taking certain actions. I did this in a non-threatening way, frequently posing challenges as questions rather than statements. I was also very careful about when, and with whom, I adopted this strategy.

The rationale for child rescue

As mentioned in the above section, strategies for protecting children became a specific topic for discussion with participants in the third round of data collection, as a way to investigate my observation that the practice I was observing was based more in a ‘child rescue’ rather than ‘family support’ paradigm. It was explained to me that there were two main reasons why they removed children rather than worked with families. One was that the Intensive Family Support (IFS) service (and other family support/education services, see below) is not designed to intervene in crisis situations and the Department’s initial reaction to an assessment that children are deemed to be ‘unsafe’ is to remove them and then to consider what supports need to be put in place for the children to return. Referrals are then made to support services (which often have waiting lists) and when parents engage with those supports, the children are then returned to their care. The other reason was that, by and large, the front line COSs are not qualified to work with families and intervene in crises in any therapeutic way and see their role as:

Very much concerned with case management rather than casework – try to get everyone else to do what should be their work, intervening therapeutically etc. (Interview 8)

Her opinion was that the Department needed to stop recruiting “anyone with a degree” and focus on recruiting staff who were qualified to intervene in crises therapeutically in order to avoid the removal of children. Another participant also described much the same process of how the Department ended up removing large
numbers of children for short periods of time, though added that the removal and short term placement of children was additionally used as a warning to parents that they need to ‘address their issues’, the threat being that if the children had to be removed again, they might not be returned at all.

Resisting child rescue

There was one particular CSSC where practice was not based in ‘child rescue’ paradigm and the staff went to considerable lengths to assist parents and extended family to care for children. As I began to discuss these observations with staff at this CSSC, it became clear that the CSSC considered itself to be different to others and that the staff had developed strategies to resist pressures ‘from above’ to practice in other ways. This was expressed by one participant as follows:

She has worked in [the protective] orders team and is aware of the harm that children suffer by being removed from the care of their parents and in the care system as they get moved from one placement to another. Hence she is very committed to working with families to keep their children with them as much as possible. She is supported in this by her team leader but is aware that this is not the norm in other offices where they remove children first and then start asking questions. (Interview 3)

‘Resistance’, though, did not mean that they disregarded the SDM tools or the Practice Manual, but they did use them differently to other CSSCs, which is discussed further in the next Chapter.

Family Support

One resource that COSs did have is a family support program (funded by the Department) which is located in different agencies and named differently in different areas. Only families that are involved with the Department can access the service
and referrals can only be made by COSs. However, this service was hardly mentioned in any of the interviews with COSs. In more than one CSSC, COSs commented that referral to the agency was pointless as there were such long waiting lists but in another, a CSO was very positive in her comments about how this service had worked with the families she had referred. Even when I asked COSs in one CSSC what they knew about their local service, they seemingly knew very little and gave me a phone number (and small brochure) to contact the agency and ask them what they did.

**Evidence to support ‘child rescue’**

As mentioned in Chapter Two, the available statistical data about the activities of the Department indicated that from 2002/3 to 2005/6, the number of children subject to child protection orders rose by 57% and the number of children living away from home rose by 76%. Even though this is snapshot data that does not reveal how many children enter and leave care during a 12 month period, the increases appear to support the statements of participants (and my observations) that practice overall within the Department was, compared to the past, entrenched in a ‘child rescue’ ideology. The data from the Queensland Magistrates Courts, also mentioned in Chapter Two, suggests that, while there has been a slight decrease in applications made by the Department from 2005-06 to 2006-07, there were wide variations between individual courts, with some experiencing large increases and some large decreases. In two of the CSSCs visited for this research, increases had been dramatic, which further supports the statements made by participants that the numbers of children being removed from the care of their parents had increased over the years. The decreases in applications in some areas suggests that ‘child rescue’ ideology was not operating consistently across the Department.

**Explaining ‘child rescue’**

As discussed in previous Chapters, the ideology of child rescue, as opposed to family support, emerges as an ideology underpinning the creation of the Department of Child Safety. As discussed above, it also emerges as a strong theme in the
observations of practice and interviews with practitioners in this research. At an individual level, previous research suggests that less experienced practitioners are more likely to blame parents and adopt a child rescue position when confronted with harm to a child (Gambrill, 2000). Hansen and Ainsworth argue that this position of parent blaming is not confined to inexperienced practitioners and applies equally to more experienced practitioners who may be suffering fatigue or ‘burnout’. The lack of experienced practitioners within the Department, as discussed above, may, therefore, be contributing to the perpetuation of a child rescue ideology.

Reflecting on the ‘insider view’

The preceding paragraphs summarise the statements made by the research participants and my observations and provide what amounts to an ‘insider view’ of child protection practice in Queensland. Much of this ‘insider view’ is at odds with the official version of practice promoted by the Department through the Practice Manual and other official documents produced by the Department. While there are some positives in the above account, there are also many negatives, and the ‘insider view’ is, on balance, more negative than positive. Partly this may be because the participants in the research saw the interviews as an opportunity to ‘offload’ their frustrations with the Department and the role they were expected to carry out. My experience of working in several jurisdictions in both Australia and the United Kingdom suggests that expressing negative views is part of the landscape of child protection practice. Dealing with child abuse and neglect is particularly challenging and the rewards of such work can be few and far between. When asked about the positives of working for the Department, most participants either avoided the question or dismissed it with a comment about ‘there not being any’. However, the negative attitudes expressed by the participants should not be taken to mean that they were necessarily demoralised or lacking motivation to do their jobs. Many participants were insistent that their negative views find some avenue for expression so that positive changes could be made.
Chapter summary

This Chapter has provided an ‘insider view’ of the Department of Child Safety using the statements of participants and my observations. It has described the context for practice and the use of the SDM tools in the Department of Child Safety, from the perspectives of practitioners, Team Leaders, Senior Practitioners and Managers. In many ways, practice within the Department and the challenges it faces are similar to other jurisdictions in Australia. Organisational change (both in terms of its pace and process) has challenged staff who have been employed in the Department for some time and brought many new staff as new positions have been created. Practice is highly proceduralised (both in terms of the Practice Manual and the ICMS) and the level of staff turnover is perceived to be high. The selection criteria for staff recruitment have been broadened, leading to the employment of staff who have little or no experience and degrees which they do not consider have assisted in them in their practice. But, from the ‘insider view’ there is the sense that this is not considered a problem by many in the Department, at least not openly. Indeed, at the time of the last round of data collection, a project was under way to expand the range of qualifications acceptable for entry into CSO positions.

Lonne and Thompson (2005) argue that a managerialist, rather than a professional discourse, has underpinned the creation of the Department (see Chapter Two). As stated in Chapter Two, Lonne and Thompson argue that, with the creation of the new Department, there needed to be a “renewed commitment to social work values and ethical practice as the foundation for reform” (p. 94). The findings of this Chapter support their concern that this renewed commitment had not been made. According to the participants, social workers within the Department were few and far between and their knowledge and skills were not accepted or promoted as particularly relevant to the business of the Department. Indeed many social workers had left the Department and taken with them their knowledge and experience. New staff recruited into the Department generally had no professional qualifications and were heavily dependent on the Practice Manual and the SDM tools to assist them with their roles, though, as the next Chapter shows, this was not a straightforward application of rules and procedures. More recently recruited COSs also saw their
role as ‘case manager’ rather than ‘caseworker’, and, prioritised administrative tasks over spending time working with children and families.

The view from the inside also confirms Tilbury’s (2005) concern that the balance within the Department falls heavily toward ‘child rescue’ rather than ‘family support’. This is encapsulated in the name of the Department, in terms of ‘child safety’ rather than, for example, ‘child and family welfare’. The emphasis in practice is on the short term safety of children, particularly from the perceived or actual threats to their safety posed by their parents. As explained in Chapter One, at the heart of this practice lies the belief that children need to be ‘rescued’ from their parents, rather than the belief that the best place for most children is with their parents and that most of the families who come into contact with a child protection service require support and guidance. While there were individual and group exceptions to the adoption of this ‘child rescue’ ideology, this was the dominant ideology in the Department. Gambrill (2000) suggests that inexperienced practitioners are more likely to adopt a ‘child rescue’ ideology

However, in summarising the ‘insider view’, I also need to suspend my own ideological positioning and adopt ethnomethodological indifference. As discussed in Chapter Two, in Lonne and Thompson’s (2004) opinion, the problems that beset the child protection system prior to the reorganisation were not conceptualised using a social work perspective or ideology, but rather a managerialist ideology. Consequently the solutions sought were aligned to a managerialist (and bureaucratic and technocratic) ideology. From a managerialist perspective, many of the goals of the creation of the new Department have been realised. The workforce has been expanded using generalist staff, whose practice is controlled and regulated by bureaucratic systems and frameworks (the Practice Manual, the ICMS and the SDM tools). Accountability systems have been introduced and the recording of decisions and actions has assumed a much higher level of importance. From the available statistics (mentioned in Chapter Two), while demand for the service has increased (in terms of the numbers of contacts the Department receives), this appears to have been managed and investigative resources have been more targeted (the number of
contacts accepted as notifications requiring investigation has dropped slightly). From this perspective, the creation of the new Department can be considered a success in terms of addressing the problems raised by the CMC in 2004 about the previous department. But the ‘insider views’ of many of the participants, and my observations, would indicate that the re-organisation has not been the success it might appear. More specifically, while the implementation of SDM might be considered a success in that all staff are compelled to use the tools, how they use them is problematic, as described in Chapters Six, Seven and Eight.

This Chapter has avoided the inclusion of any detailed statements or observations about how SDM was used in the Department but the themes identified in this Chapter resurface in later Chapters and provide an important backdrop against which the use of the SDM tools can be considered. In the next Chapter, how staff regarded the tools and described how they used them is explored in detail.
Chapter Six: SDM as a Practice Framework: the Unstated Conditions

Introduction

In this Chapter, how departmental staff considered SDM as a framework or approach to child protection practice is explored using their descriptions and my observations. During the interviews, participants were keen to discuss their views about SDM and many reported that they had had little, if any, chance to reflect on and discuss how they used the SDM tools. The interviews for this research appeared to provide a useful forum for the participants to do this. The interviews were, in an ethnomethodological sense, the most important means by which, for the purpose of this research, the unstated conditions (Garfinkel, 1967) became verbalised as ‘stated conditions’.

In this Chapter, statements made by participants about the introduction and continuing use of SDM in their practice are presented according to the various themes that emerged from analysing their interviews. An important point to be borne in mind is that many of the participants started their interviews by making positive statements about SDM, but then later went on to either qualify these statements further (making them less positive) or contradicting themselves. Some of the positive statements made at the beginning of the interviews were more akin to ‘conversation openers’ than reflective comment and were in response to very general, rather than penetrative, questions by the interviewer. Therefore, in presenting statements made by participants about SDM, I have been wary of ascribing meaning mistakenly by decontextualising them.

There was also a disjuncture between public and private opinions about SDM within the Department. An example of this disjuncture between the ‘official’ and ‘unofficial’ versions of practice occurred when I arrived at one of the CSSCs. At first, there was confusion about who I was as the staff I had corresponded with had left. As I was
introduced to staff, they formed the view that I was from Head Office and had something to do with the implementation of SDM. Most made very positive statements about SDM during these introductions, but were less positive when they found out that I was a researcher from the University of Melbourne.

The ‘unofficial’ version

Implementing SDM and SDM training

When the SDM tools were initially implemented in the Department, expectations were high that they would make a positive contribution to practice:

She started in the job when SDM was being rolled out. She thought it was brilliant because she had no practice framework. Still thinks it’s brilliant if it is used properly. (Interview 33)

They were promised that they would see a difference straight away when SDM was brought in. . . (Interview 34)

SDM was also promoted as:

. . . something that would solve all their problems. . . (Interview 2)

However, many participants were disappointed about the initial two day training they were required to attend, which they linked to the implementation process:

Problems with implementation of SDM in that they have not been able to do the follow up training that they thought they would. (Interview 27)

SDM training was very tedious and badly delivered. (Interview 37)
Also very open to interpretation and training did not help with this – even at training there was disagreement about the sample cases they used. (Interview 23)

When Structured Decision Making came in they had a visit from DDG [Deputy Director-General] and she was asked how they were getting on with it – she dutifully said that they thought it was great and they all understood it – but she was lying as the training was terrible and did not really help other than tell them how great it was. (Interview 15)

While the above quotes reflect the general attitude of participants toward the initial training, there was an exception:

Did the two days training at zone HQ re SDM and found it useful – main message that needed to be able to understand the definitions otherwise will be used differently. Also that SDM is not the ‘whole thing’ – also have to use own judgement and experience. (Interview 26)

Some commented on a lack of balance in the way that SDM was presented as an approach to practice during the training:

Also mentioned that they had been brainwashed into thinking that practice not possible without SDM and that it did not happen as well as it now does before they got it. Training was very much about how good it was. . . (Interview 17)

Training did not give any opportunity to look at how SDM was developed, nothing critical was mentioned, it was just ‘this is how you use it, so go and do it’. (Interview 28)

Training was very much about how good it was but they did not think the FRET through (people can change). (Interview 17)
Many also commented on the lack of subsequent training that they had been informed would follow:

Did the 2 day training in SDM with SP [Senior Practitioner] last September but there has been no follow up and no opportunity to discuss it with colleagues at other centres. (Interview 28)

Biggest disappointment with SDM is that there has been so little investment in training that goes beyond the initial training. (Interview 1)

The need for further training and the opportunity to discuss use of the SDM tools was also identified by participants:

Would love to know how others are using SDM as there has been no further training or follow up. Perhaps they are waiting for the review by CRC. (Interview 44)

No training since implementation and no feedback sought by the Department about how it is working at the front line. (Interview 32)

Workers who don't like it probably don't understand it and they need more training, in fact everyone does as there has been none since initial training. (Interview 41)

While many participants commented on the need for further training, some did mention that within zones and centres there had been useful sessions convened by Senior Practitioners to discuss use of the tools. Some participants also reflected positively that this research was a process by which the Department was seeking feedback about the tools.

**SDM tools as central to practice**

As described in previous Chapters, the SDM tools are embedded in the ICMS and the *Practice Manual* and COSs have to engage with them, at some level, to conduct
their work. The position of the SDM tools as central to practice in the Department was expressed by one participant as there being:

No room for dissent about SDM within the Department— they have to use it. Also no real discussion as a group about how they are using it. (Interview 40)

For many of the participants who had joined the Department since the implementation of SDM, there was the sense that there was no other way to practice and they relied on SDM:

Wants to cling to SDM because it is comforting and can be used to pull people into line. (Interview 33)

Could not imagine what would happen if there was no more SDM tomorrow, does rely on it to guide her practice. (Interview 29)

Could not do her job without SDM. Second week here she was sent out on an investigation and without SDM tools she would not known what to have done. (Interview 17)

The reliance of less experienced staff on the SDM tools was also seen as problematic by more senior staff:

SDM is a very good tool and it gives new workers something to start with. Shares concern with other senior staff that workers become too dependent on it and believe that absolves them of responsibility – which is reinforced by team leaders having to sign off on everything. (Interview 14)
[New staff] don’t have practice frameworks and knowledge and so use SDM as this. (Interview 21)

The theme of reliance on the use of the SDM tools was further exemplified by the following statement:

If SDM was stopped tomorrow she thinks that there would be quite a few people in this office who would have ‘a special moment’ or a complete breakdown and not know what to do next – especially the [protective] orders team who are very task oriented and always do their SDM tools before meetings etc. (Interview 26)

This statement prompted me to ask subsequent participants what they thought would happen if the decision was made to stop using SDM in the Department. Some echoed the sentiment above:

If SDM was stopped tomorrow, she would not be bothered but some of her colleagues would fall on their arses. (Interview 21)

Others were less concerned:

If it was taken away tomorrow, practice would still continue. (Interview 36)

Some expressed a clear choice about the removal of SDM from the Department:

Given the choice, she would stop using SDM tomorrow. (Interview 37)
As mentioned above, though, these statements need to be considered in context, particularly in terms of who made them. The statements that place SDM as central to child protection practice were made by participants with relatively less experience, with more experienced participants regarding the tools as only part of a larger ‘practice framework’:

Could be part of practice but only a tool. What they do cannot be broken down and reduced to a set of tick boxes – it is greater than the sum of its parts. (Interview 39)

Talked about having a professional framework which comes from her years of experience in child protection. SDM is not the be all and end all – needs to be backed up by professional judgement. (Interview 24)

But SDM does not replace a practice framework, still need something else. (Interview 33)

But SDM cannot tell you what to do, only what to consider – it is not a framework but just a tool. (Interview 3)

The distinction between less experienced staff regarding SDM as their practice framework rather than just a part of it was remarked on by the following participant:

. . . has observed some workers who are too scared to disagree with what the tool says but they do not treat it as just a tool, rather a way of doing things. (Interview 3)
This distinction was also reinforced by a less experienced member of staff who pointed to what might happen for her in the future:

> Could see that, as her experience grows, she would outgrow SDM and not be so reliant on it. Then she might be less likely to use it. (Interview 29)

In identifying SDM as insufficient it itself as a ‘practice framework’, some identified other facets of what was required in a framework:

> Practice wisdom is what workers need rather than SDM – but presumably the people who decided to implement SDM think they haven't got any. (Interview 39)

> She hopes that they will modify SDM as they go along and make it more usable. Main problem they have is the lack of experience in workers and SDM does not make up for that. (Interview 14)

Both of these quotes also challenge the claims made by the CRC about the utility of SDM in organisations where there is high staff turnover and inexperienced staff. They align with the Departmental position that the tools have been provided to assist rather than replace professional judgement. This position was articulated well by the following participant:

> Her world would not stop if SDM was stopped tomorrow but she does like to use guides in her practice – still has one from mid nineties which helps her to articulate rationales. (Interview 21)
In summary, a strong theme emerges from the data that, while SDM is central to practice in terms of its positioning within ICMS and the *Practice Manual*, its centrality to the actual practice of COSs was linked to their length of experience. For less experienced staff, the centrality of SDM to their practice was characterised by a sense of reliance and dependence, while more experienced staff regarded it as only part of a ‘practice framework’. The apparent dependence and reliance of less experienced staff coincided with the theme of SDM as a ‘learning tool’ (as discussed below). A slightly different perspective on this theme suggested that some of the more experienced staff may have had problems with the use of SDM, rather than just adding it to their ‘practice framework’:

SDM seems to be very good for new staff but more experienced staff had a hard time adjusting to it. (Interview 32)

**Focussing and structuring the work**

Participants commented on how SDM focussed their practice in a constructive way:

Purpose for SDM was to assist them to get to the tip of the iceberg – significant harm rather than just harm. (Interview 34)

SDM does provide clarification of types of harm, particularly emotional and sexual (guidance on line between abuse and normal behaviour between children). (Interview 44)

Some participants were concerned that the tools focussed practice in less constructive ways:
Takes the focus away from the child at times, more concern about the boxes that need to be ticked. (Interview 36)

Some participants commented on how the introduction of SDM had helped them to structure their work:

SDM provides structure and the job would be more effort without it – it would also take longer. (Interview 26)

She loved it when it first came in because it gave her a sense of order, told her what to do. (Interview 42)

Quite impressed when SDM first introduced – creates some structure for practice, everyone on the same page. (Interview 41)

Some participants also saw SDM as a form of checklist for their practice:

SDM will help people to pick up on things that they may have missed in the past. (Interview 44)

Positive thing is that it can be used a checklist to ensure that all bases have been covered. (Interview 21)
Another participant went further and described how the tools had gone beyond prompts on paper or a computer screen:

Has internalised some parts of various tools and it is useful as a prompt to ensure that you have collected all the information you should have. Sometimes gets back to families to get info she has missed. (Interview 37)

The structuring effects of SDM also provided other benefits to practice:

Thinks SDM is a good 'rigid' framework as helps to standardise things – some people very lenient, some too strict. (Interview 43)

But while for some, the structuring effects of SDM were positive, some considered that it was too rigid:

Bit too rigid at times – example of child bruised by mother throwing a toy at him – rules too rigid in this case, one of the exceptions, but SDM does not allow for exceptions to be made. (Interview 43)

However the following statement, from the same participant, suggests that rigidity might be locally produced, and it differs from one CSSC to another:

But while it is rigid, it is open to interpretation – she has learned that, in this office, the definition of what constitutes 'serious injury' can be any kind of bruise (as long as there is some physical evidence of injury) – might be different in other offices. (Interview 43)
More generally, there was concern that the rigidity of SDM misled practitioners:

Both [SDM and the *Practice Manual*] make the job very concrete but sometimes wonders where ‘common sense’ is in all of it, sometimes the procedures get in the way and are more important than the child’s interests. (Interview 44)

Rigidity was also problematised by participants in relation to the capacity of SDM to deal with complexity.

SDM has made the focus of the work clearer but she is not sure that this is always a good thing – real life not as simple as the tools make it appear sometimes. (Interview 42)

This was also expressed as one of the limitations of SDM:

SDM tools limited by fact that they do not fit all the cases. (Interview 24)

Other participants were concerned that SDM, in turn, had the effect of limiting their practice and that the reality of clients’ lives rarely fitted into the ordered world of the SDM tools:

Not a big fan of SDM as she does not like to be limited by it – can’t really use a set of rules and tick boxes to understand what is happening in people’s lives. SDM does not deal with the complexity of real lives and they are constantly facing situations which the tools cannot cater for. (Interview 3)
Sometimes hard to fit children’s lives into the tools and definitions. (Interview 28)

Has difficulties when the information she has about a child or family does not fit into one of the boxes. (Interview 37)

Struggling to make the link between what is on file and the tools and the reality for the children he has seen – notably 11 year old yesterday. (Interview 9)

Quite hesitant about SDM when it was first introduced. Concerned that it was not particularly fair on families, many did not seem to fit in with the definitions. (Interview 23)

**Restricted practice**

Participants discussed how use of the tools limited their practice by restricting the processes and information they engaged with:

Does not always agree with the tools and will articulate her disagreement – the tools just don’t include all relevant information sometimes. (Interview 21)

Some participants were concerned that while the SDM tools might assist in the identification of problems, they do not provide guidance about intervention:

Tells you what needs to be addressed, but not how. She has some idea of how you might start to address change in people’s lives but the problem is
that the caseplans are very child centred and they are not the ones with the problems. Emphasis needs to be more on how parents can be helped sometimes. (Interview 33)

Neither does it give any indication that risk can be managed. (Interview 42)

The tools were also considered to be restrictive in terms of how problems faced by children and families are conceptualised:

SDM is too specific, too focussed, everything has to be considered as abuse or not when family life is far more complicated than that and it cannot be reduced – danger is that workers seem to think it can be because they have this tool that tells them that it can. (Interview 10)

SDM does not account for poverty or the cumulative stress of poverty on families. The issue is never addressed or even talked about in the Department. (Interview 13)

Linked to this was the idea that use of the SDM tools restricted what was perceived to be the knowledge required to practice:

Concern that workers do not go beyond the tools to learn about, for example, domestic violence – don’t even read the Practice Papers – SDM gives them this false confidence and they are not using the tools with any real knowledge – don’t realise that they are using some form of knowledge to interpret the definitions. (Interview 27)
Some were concerned that proficiency in use of the SDM tools had become ‘the knowledge’ required to practice:

Tools can give workers a false sense of confidence and security in their decision making as this is not a ‘tick and flick’ job. (Interview 7)

There was also concern that, for many, use of the SDM tools had restricted practice options as it had become a ‘tick and flick’ exercise:

Takes the focus away from the child at times, more concern about the boxes that need to be ticked. (Interview 36)

Workers see SDM as a ‘tick and flick’ form. (Interview 25)

The effects of ‘restricted practice’ were expressed in the following ways:

Many workers admit that they do not know how to ask questions about difficult topics and when they do investigations they only stick to the allegations – don’t even know that perhaps they might need to go beyond what is presented to them. (Interview 25)

But the tools are leading to a dumbing down of what they are doing – very concerned that it might get worse in the future with the new strategy to recruit teachers and nurses etc. (Interview 5)
A different perspective on the restrictive effects of the tools was expressed in relation to organisational reality rather than clients’ lives, and again casts doubt on the ability of SDM to promote ‘consistency’ in decision making.

One thing that SDM tools do not capture is the context for practice – technically a case might screen in but reality is that they will not be able to respond or just would not. (Interview 24)

The need to fill in the tools and move cases on through the system was important in all the CSSCs visited and it appeared, at times, that COSs and Team Leaders were required to make decisions more quickly than they felt they should:

SDM also makes her make decisions about a case before she really feels she is able to – would like to do several visits sometimes to really understand what is happening in a family. (Interview 37)

The use of SDM – interpretation and knowledge

Participants identified two key factors which affected how the SDM tools were used. The first factor was knowledge in terms of what knowledge and experience that COSs brought to the task of using the tools. The second was ‘interpretation’, in terms of how the definitions of abuse and neglect were interpreted in the process of using the tools.

One participant noted how COSs with different professional or tertiary education backgrounds differed in how they used the tools:

Identified that knowledge does affect how people use the tools – particularly what degrees they have. (Interview 17)
In addition to commenting that knowledge was required to use the tools, participants also pointed to a lack of knowledge, again emphasising the point made above that SDM was either replacing knowledge or becoming 'the knowledge':

Agreed that need knowledge to be able to apply it – in itself the tool is not enough but is being considered as such in offices where they don't appear to have any choice but to employ inexperienced people. (Interview 2)

Agrees that it requires knowledge to use and that this is something many of the workers lack. (Interview 25)

The definitions within the tools are quite terrible and do rely on a lot of knowledge to apply, which is where newer workers come unstuck in interpreting them wrongly. Newer workers also don’t use it as a guide to professional judgement – they take it literally.

(Interview 21)

While some participants criticised the SDM tools themselves, some commented that the problems with using them were more about how the tools were used:

Limitations also about the way it used rather than the tool itself. People use the definitions too narrowly or too broadly. Other forms of knowledge need to be used, ie child development etc. (Interview 24)

Part of the way that the tools were used concerned the way that the definitions of abuse and neglect were interpreted by COSs:
Also very open to interpretation and training did not help with this – even at training there was disagreement about the sample cases they used. (Interview 23)

The process of interpreting the definitions within the tools also affected by the knowledge that COSs had:

Much of the way that SDM is used comes down to interpretation and what knowledge and attitudes you bring to the job. Example of 13 year old girl having sex with 20 year old – is this sexual abuse or is it failure to protect (SDM initially said the latter in screening tool but she felt it should be sexual abuse)? (Interview 26)

Some of the less experienced staff identified their lack of knowledge and were taking steps to gain knowledge to help them use the SDM tools. More broadly, they were keen to understand more about what might be happening in the lives of the children they were dealing with (as mentioned in Chapter Five). The following quote exemplifies the attitude and efforts of some of these COSs, though the lack of support for their efforts is notable, in that it suggests that the Department perhaps considered that SDM was ‘the knowledge’ and nothing more was required:

In order to interpret the tools she uses all sorts of knowledge. Previous cases she has dealt with and also uses departmental and external resources – actively seeks out research etc. She is one of only two people at this office who have internet access and research is what she uses it for. Also tries to seek out training to attend – none of this supported by the Department but at least they do not try to stop her (unlike at previous office). (Interview 23)
As a tool for staff development

In contrast to the statements made that use of the SDM tools tended to restrict the knowledge that was perceived to be required for practice, some also saw the potential for SDM to be used as a tool for staff development. Some participants described how there had been interesting debates about how to use the tools and interpret the definitions when the tools had been introduced:

Only consistency she has seen has been within this office and that is because of the senior practitioner – she has been very supportive and active in promoting SDM – frequently challenges workers to think and she encourages debate about it. (Interview 33)

This debate though had subsided with time as SDM became more familiar:

But SDM is now slipping off the agenda so new workers would not get the same experience and so would not have the opportunities to learn so much about it. (Interview 33)

Reflecting the statements above about how the tools might restrict practice and the perception of what knowledge is required to practice, some participants considered that SDM restricted the development of staff:

Re SDM – good for inexperienced staff but it does not help them to develop analytical skills – just breeding workers who are good at ticking boxes and deskill the more experienced. (Interview 31)

SDM and all the other forms and procedures deskill workers (not that the people they are recruiting actually have any but SDM does not facilitate the development of any) – very poor assessment and intervention skills. (Interview 8)
From the statements made above, it appears that the SDM tools, when they were introduced, stimulated debate among staff about how they might be applied in practice. They provided what some considered to be much needed focus and structure to their work, which was, and continues to be, important to new and less experienced members of staff. For new staff, the tools also provided a starting point for their development of knowledge about their work. As time passed though, the more negative effects of using the tools became apparent to more experienced staff. The tools began to restrict practice through the rigid nature of SDM as a framework for practice, particularly as staff found that they were sometimes difficult to apply to the situations of the families they were dealing with, at least in any way that was helpful. The tools also became restrictive in relation to the knowledge that more experienced staff considered was required to practice, though some of the less experienced staff also realised that they required more knowledge than that provided by SDM. It also appears that, given the lack and poor quality of training about SDM during its implementation and the subsequent lack of training (identified by many participants as an important need), there is an organisational belief that the tools, in themselves, are sufficient and (as promised by the CRC) straightforward to use.

Making decisions

As mentioned in Chapter Three, the Practice Manual makes it clear that the SDM tools should not replace professional judgement but they that they should be used to assist decision making. Some of the more experienced participants were clear that this was how the tools should be used:

Uses tools only as a guide, something to be taken into consideration.  
(Interview 34)

Likes SDM – can be quite useful as a guide to decision making. Uses it to guide her thinking rather than as a prescriptive tool. Makes her think about
why she is making a decision and makes her provide a rationale if she disagrees with a particular tool. Also uses the tools as a checklist to ensure that she has taken everything she should into consideration. (Interview 21)

SDM is useful as it provides a platform for making decisions. But she does not use it as intended, uses professional judgment to assess a case and then uses tools to see if they agree with her. (Interview 24)

This statement also suggests that use of the SDM tools is not necessarily a part of the initial process of making a decision, rather that they are applied after the decision has been made. Some participants made it clear that they used to tools only after they had made a decision:

Already made their decisions before they use the tools. (Interview 7)

There was some suggestion that use of the tools after a decision had been made was a practice of the more experienced practitioners:

People who are experienced in the field only apply it after decision made because that is what they have to do. (Interview 28)

But use of the tools after a decision has been made may not have been confined to the more experienced practitioners. The same participant went on to say that she was also:

Concerned that some people just use the tools to confirm what they already thought. Also concerned that they are not using any professional framework
when they do this, just personal opinion based on personal values.  
(Interview 28)

The reason why decisions were made before using the tools was explained by one participant:

Most of the time they have to think on the run so make decisions without using the tools. Fine point about whether their thinking is affected by the tools anyway – but in serious cases then common sense takes over anyway.  
(Interview 13)

The above point relates not only to the pressures felt by busy practitioners but also to the physical location of the tools in the ICMS and the Practice Manual, neither of which are readily available to practitioners when they are out of the centre interviewing children and parents. As mentioned above, though, some participants described how the tools had become integrated into their thinking by repeated use and developing familiarity. The following statement was made in relation to how the tools were used while practitioners were out of the CSSC:

Tend to have made up their minds before they use the tools. Have to be aware of how to use the tool to get the outcome they want. (Interview 41)

This statement also points to the process of anticipating what outcome the tools might give, and of another theme, which was the deliberate manipulation of the tools to get the desired outcome:

Have to manipulate SDM tools to get what you want and get it to say what you want it to say. (Interview 36)
SDM can be manipulated to give you whatever outcome you want, especially the safety tool. Just a matter of ticking or not ticking a particular box. (Interview 32)

Has observed how the tools can be manipulated by workers to give the answer they want – gave example of worker who did not like dad so got the tool to indicate long term care, when the opposite was the case when she really looked at the case and used the tool differently. (Interview 27)

The finding that COSs were deliberately manipulating the tools to get the outcome they wanted, having already made their decision, emerged strongly from the beginning of the fieldwork. COSs showed me how to fill in the FRET so that certain scores would be produced and a certain risk level ascribed and how to go back through the form and tick or untick the answers to questions. During this process, I asked participants what they did if they did not know the answer to a particular question in the forms and some said they would make an ‘educated guess’ and others said that if they did not know, then they would just tick ‘no’.

The process of how decision making had changed over time and with the implementation of the SDM tools was reflected on by one participant:

Maybe it has helped him to make decisions, but not as much as consultation and discussion, which though it still goes on is far less than it used to be. (Interview 7)

This experienced practitioner lamented that the level of discussion about cases had dropped since SDM was implemented and that there was less discussion than in other jurisdictions that he had worked in. The SDM tools had, for this participant, replaced an essential part of the decision making process. For a participant who had
only recently started as a practitioner, the role of the tools in the process of making decisions had become confused as he learned that other factors also affected how the outcomes of the tools were reached.

Still trying to find his way through SDM tools and definitions – thought it was straightforward until this morning when he is now being expected to change an assessment in response to workflow pressures and staffing within the office. (Interview 9)

For some, though, the SDM tools had little, if any, place in the process of decision making:

Workers seem to like SDM but they have had a lot of change to adjust to – mainly complain about the amount of admin they have to do and SDM can seem like just another form they have to fill in. (Interview 40)

As discussed in Chapter Three, there is some evidence to suggest that in some jurisdictions in the USA where the SDM tools have been implemented, some practitioners have chosen not to use them (ACNJ, 2004). Some of the statements mentioned above by would suggest that many of the participants in this research would make the same choice, however, such a choice is not available to them as the SDM tools are embedded in the ICMS and they cannot avoid using them. From the above statements and my observations, practitioners who used the tools to assist in the process of decision making were in the minority. It appeared to me that most of the time, the decision had already been made before using the tools. For some, even though they had already made a decision, engaging with the tools in the ICMS was a useful process as it helped them to clarify, reflect or even change their decision. For others, though, if the tools provided an outcome they disagreed with, they would manipulate the tools until they provided the outcome they wanted. Some could
anticipate the outcome of the tool to the extent that their use of it would always produce an outcome with which they agreed.

The descriptions of practice regarding the use of the SDM tools to assist decision making provided by the participants, while they coincide with my observations, perhaps hide a more subtle way in which the tools were part of the process. As already stated, practitioners have to engage with the tools to record their work (an important part of practice, as mentioned in Chapter Five), so even if they do manipulate the tools and anticipate the outcome, the tools have to be part of their thinking when making a decision. While the tools can be overridden, this was rarely mentioned by participants. One described how she frequently disagreed with the outcomes of the tools and used the override function, most of those who mentioned this function expressed a reluctance to use it. This reticence is perhaps related to another way that the tools were perceived to be used by the Department, which was as an ‘accountability tool’.

SDM as an accountability tool

In Chapter Five, the ICMS and the importance given to case recording emerged as a strong theme, particularly in relation to how accountability for actions and decisions was demonstrated within the Department. As the following quotes show, the SDM tools were considered to be part of this process of demonstrating accountability:

Accountability is a central part of the SDM system. Only difference she has seen in the Department since the changes is that they have more people looking over their shoulders now than they did in the past. (Interview 23)

Admitted that the main reason she is making the effort is she recognises that SDM is being used as yet another accountability tool – if something goes
wrong on a case then have to show that it has been used correctly. (Interview 20)

Problem is not SDM but more how it is used. More about the bureaucracy and has become an accountability device. He sees it as a guide, something that can channel practice. (Interview 6)

Accountability as part of using the tools also eclipsed their use as an aid to decision making for some managers:

Also stresses to workers that they need to use them in order to cover themselves if things go wrong – show that they have done the ‘right thing’ by the procedures whatever has happened – underlying assumption that the tools and procedures are ‘a good thing’. (Interview 24)

For practitioners rather than Team Leaders or Managers, the tools were also considered as a form of protection:

Offers comfort to some who use it as a shield to hide behind. (Interview 7)

Use of the tools was also considered as a means to distance practitioners from their decisions:

SDM takes responsibility away from them (the tools made me do it). (Interview 21)
This view about the ability of the tools to absolve practitioners of responsibility was expressed by a relatively inexperienced practitioner. It was also mentioned by senior staff in relation to how they had perceived the attitude of some of their staff toward the tools, though the naiveté of such a position was also articulated. If something went wrong on a case, the more senior staff argued, the question would not just be about whether the tools had been used, but whether they had been used properly.

**Consistency**

As explained in previous Chapters, the need for consistency in decision making identified by the CMC Report (2004) and the Blueprint (2004) was matched by the claim of the CRC that SDM would promote consistency. Participants also considered that consistency was important, especially those who had moved from one centre to another and been surprised to find that practice was very different:

Department should be like MacDonald’s – expectation should be that when you go into an office and ask for a cheeseburger it will be the same wherever you go. (Interview 17)

Need consistency as it is not fair to families that they might get one response from one office and if they move to another suburb they get a different one. No idea how this could be achieved though. (Interview 32)

Plus they do need some consistency in practice – particularly between the offices – both for clients and other agencies who are constantly making comparisons and complaining that another office would or wouldn’t have done something for them. (Interview 17)
For at least one participant, SDM was considered as a means to achieve consistency:

SDM is a step toward consistency and that is great. It provides really good guidance to people who are new to the Department and child protection, particularly about what constitutes risk. (Interview 28)

However, for staff who had moved from one CSSC to another and Team Leaders who dealt with case transfers from other centres, SDM had done little, if anything, to promote consistency:

Huge differences between service centres – some things go from one extreme to another – a P1 [notification requiring a response within 24 hours] from another centre might only be a CCR [Child Concern Report not requiring a response] if she accepts it in this office. (Interview 34)

Huge differences between how different offices use the tools. (Interview 32)

Started in Department before SDM and could see the need for it but has not worked out as promised in terms of consistency or making the job any simpler. (Interview 11)

The main reason why SDM had not promoted consistency was that practitioners were not using it consistently between centres, teams and individuals:

SDM is a good thing but it is not used consistently even within this office. Not hard to misinterpret the definitions and it requires a lot of concentration to use it properly. (Interview 26)
Never will get consistency through using a tool because everyone uses it differently – also questions the need for consistency given the range of things they deal with – need flexibility. (Interview 3)

Lack of consistency in how the tools were used was baffling and frustrating for some participants:

Tools are guided by the definitions – quite baffled as to how people still don’t get it right. They have been kept on track by their senior practitioner. (Interview 33)

Experience is not a factor as there is only one right way to interpret the definitions and use the tools. The definitions are very clear. (Interview 33)

Part of the reason for the inconsistent use of the tools was offered as:

SDM tools supposed to promote consistency but they do not – just get used by workers and team leaders to promote what they consider to be abuse and harm etc. – example of team leader who considered that all sexual abuse cases must be substantiated. (Interview 4)

Other reasons (experience, knowledge, personality, values) were offered as to why the tools were not used consistently, which relate to the points made above about the factors which affect how the definitions within the tools are interpreted by practitioners:
Big influence on how it is used is personality and personal values. (Interview 33)

Little consistency in how it is used because of people’s different experiences and knowledge because this impacts on how they interpret the definitions within SDM – particularly words like ‘cruel’ and ‘usual’. (Interview 34)

As mentioned above, there was also the way that the definitions within the SDM tools were interpreted that led to inconsistency:

But it is open to a lot of interpretation and need to keep consulting the definitions – some workers get a bit blasé about this and this might be why they do it differently. (Interview 16)

As mentioned in previous Chapters, every decision made by a CSO has to be approved by a Team Leader and so, for some participants, any consistency that did exist related to the role of Team Leaders:

The only consistency that exists in this office is her as team leader because she has to approve everything. And her workers know that she will demand a professional rationale for their decisions, not just that the tools say they should do something. (Interview 34)

Since everything has to be approved by team leader, then it becomes her thresholds rather than those of SDM which determine what gets in and what stays out. (Interview 35)
Frequently workers at the front end fill in the tools by trying to second guess their team leader as they have to approve it. They are so busy that they cannot afford the time to disagree with the team leader. (Interview 27)

There was, however, inconsistency between Team Leaders, which, as the following quote shows, could lead to some very different outcomes:

When they got a new intake team leader last year for a while, notifications went down to about one a week instead of 9 or 10 – then went back up when original team leader came back. (Interview 4)

That there was little, if any, consistency in the way that the tools were used, or the outcomes came as no surprise. Previous research in child protection agencies has shown how practice differs from one office to another, despite the presence and mandated use of detailed procedures and prescriptive legislation (for example, D’Cruz (2004)). This finding is significant, though, given that the Department acknowledged the need for consistency as a priority and then purchased and implemented the entire suite of SDM tools as a means to meet this need. The finding of this research would suggest that, so far, there is little, if any sign that, consistency in practice, either in the process of decision making or service response, has been achieved.

There is an important distinction to be made between inconsistency in the ways that the tools were used and the outcomes achieved through using them, such as thresholds for intervention. It could be argued that, at the time the fieldwork for this research was conducted, it was, as yet, too soon to expect that SDM, as an approach to practice, had been fully absorbed into the culture of the Department. Therefore it would be reasonable to expect that practitioners would not be using it consistently yet but that, with time, greater consistency of use might be achieved and this would lead to greater consistency in outcomes in service delivery. However, the
opposite might also be true given the experience of jurisdictions in the USA (mentioned in Chapter Three) and the statements of participants that indicate that enthusiasm for SDM is waning and that, as experience grows, their (apparent) reliance on it diminishes.

**Use of the SDM tools – the official version**

During the second round of data collection, the Annual Report 2006-07 of the Child Death Case Review Committee (CDCRC) (Fraser, 2007) was released. The report is a review of all children, known to or involved with the Department who died during the reporting period and it identifies various areas for change and development in service delivery. Of particular pertinence to this research, the Report makes the following statements about the use of the SDM tools. SDM tools had been applied in 46 of the 62 cases considered in the report but “(i)n 57.0% of these cases the CDCRC identified concerns of varying degrees about the department's use and/or application of SDM” (page 34). The report goes on to list these concerns as:

- The SDM tools were not used at all to assess information
- Relevant information required to accurately assess risk using SDM was not sought and/or interpreted in a manner which was compatible with SDM
- The discretionary override option was not considered and/or used, even when professional judgement ought to have raised doubts about the sufficiency of the SDM outcome
- There was evidence that the SDM tools were not always completed correctly or contemporaneously
- All harm types had not been included in the screening tools
- The SDM response priority tool had not been selected appropriately, resulting in a 10 day response time frame rather than a 24 hour time frame
- There were delays in the electronic recording of the completed SDM tools
• The Safety Assessment was not documented within 72 hours of the decision being made, as required by the Child Safety practice Manual, or it was found not completed at all
• the Family Risk Evaluation either was not completed or was completed prematurely, and in some cases was not completed until after the child had died, and
• the Child Strengths and Needs Assessment was not approved and/or did not address particular risk factors. (page 34-35)

Clearly many of these ‘concerns’ relate to and are reflected in the findings of this research. They also hint at certain assumptions, which could amount to unstated conditions about how the SDM tools should be used and again there is a disjuncture between this and how they are actually used. For example, participants in this research rarely mentioned the professional over-ride option, with some saying they only hardly ever use it. Participants were more likely to manipulate the tools than over-ride them.

Chapter summary

According to the participants, when SDM was implemented, it was promoted within the Department as a set of tools that would assist greatly with improving their practice. In Chapter Five, the relative inexperience and lack of professional qualifications of staff who had joined the newly formed Department of Child Safety since its creation was highlighted in considering the context for practice. The initial promises of SDM to provide a framework for practice and promote consistency were met with optimism by this group of staff. However, the initial training of two days was considered inadequate and insufficiently critical in its approach and, though it was intended that it would be supplemented by Senior Practitioners at individual centres, there has, for most COSs and Team Leaders been little, if any, follow up training.

For some participants, particularly those with less practice experience, SDM, as an approach to practice, has become central to their practice and they have come to
rely on it. For them, SDM provides structure for, and focus to their work. SDM was considered as useful as a learning tool for the development of new staff, but it could only take them so far in developing what more experienced staff defined as the knowledge required for competent practice. Given the centrality of the tools to practice for some staff, more experienced staff were concerned that SDM could, by being regarded as ‘the knowledge’, lead to a ‘dumbing down’ of practice. More experienced participants regarded SDM as only part of their practice framework and were concerned that newer staff were apparently reliant on SDM. They also felt that the SDM framework was too rigid and tended to restrict their practice. Both less and more experienced staff commented on the difficulty of using the tools and applying them to real life situations and some considered that they oversimplified the complexities of dealing with child maltreatment. The ‘tick and flick’ nature of the SDM forms added to this view about SDM. This difference in attitude toward SDM as a practice framework or as a part of a more extensive knowledge base between less and more experienced staff raises the question of whether, as experience grows, staff become less dependent on SDM. There was evidence that some of the less experienced participants would ‘outgrow’ SDM and become less dependent on it as their experience grew. There was also the sense that use of the tools over time had led to practitioners becoming disenchanted with them as their shortcomings emerged, which is discussed further in the next Chapter.

Despite the descriptions of some participants of SDM as central to their practice and their reliance on it as a framework for practice, the extent to which the tools were used to assist in decision making was questionable. Participants described having already made a decision before using the SDM tools. Some participants described and demonstrated to me how they manipulated the tools as they filled out the forms so that they got the outcome they wanted. Others disregarded the outcome of the tools and justified this by providing a rationale for not following the recommended action (discussed further in Chapter Eight). More experienced participants could articulate how they used the tools to assist their decision making in line with the guidance from the Practice Manual, as a ‘checklist’ after they had already made a decision, but there was no evidence that this led to a change of decision.
Accepting the accounts of the participants of their manipulation of the tools and their disregard for the outcomes of applying them at face value perhaps underestimates the influence the tools were having on the process of decision making. There was some evidence to suggest that the basic concepts of the tools, such as what constitutes significant harm, had become a part of practice as participants had internalised the concepts. An important factor in this process of internalisation is that COSs and Team Leaders are compelled to use the tools and so, as they do their work, they have to anticipate how they will fill in the tools when they come to record their work. Even if they have not anticipated how they would fill in the tools, this inevitably becomes the way in which their work is presented in the casefiles, a theme which is explored further in Chapter Eight.

The aim of achieving consistency in decision making and service response between individuals, teams and centres, as initially promised with the implementation of the SDM tools did not seem to have eventuated. Participants pointed to the different ways that the SDM tools were used in different teams and CSSCs and to the process of interpretation required to apply the definitions within the tools to the situations they were dealing with. An important influence on how they were used was the perceived level of pressure a particular centre might be under from numbers of contacts (which is discussed further in the next Chapter). Participants also pointed to a range of factors at a more individual level which affected how SDM was used, such as level of experience and qualification (both of which are important parts in the knowledge individuals bring to practice), personality and attitude. The factors which affect how SDM was used are discussed further in Chapter Nine.

Two unstated conditions emerge from the statements made by practitioners about SDM as a framework for practice. Firstly, SDM was an accountability tool rather than a decision making tool. Participants described how they would be held accountable for whether the tools had been used and how they had been used. The attention given to the use of the tools in the CDCRC Report (2007) appears to support this
view; the implication of this attention within the report to how the SDM tools were used is that, had they been used ‘properly’, then the outcome for the child may have been different. Secondly, for some participants, the SDM tools, embedded in the ICMS, were another set of forms to be filled in and, as such were an administrative burden.

In this Chapter, the unstated conditions of the use of SDM as a framework or approach to child protection practice have been articulated through a thematic analysis of statements made by participants during the interviews. In the next Chapter, the process of articulating the unstated conditions of SDM use is continued, focussing on the participants’ descriptions of how they used individual tools.
Chapter Seven: Use of the SDM tools: the Unstated Conditions

Introduction

As described in earlier Chapters, this research focussed on the intake and investigations stages of child protection practice in the Department of Child Safety. During these stages, COSs and Team Leaders are required to use the SDM Screening tool, Response Priority tool, Safety Assessment tool (and Safety Plan) and the Family Risk Evaluation tool (FRET).

In the last Chapter, the statements made by participants in relation to SDM as a framework or approach to child protection practice were organised according to themes and presented as part of the process of articulating the unstated conditions of the use of SDM. In this Chapter, this process is continued in relation to how participants specifically used each of the four tools.

The Screening tool

As explained in Chapter Three, the Screening tool is used to determine whether a contact containing information about a child is recorded as a notification, which requires investigation, a Child Concern Report, which does not require any further action or as a ‘contact’. Every contact is screened using the SDM tool which is a page within the ICMS that contains a list of brief definitions of various forms of child maltreatment (see Appendix 1). These brief definitions are linked to more detailed definitions in the Practice Manual. For a contact to become a notification, the intake worker has to tick at least one of the boxes within the tool and then provide a rationale for having ticked the box.

Many of the intake workers’ initial statements about the Screening tool were positive. They liked the fact that it gave some focus to their decisions about whether to open a case or not. However, discussing with them how they did their job, observing them
doing it and reviewing files revealed that there were several influences on how they did it. While these influences are separated out for discussion below, each is very closely affected by and linked to the others.

**Restricted information**

The first influence was what information Intake workers used to make their decision about whether to record a contact as a notification. While some reported that they sometimes might phone agencies that know a particular child to get additional information, this was not a general practice as much of the time they were too busy to do so. There was little evidence in the files that supported this practice:

Also massive differences [between CSSCs] about whether pre-notification checks are done and the ways in which they are done – deep and shallow information. (Interview 4)

Consequently they made their decision based solely on the information provided by the notifier.

[Participant] kept saying that they can only go on the information they are given – admitting that they do not go looking for information. (Excerpt from Field Diary)

Clarification of the information provided in a contact was sought through the questions asked of the notifier by the intake worker in the case of phone calls or ‘pop-ins’, and this process of questioning was very much directed by the definitions within the SDM tool. Information about a history of previous involvement with the Department was also considered and, in one case (as explored more fully in Chapter
Eight), was used to elevate an accidental injury to a potentially serious episode of physical abuse.

The intake workers were also reticent about making inferences from the information provided by a notifier. Again this is explored further in the next chapter, but was explained as follows by one of the intake workers:

Reflecting on all of this, [participant] said that unless there was direct evidence of actual or a risk of physical or emotional harm, it would not get past the team leader and be screened in as a notification. So, children just witnessing DV over a period of time (as long as it is not ‘escalating’ in severity or frequency, but how would they know?) is not enough to screen it in. This is because they have so many that they would never get around to dealing with them. (Excerpt from Field Diary)

The intake workers in all the CSSCs visited reported that they dealt with large numbers of domestic violence reports from the police and sometimes phoned the referring police officer involved to clarify points, but as one worker commented, they do not go looking for work and they could not respond to every incident of domestic violence that the police report to them.

Interpretation

The second major influence in their decision making and use of the screening tool was how they interpreted the definitions, and this a recurring theme in discussions about all four tools. The workers described how the definitions of child maltreatment and what constitutes risk to children were interpreted differently, by different workers in the same CSSC and between different CSSCs.
Evidence that the definitions were not easy to apply and open to a fair degree of interpretation were what workers referred to the ‘great debates’ that occurred about whether a particular case should be accepted as a notification. As one participant pointed out, if the definitions were clear and easy to apply, then there would be no need for debate and there would never be any disagreement between her and her Team Leader. Team Leaders also reported that sometimes it was difficult for them to understand how definitions had been interpreted when they were reading through the files of cases transferred from another CSSC and again this was not limited to the use of the Screening tool.

Knowledge

An important dimension of how the definitions were interpreted appeared to be the knowledge that was used, for example, knowledge about the dynamics of domestic violence and child development, especially given the lack of experience and specific qualifications of many of the COSs. One Intake worker showed me how she sifted through up to twenty ‘DV reports’ from the police each week and made decisions about which to ‘screen in’ as notifications. During the discussion, though, she admitted that she had no specialist knowledge about domestic violence and its effects on children, neither had she received any training or even read the ‘Practice Paper’ in the Practice Manual.

Demand

A particularly strong influence on how the Screening tool was used was how busy a particular CSSC actually was. In the busier offices some referred to what they considered to be a ‘siege mentality’, feeling that they were inundated with notifications:
And so their use of the tools is dictated, to an extent, by what she refers to as the resources they have. (Interview 35)

An imperative to screen cases ‘out’ rather than ‘in’ seemed to be operating in five of the six CSSCs that were part of this research. In the least busy CSSC, an intake worker commented that she accepted some notifications because ‘the girls wanted something to do’ (referring to the IA workers):

Process of thinking confirmed by worker, but added that they were not busy that week – on a busy week that might have been a CCR. (Comment by participant, excerpt from Field Diary)

Conversely, in busier CSSCs:

Used to work in [another CSSC] where it was much busier and there she used the tools differently – there was no point in screening in things up there that she would here because they would just never get to them anyway. (Interview 21)

Making decisions and ‘gatekeeping’

For most of the intake workers, particularly those who were more experienced in the role, the decision about whether to screen a contact in as a notification was made before they used the Screening Tool. Some described how they made a ‘judgement call’ before they even started to record a contact on ICMS.

Using the screening tool – very much about whether you want to screen it in and the way you interpret the definitions. (Interview 22)
The task then became choosing which box to tick. But it was the rationales that they recorded for the decision that were described as more important than which box they ticked, especially in busier offices when the intake worker was recommending an investigation. One participant described the Screening tool as a good tool for screening out most of the contacts the department received and justifying inaction.

Emphasis on screening things out rather than in – can only deal with the serious stuff otherwise they would be ‘snowed under’. (Interview 35)

This was also reflected in statements about the Screening tool either being too general in its definitions or too specific in that it does not account for all the circumstances or occurrences that could lead to harm to children. Participants mentioned a process of comparing the details about the information contained in a contact and the definitions and trying to fit the case to the definitions so that it would ‘screen in’. Several mentioned the need for there to be some ‘concrete’ information in the contact for it to be able to be screened in, that is, some evidence that a child had been harmed. One participant reflected that, because of the need for some ‘concrete’ information, contacts from professionals such as teachers were more likely to be recorded as notifications than contacts from people in the community. Teachers, and others who were used to dealing with the department, would phone having anticipated the questions they would be asked by the Intake worker and provide some ‘concrete information’. The information provided by community members was more likely to be vague and lacking detail and so less likely to result in the recording of a notification.
The Response Priority tool

Once a contact has been recorded as a notification, the Intake worker is automatically directed to fill out the Response Priority tool in the ICMS. Having ticked the appropriate box (or boxes) the tool then gives the notification a response priority rating of 24 hours, five days or ten days.

Manipulating the Response Priority tool and achieving the desired response

Participants described (and demonstrated to me) how this tool can, and is, manipulated, to give the response desired.

Not sure they actually need the Response Priority tool as there are not enough investigations to have to make decisions about which should be first. Usually her colleagues are asking her for work as there is so little to do. But she does them anyway because she likes them. She likes them because they can be so easily manipulated – a ‘one day’ can be turned into a ‘ten day’ very easily, and vice versa. Very flexible in terms of interpreting the definitions and how you use it. (Interview 43)

If the tool was used as intended and without ‘manipulation’, then:

Hardly ever get a 5 day response – either 24hr or 10 days (Interview 28)

Re response priority– most things screen as either 24 hour or 10 days, which is ridiculous, she uses the over-ride to make it 5 days sometimes. Particular problem with sexual abuse which always screens as 24 hour. (Interview 34)
Rather than manipulate the tools, some participants reported that they used the over-ride function within the tool to adjust the response time:

Only used manual over-rides when she has covered intakes and then only with response priority – they knew something about a family which meant that response should be quicker than SDM indicated. (Interview 26)

The desired response appeared to be mainly a function of how busy the IA (Investigation and Assessment Team) team might be, at a particular time. While some responses could only be 24 hours, participants described how there was more scope for manipulation with the five and ten day responses and so the response allocated might well be derived from the worker’s sense of when the IA team had the capacity to investigate, rather than a strict application of the Response Priority tool.

It was also explained to me that the only response priority that anyone takes any notice of is the 24 hour. The five and ten day required responses are therefore fairly arbitrary. What was driving this manipulation of the response priority was the need to comply with ‘key performance indicators’ about whether cases were investigated in time, described as the need to “keep the stats looking good”.

Each CSSC takes notifications for other CSSCs if a notifier phones the wrong CSSC, rather than referring the notifier to the correct CSSC. But in taking a notification for another CSSC and filling out the Response Priority tool, Intake workers have to take into consideration which CSSC they will be transferring the case to, as shown in the following excerpt from the Field Dairy:

Observation – Team leader and intake worker trying to fill out response priority so that it comes out as 5 day rather than 1 day. Reason being that they know that the office to which it has to be transferred has already had 4
P1’s [contacts that require a response within 24 hours] today and they will not be able to get to it today and that will make their stats look bad. Worker also knows that child will not see father for access until weekend, so included that in the section on whether there is a protective parent (presuming that mum knows re disclosure and won’t let dad have contact before his time anyway). Also had to fax it to police and they may just want to deal with it immediately anyway. (Excerpt from Field Diary)

Team Leaders also described how they would be surprised at the response priorities allocated by workers in other CSSCs when cases were transferred and how they would change the priority, sometimes from a 24 hour to a ten day.

Huge differences between service centres – some things go from one extreme to another – a P1 [notification requiring a response within 24 hours] from another centre might only be a CCR [Child Concern Report not requiring a response] if she accepts it in this office. (Interview 34)

This demonstrates that there were different rules or unstated conditions in different offices about what constituted a notification requiring a certain response priority.

The Safety Assessment Tool and Safety Plans

As described in Chapter Three, the Safety Assessment tool is supposed to be completed by a CSO within 24 hours of an initial visit to a family. Three outcomes are possible in that the child can be assessed as ‘safe’ which requires no further action, ‘conditionally safe’ which requires that a Safety Plan be prepared or ‘unsafe’ which requires that the child be removed from the care of parents.
Emphasis on safety

The introduction of the Safety Assessment and Safety Plan was seen as a positive move by some participants:

Removal rates did initially drop as workers got into ‘safety planning’ with families and tried to draw in resources to support families but she has noticed how this has dropped off more recently. (Interview 27)

In particular, the introduction of the tool shifted attention to working with families to protect children:

Positive about ‘safety assessment’ – internalised this plus really good that they have to get a plan signed off with parents. (Interview 23)

Safety Assessment only really useful for working out a safety plan with parents – helps to articulate the concerns and what needs to be done about them. (Interview 43)

As mentioned above in the more general statements made about the SDM tools, the Safety Assessment tool was considered as a good checklist:

Safety assessment – good checklist to ensure that haven’t forgotten anything but since it is done after the event then it becomes less useful. (Interview 22)
But the tool sometimes conflicted with the intuitive reasoning of practitioners:

Re safety assessment – does use this with families but recent case sticks in her mind. Went through tool on her own and then with team leader and both times it said the child was safe. However she felt intuitively that this child was not safe. Mother saying all the right things about how she would protect the child from father’s violence and she did not doubt this woman’s willingness. However she did not trust the father to keep to his end of the bargain and consequently questioned the mother’s ability to protect. But she was not able articulate this at the time. . . the tool told them that the child was safe and so no safety plan was formulated. (Interview 29)

Another felt that COSs should be focussed on protecting children without the need for a tool:

Re Safety Assessment – if people actually need to use this to make their decisions then they should not be working for the department. (Interview 21)

After the event

This last statement also points to a problem that several participants mentioned which relates to how the Safety Assessment tool was used, specifically about when it is used. Participants were concerned that the ways that they could use the tool had changed since it had been first implemented, prior to the ICMS and, in particular that it was only used after COSs had completed interviews:

Re Safety assessment – don’t do this with families anymore – she used to take the forms with her and get families to sign off on them – not sure what the workers are doing now. (Interview 16)
The following participant explained how and why the ways the Safety Assessment was used had changed over time:

Went on an [investigation] with [participant]. Interesting point about the safety assessment – used to take forms with them and do safety plans with parents but no longer allowed to or able. The forms used to have to be signed by team leader and included all forms of abuse which freaked parents out. Now they have to fill the forms out when they get back to the office because they are embedded in the ICMS system and cannot be printed out. So gone from a tool that might have been useful with parents to just another accountability tool. (excerpt from Field Diary)

Workers are using the tools as intended although safety assessment not always completed within 24 hours. Questioned the utility of the Safety Plans which are embedded in ICMS and so cannot be filled in with families. (Interview 10)

But while the tool may have not been available to use with families during the process of an investigation, one participant could still see how the tool affected practice in a positive manner:

Safety Assessment forms also rarely used at the time but workers would have the immediate harm indicators in their heads anyway and would then use the forms if they had to do a safety plan. (Interview 44)

At the other extreme, it was also subject to manipulation and considered as a ‘tick and flick’ exercise:
SDM can be manipulated to give you whatever outcome you want, especially the safety tool. Just a matter of ticking or not ticking a particular box. (Interview 32)

As an accountability tool

As suggested above in the excerpt from the Field Diary, the Safety Assessment tool was also considered to be an accountability tool:

Reflected on how she uses the safety assessment (only to cover her arse when she gets back to office). (Interview 12)

Discussed safety plans and how they are more about protecting the worker than the child – in real life they actually mean nothing for much of the time – ie getting mum to sign an agreement that she won’t let dad back for the weekend if he is discharged from hospital. (Interview 20)

This last quote also reflected the concern for this participant that, at times, Safety Plans could give practitioners a false sense of security. Elaborating on the above scenario, she described how she had prepared a detailed Safety Plan with the child’s mother, after the child’s father had assaulted both of them and he had been admitted to an acute psychiatric ward as a voluntary patient on a Friday afternoon. The plan contained a clause that the mother would not allow the father to move back into the house if he was discharged from hospital. But, given that the plan was based on the belief that, at least for the weekend, the child’s father would be in hospital, this particular part of the plan was not scrutinised sufficiently. There was no contingency plan or guidance for the mother if the father was discharged from hospital and tried to return to the family home. She described how, on the Sunday morning, the
hospital had decided to discharge the father, without warning the mother, and he returned home and assaulted her and the child again when the mother tried to stop him entering the house. This participant was concerned that Safety Plans sometimes rest on untested assumptions about what may or may not happen and, in the act of writing them, provide false confidence about the ability to control future events and the actions of others (especially other professionals).

An example

During the fieldwork, I was only able to observe how a Safety Plan might be used on one occasion, but it was an insightful experience in illustrating some of the statements that participants had made. In this particular case, an investigation had already been carried out and it had been found that the children had witnessed their father assaulting their mother on a regular basis and that this mostly occurred at night after the father had been drinking. The CSO had prepared the Safety Plan, in consultation with the Team Leader before visiting the family home to discuss it with the mother and this is how it appeared after deleting personal information:

<table>
<thead>
<tr>
<th>Description of the immediate danger to the child</th>
<th>1. Children exposed to significant domestic violence</th>
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| Safety Plan Agreements                           | 1. Parents will refrain from verbal and physical domestic violence. |
|                                                  | 2. Mother will contact police immediately if father becomes aggressive. |
|                                                  | 3. Parents to engage in domestic violence counselling. |
|                                                  | 4. Parents to engage in relationship counselling through Relationships Australia. |

| What must the parent do                           | 1. Parents agree to engage with departmental workers to address concerns. |
|                                                  | 2. Mother will call and arrange an appointment with domestic... |
What must other people do immediately (such as extended family, other professionals)?

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</tbody>
</table>

Signing this safety plan means you:

- Agree to work directly with the Department
- Are willing and able to act protectively of the child
- Are capable of prioritising the child’s safety needs

**NAME**

**SIGNATURES OF PARTICIPANTS**

**CSO:**

**TEAM LEADER**

**APPROVED**

**Date:**

---

The CSO explained the plan to the mother and waited while she phoned the domestic violence service to make an appointment. The CSO had had difficulty meeting with the father, who worked office hours and told the mother to encourage him to come to the CSSC. The CSO also warned her that the Department would be assessing, in relation to the Safety Plan, how protectively she was acting toward her children and that another incident of domestic violence would result in serious consideration about removing her four children. This was slightly tempered by the second CSO taking the notes who added that she needed to phone the police if her husband became aggressive either verbally or physically. However, it was clear to me that English was this mother’s second language and she did not understand fully what was said to her, she continually nodded and responded ‘yes, yes’ in attempt to appease the CSO. She signed the Safety Plan without reading it. On the journey back to the office, the CSO expressed concern that she had not yet had the
opportunity to get the father to sign the agreement and discussed how she could do so.

In this case, from my observations and statements made by the CSO, it was clear that this Safety Plan was something the CSO had been told to do, but she did not really understand the point of it or how it might promote the safety of the children. It reads like a list of instructions (that were not fully explained to or agreed with the mother) and which it is doubtful the mother could understand. As noted above, it also required commitment from the father of the children who, as yet, had not been interviewed. Despite this, as the CSO explained to the mother, the Safety Plan was ‘putting the ball in her court’ as far as the safety of her children was concerned and her ability to protect them would be measured against it.

The Family Risk Evaluation tool (FRET)

As discussed in Chapter Three, the FRET could be described as the ‘centrepiece’ of SDM in that the CRC claims that it assists with identifying which children and families most require the limited resources of a child protection agency. Reviewing the data from the interviews confirmed my observation at the time that the participants commented most on the FRET and that their statements were generally critical.

After the event and decision making

In reviewing case files for this research, it was difficult to find FRET forms that had been filled in on cases that the participants were working on. The following participant explained why this was so:

FRET usually not filled in until weeks or months after seen the family – only required to do so when case is closed or moves on to other teams. Might use it when worker returns [to the Centre] to assist decision making but only
if they are really not sure whether to intervene or not. Also cannot tell when workers have filled them in just by looking at the file on ICMS. (Interview 44)

The following quotes support the notion that the FRET was not used at the time decisions about cases were made and had little role in assisting decision making:

FRET done as an afterthought and has little influence on what they do with a case subsequently. It does not determine the service level and it overestimates the risk level nearly every time. (Interview 42)

FRET as another piece of paperwork when she is moving a case on or closing it. FRET is not sophisticated enough to predict risk – only a very general thing – and she has already made her mind up anyway. If actually needed the tools to assist decision making then probably should not be making the decision anyway. Does not even use FRET tool to make her think or reflect on case. (Interview 12)

Risk Factors

Participants expressed both concern and confusion about what was considered to be a risk factor within the FRET:

Assumes that the questions (which she disregards) are in the FRET because there has been some research – but no idea what that research was about. (Interview 41)

Feels the Department really need to review the research that informs what constitute factors that indicate ‘risk’ to a child. (Interview 43)
In particular, the inclusion of criminal history was criticised by participants as not always relevant:

FRET – workers miss things and if she does not know then she always answers ‘no’ (so as not to add to the overall score). Example is the question about previous criminal history, may not be pertinent to ask. Also questioned the relevance of involvement with the police when it was isolated and some time ago. (Interview 44)

There was also confusion about what ‘criminal history’ actually meant when it came to filling out the FRET. This confusion was brought to my attention by the participant above and led to discussions with COSs and Team Leaders about whether ‘criminal history’ meant having been convicted of an offence, having just been charged with an offence, or having had ‘police involvement’, that is, a family ‘known to the police’.

More generally, the inclusion of ‘historical’ factors was considered problematic:

Family Risk Evaluation form is useless – too many questions are about historical rather than current circumstances. . . (Interview 43)

Risk levels

It was the inclusion of ‘historical factors’ which led to what participants considered to be risk levels that were too high. Some were also concerned that inclusion of historical factors ignored the possibility that people might, over time, change:
Never get categorisation of a case as low risk from the FRET because there are so many factors involved in the questions, which may not even be relevant. (Interview 44)

Problem with FRET is that most families come out as high or very high and that does not change because many of the factors are historical. So, they end up closing lots of high risk cases after voluntary involvement. So, FRET not really helpful here as it does not give enough weight to the current situation and how much people might have achieved with the involvement of the Department. (Interview 34)

As the following quotes illustrate, participants felt that the FRET generally provided scores and consequent risk levels that were too high:

In her opinion also gives too many ‘high’ risk cases which she would deem to be moderate. (Interview 44)

... and almost every case comes out as high – indeed most families would – ie more than three children, crim history. She and her colleagues sometimes laugh at the high scores that families get. (Interview 43)

FRET nearly always gives a high or very high – office joke that one of the team leaders family would get high or very high on a bad day because of the number and ages of her children plus a murky past...(*said as a joke rather than a slur*). (Interview 32)

Re FRET – it is OK but sometimes comes out a bit higher than she would expect. (Interview 29)
It was this tendency of the tool to ascribe what participants perceived to be overly high risk levels to families that drew severe criticism and undermined their confidence in the efficacy of using the tool:

FRET is generally useless in that gives too high most of the time but once it came out too low – family clearly needed the involvement of the Department and other services - defining ‘risk’ as the need for services to be involved. (Interview 21)

FRET is shithouse and she takes little, if any notice of it. The risk factors it contains are not reflective of real risk. One tick and you get ‘moderate’, which would be most families. It is meaningless in terms of the real world. (Interview 33)

In addition to a lack of confidence about the risk levels produced by the tool in relation to particular families, participants also felt that, more generally, the FRET added little, if anything to their practice:

Already knows the answer and it does not tell her anything that she does not already know. (Interview 29)

FRET does not tell them anything they do not already know about a case and has got to the point of being just another form they have to fill in – it is obsolete. (Interview 32)
The yes/no questions are insufficient and do not account for circumstances (ie criminal history of parents, she does not distinguish between charges and convictions). Sometimes she does not want to have to complete it as it gives such a skewed view of the family. It then becomes ‘just another form we have to fill in’. (Interview 42)

Consequences of Risk levels

The use of the FRET to assign a risk level to a case is supposed to guide the CSO and Team Leader in their decision about whether a case should be opened for further intervention, at the conclusion of an investigation. When finishing an investigation, a CSO is also required to make the decision about whether to ‘substantiate’ the case and decide whether a child is ‘in need of protection’. The role is of the FRET is defined in the Practice Manual as:

The assessment of the CSO must be informed and challenged by the outcome of the family risk evaluation tool, which estimates the probability of a future abuse or neglect incident, which may result in harm to a child occurring in the family in the following 12-24 months. It will be relatively rare that a CSO assesses that there is no risk of future harm to a child when the outcome of the family risk evaluation is ‘high’ or ‘very high’ (page 75).

The reasons for not following the Practice Manual’s guidance to open cases that score ‘high’ or ‘very high’ were usually recorded in the files as part of the outcome and decisions about substantiation and the need for protection. Participants explained how the FRET, using historical factors, can still give quite a high score, but the child be at no risk and not in need of protection because immediate factors in the family have changed - for example, the abusive parent has left the home and/or no longer has contact with the child. Interestingly ‘risk of harm’ as well as actual harm to a child can be ‘substantiated’ by the CSO, as explained in the Practice Manual:
no actual harm has occurred but there is risk of unacceptable harm and the child does not have a parent able and willing to protect them, whether or not the harm was part of the concerns received. (page 78).

A ‘high’ or ‘very high’ outcome from the FRET can be used to support the decision to ‘substantiate risk’, but there was confusion among participants about whether they were required to substantiate that a child was at risk historically, for example, was left unsupervised, or would be in the future, that is, might be left unsupervised again in the future:

But can close high risk cases anyway, just that there is a record against these people and nothing may have been substantiated. Even if there has been no harm to the child, can still substantiate risk, ie children at home alone while mum at the casino. She was not going to substantiate anything because nothing happened (mix up between parents and no other matters of concern) but manager intervened and insisted that she substantiate risk – because the children were placed at risk of harm. (Interview 44)

Despite the guidance provided by the Practice Manual, cases that had been assigned a ‘high risk’ level were routinely closed:

Uses Family Risk Re-evaluation form daily – in her team they can only close when risk level has gone down to moderate. Having said that some cases still come out as high but they can still close if they include a decent rationale. (Interview 41)
The reasons for not opening all ‘high risk’ cases for further intervention were linked to the perceptions noted above that the FRET tended to overestimate the level of risk. The decision to disregard the FRET risk level and close these cases was, as with the Screening and Response Priority tools, affected by work demands:

FRET is fairly useless as always gives high or very high – they do not automatically open very high cases as they do not have the staff to do so. (Interview 24)

Also means that system becomes ‘clogged’ with cases that should not be there. (Interview 44)

In one CSSC, so called ‘high risk’ cases might not actually be closed:

They could not possibly keep open all cases of high or very high – they do on the system but these cases get little if any attention. (Interview 32)

Organising work

As mentioned in Chapter Three, the risk levels assigned to a case by the application of the FRET can be used to prioritise the work of practitioners, in terms of the level of service they provide to each case. There was only one participant who mentioned that she uses this function of the tools, but, even then, there were other stronger influences on how she prioritised her work:

Uses the risk re-evaluation tool quite a lot and in particular uses it to determine the frequency of her visits to families (contacts per month – very
high=4, high=3, moderate=2 and low=1). Also uses it to prioritise families for home visits. But over-rides this at times – ie the family that she referred to SCAN are causing a lot of anxiety through the agencies so they get more attention than they should. (Interview 26)

Chapter summary

The themes identified in this Chapter about how participants used the individual SDM tools reflect some of the themes identified in the last Chapter about how they regarded SDM as a framework for practice. The focus, in this Chapter, on the individual tools provides greater detail about the unstated conditions about the use of each of the tools and allows some differentiation to emerge about the different unstated conditions for each of the tools. Broadly, the data presented in this Chapter support the finding that the four SDM tools focussed on in this research were not used as they were intended to be by COSs and Team Leaders in the Department of Child Safety. In short, they were not used to assist decision making and were frequently only used after decisions had been made. Again, some practitioners may have used the tools as a form of checklist, against which they might test and modify their decision but many also manipulated the tools to provide the outcome that they had already decided upon.

The Screening tool, while initially promising when it was introduced, tended to restrict the type and amount of information that was used to decide whether a contact was accepted as a notification or ‘screened out’ as a CCR or a contact. The definitions within the tool may appear to be quite clear, but participants found them difficult to apply in practice to the lives of children and families. The definitions were subject to the interpretation of individual COSs and Team Leaders. How it was used differed from one CSSC to another, particularly in terms of setting thresholds for intervention. An important factor that affected how thresholds for intervention were set was how busy a particular CSSC was. It would appear that implementing the Screening tool to promote consistency between CSSCs in order to target the children most in need has not been successful.
Consistency in terms of time of response has also not been achieved through the implementation of the Response Priority tool. Different CSSCs, using the same tool on the same notifications, produced very different results in terms of the priority given. Again this appeared to be affected by how busy a particular CSSC was and by a concern to achieve the statistical goals set by ‘Key Performance Indicators’ about starting investigations within assigned time periods. Practitioners also deliberately manipulated this tool to achieve the outcome that they wanted.

The Safety Assessment tool was initially seen as a useful tool and, positively, the concepts and constructs of safety that it contains may have found their way into practice through becoming embedded in the minds of practitioners. Given its location in the ICMS, though, it was most likely to be used ‘after the event’, that is, after the CSO had returned from an investigation and so its utility was limited to a ‘checklist’ to ensure that nothing had been missed in the investigation. As some participants mentioned, it would have been more useful if it could have been used with families. Similar statements were made in relation to the Safety Plan that forms part of the Safety Assessment tool (if required) which also appeared to have become a tool to ensure accountability. From the example given, it also appeared to be a tool that was used to confirm the accountability of parents to ensure the protection of children by instructing them how to ‘act protectively’ - or risk having their children removed.

The main use of the FRET is supposed to be in assigning risk levels to cases to assist in the decision making about whether to keep cases open for further intervention or close them at the conclusion of an investigation. It did not appear to be used by COSs and Team Leaders for this purpose. Frequently, it was not filled in until long after the investigation had been completed, and then perhaps only with limited information. Sometimes the FRET was deliberately manipulated to provide the desired outcome. Even when it was not manipulated the outcomes were frequently ignored as the widespread perception was that it tended to assign overly high risk levels that did not reflect the circumstances of a case. While participants
could articulate how the other three tools could be, but not necessarily, were used in positive ways to enhance their practice, none could be articulated for the FRET, and it appeared to have become another form to fill in when the case was to be transferred to another team or closed. When this finding is considered with the finding in Chapter Six that practitioners also manipulate the tools to get the desired outcome, the unstated condition that emerges is that *It's OK to manipulate/ignore outcomes.*

Throughout this Chapter and the previous Chapter, several influences have emerged as themes which affect how the tools were used. At the level of individuals, the knowledge they used to apply the tools to the situations they face was important, with knowledge defined in terms of length of experience and type of qualification. At a CSSC level, how the tools are used was affected by how busy the CSSC is perceived to be. The unstated condition that existed in the minds of practitioners and which affected how they used the tools can be framed as the question, *How busy are we?* Expressed as a rule which guided how the tools were used, the unstated condition becomes *according to the pressure of demand.*

Drawing from the last Chapter, a very important factor that affected how the tools were used was how practitioners regarded them. While many of the participants were enthusiastic about the tools when they were first implemented or when they started work in the Department, the experience of using them and the difficulty of applying them to real world situations curbed this enthusiasm. This was particularly so with the FRET, which attracted the strongest criticism from the participants as it did not assist them in understanding the situations they were dealing with or with making decisions about which cases should be prioritised for intervention.

In the next Chapter, the unstated conditions are further articulated by an analysis of the case files I viewed in the CSSCs I visited.
Chapter Eight: The Case Files

Introduction

In this Chapter, data from the analysis of the case files is presented to explore the unstated conditions of the use of the SDM tools. As with previous Chapters, the themes that emerge from this analysis are presented using quotes from the case files. Five major themes are presented: constructing the case and recoding, restricted information and its interpretation, thresholds, outcomes and rationales and finally ideology. Before presenting these themes some reflections on the process of auditing the files are presented and the context for the creation of the case files is presented.

In each of the CSSCs that I visited, the creation of case files was a priority for COSs and Team Leaders. COSs commented on how much time they spent completing case notes and filling in forms, reflecting that they spent more time doing this than visiting children and families. One participant estimated that COSs spent 80% of their time completing their case files and 20% in contact with clients and other agencies. This reflects the results of a survey of social care workers in the UK by Samuel (cited in Parton, 2008) in which over half of the respondents reported that they spent more than 60% of their time on administrative work and one-fifth spent over 80%. The importance of recording was reinforced by posters on the walls of every CSSC I visited which were headed “Records – everyone’s responsibility”. Underneath this heading was the caption “Well kept records support business decisions”. I also saw coffee mugs that proclaimed “I’m no mug – I keep records”.

In addition to the difficulties in accessing files noted in Chapter Four, another challenge was that case notes were frequently very long and much time was required to understand what the case was about and/or what action had been taken. COSs reported that they were required to record ‘everything’ and the length of some of the case notes bore testament to their attempts to do this. Records of interviews
with children and parents were rarely neatly summarised and appeared to be attempts to capture exactly who said what, rather than the meaning of the words spoken. Assessments providing rationales for further action were also very long, one example was a case which had been ‘substantiated’ and the children found to be ‘in need of protection’ where the assessment document alone is 2 588 words long. This is an example of how ICT systems may address the technical aspects of recording information about cases - typing is easier for most than writing by hand - but do not address the problem of helping practitioners to know what information they need to collect (Munro, 2005b).

In previous Chapters, the theme emerged from the interviews that COSs did not use the SDM tools as they were intended to be used and/or did not use them at all to assist with their decision making. The case files provide a different perspective on how the tools were used because it is the forum in which COSs have to use them. Not only do the tools have to be filled in so that cases can proceed through the system, but, as will be shown, actions and decisions have to be accounted for, to an extent, in relation to the tools. As Garfinkel (1967) argues, in relation to the process of creating records, action is decided upon and then information arranged in the files to support the decision. Consequently, case files are an ‘after the event’ account of decision making and action, though the time between action/decision and recording might differ between different CSO’s and Team Leaders. Some COSs reported that they do try to complete their records as they conduct visits to families while others COSs commented that they do not complete their records until they absolutely have to - such as when they want to close or transfer the case - and so case files are written with a significant degree of hindsight.

While acknowledging that the case files are an ‘after the event’ account constructed to justify or rationalise decisions and actions, studying them did prove useful in uncovering unstated conditions about how the SDM tools were used in this process. As mentioned in Chapter Five, the lexicon of the Department was distinctive and it was apparent that the lexicon of SDM was used by COSs and Team Leaders in the case files as a rhetorical and accounting device (Maynard and Clayman, 1991). The
use of a similar language did not, though, lead to consistency in decision making between CSSCs, a point which was commented on by Team Leaders. Part of the role of the Team Leaders was to accept cases transferred by other CSSCs and so they were in a good position to be able to observe how the tools were used differently by other CSSCs and how the definitions were interpreted differently in other CSSCs. The main task for Team Leaders associated with accepting a case from another CSSC was to read the case file.

As mentioned in Chapter Four, a key factor for consideration in studying the case files was that as case records, they did go beyond what might normally be considered as a ‘passive’ version of events, constructed for an as yet unknown audience, and used possibly to justify a worker’s versions of events and their decisions and actions (Hall et al., 2006). All records created by COSs had to be approved by their Team Leader and so there was an immediate ‘known’ audience. The emphasis on accountability within the Department, mentioned in previous Chapters, also created a wider ‘known’ audience for the COSs, in the form of file auditors, senior managers and/or the Child Death Review Committee or the organisation more generally. Indeed the main reason for creating case files was, for many participants, to demonstrate accountability.

Aas (2004), in discussing the use of electronic databases and risk assessment tools to record and process information about offenders, suggests that these new forms of case recording are not concerned with understanding why something has occurred, but what action should be taken as a response. Similarly the SDM tools, embedded within an electronic database, focus on the action that needs to be taken rather than understanding what might be happening in a child’s life. Team Leaders and COSs are prompted by the tools to make decisions and act, for example to accept a contact as a notification or not or to decide whether a child is safe or unsafe. But despite this apparent urgency, these decisions and action, in relation to the SDM tools, are not ‘in the moment’. The use of the tools as recorded in the case files is an ‘after the event’ version that aims to justify decisions that have already been made and actions that have already been taken.
Access to the case files revealed the kinds of information that COSs and Team Leaders considered should be included in their decision making, how this information was used and how their practice was related (at least rhetorically) to the SDM tools. The analysis of the contents of the files revealed patterns and themes that both support and expand upon the themes identified in previous Chapters in which participants discussed how they used the SDM tools. As mentioned in Chapter Four, the analysis of the casefiles and the identification of themes started as parts of files were recorded in the Field Diaries and the case file data was separated from the interviews for analysis after the fieldwork had finished. Of the 51 case files that I viewed, this Chapter contains 27 excerpts from 21 files. Excerpts from the case files have been de-identified by the deletion of names, place names and dates but I have not corrected grammatical errors. The excerpts have been placed in boxes and within some of the boxes there are notes from the Field Diaries in italics which explain and add information from other parts of the case file. The excerpts represent the best examples of the particular themes and I have chosen not to include all the examples that relate to a theme because this would expand the Chapter to many more thousands of words.

The case files

‘Constructing the case’ and ‘Recoding’

As a researcher trying to gain ‘ethnomethodological membership’ (ten Have, 2002), the language or ‘lexicon’ used in the case files was noticeable as different from everyday language. This lexicon was an important part of the creation of the case files and the process by which the ordinary and everyday events of people’s lives were lifted out of context and reorganised according to organisational matrices (de Montigny, 2007) or ‘recoded’ (Hall et al., 2006). Using the matrix of the Department, all matters concerning children were defined as either child maltreatment or not, a child as safe or unsafe, at risk or not at risk. This led to some of the possibly more mundane occurrences and experiences in families being defined as possible child
maltreatment, as demonstrated in the following example:

On (date) a notification was recorded at the (name) CSSC based on the following information:

- On (date) arrangements were made for (3 year old girl) to be assessed by a Paediatrician at the Child Advocacy Clinic. Child did not attend this appointment despite a letter being sent to her father advising him of the appointment.
- On (date) arrangements were made for child to be seen by a speech pathologist in relation to her speech and language impairments. Child did not attend this appointment despite a letter being sent to her father advising him of the appointment.
- On (date) arrangements were made for child to be seen by a speech pathologist in relation to her speech and language impairments. Child did not attend this appointment despite a letter being sent to her father advising him of the appointment.
- On (date) arrangements were made for child to be seen by a speech pathologist in relation to her speech and language impairments. Child did not attend this appointment despite a letter being sent to her father advising him of the appointment.
- Concerns exist that child’s care providers are not seeking appropriate health care for her.

(Case file 20)

In the Screening tool, the CSO who accepted this notification had ticked the box indicating ‘neglect – inadequate basic care (food/nutrition, shelter, medical/mental health care, clothing/hygiene). There was no previous history of Departmental involvement. This case demonstrated how the CSO was compelled to interpret the situation as child maltreatment or not. No other interpretation could be considered, such as the family had decided to take the child to a different paediatrician and speech pathologist, or that they had moved house and the appointment letters had been sent to the wrong address. This case also provides an insight into how the notifier (the clinic) perceived the role of the Department, in particular, as an agency that follows up on missed clinic appointments. It is notable that there is no information about any serious medical condition which left untreated might result in significant harm to the child. Considering the information provided by the notifier
there was the possibility that the child was neglected and, while there might be other possibilities and explanations, it was this possibility that appeared to compel the CSO to record it as possible maltreatment.

The theme of the SDM tools being used to interpret or ‘recode’ situations as ‘child safety concerns’ was also reflected in the following case, though in the following example, the emphasis, for the CSO involved, was more that there might be a more appropriate way of dealing with the situation. The contact from a hospital was screened in as ‘inadequate basic care (food/nutrition, shelter, medical/mental health care, clothing/hygiene)’ and given 5 days in the Response Priority tool, with the following information:

- Baby was born at 29 weeks with complex medical needs. Baby has a feeding tube, was born without a urethra and has only one functioning kidney.
- On (date) mother presented baby to hospital as her feeding tube needed replacement. The baby was observed to be extremely unwell with pus oozing from vesicostomy site, fever and urinary tract infection. The baby has also developed meningitis which may be a result of the urinary tract infection being untreated.
- The meningitis is likely to result in brain damage.
- Mother was unaware that the baby was so ill and had presented the baby for a simple procedure of having the feeding tube replaced.
- Mother told medical staff that the child has had fevers for the past 5-7 days. She indicted that she had taken the child to the GP who had prescribed Amoxil. Mother indicated she did not tell the doctor that pus was coming from the vesicostomy site saying that she forgot to tell the doctor about this. Mother observed the pus about 6 days ago.
- Mother presents as having an intellectual impairment. She was unaware of how ill the baby was on presentation despite it being very obvious that the baby was extremely unwell. The baby has only one functional kidney and parent's failure to seek medical attention could result in further renal impairment. Baby is also likely to suffer a degree of brain damage from the meningitis - this could have been prevented if appropriate medical treatment had been sought for the baby.
- Notifier believes that mother is very willing to care for the baby and tries hard to provide the right care for the baby. Mother also has support from a number of community agencies. Despite mother's best efforts notifier believes that mother is unable to provide appropriate care for the child because of her intellectual limitations. Mother is unable to meet the needs of an infant with significant medical needs and the result is the baby's
intellectual and physical health has been seriously compromised.

Other Relevant Information

Baby has been admitted to the (Name) Ward and is likely to be in hospital for at least 2 weeks.

A vesicostomy is an opening in the abdomen that allows urine to drain continuously from the bladder as the baby has no urethra. The opening is made by making a small incision (cut) through the skin and into the bladder during a surgical operation.

(Case file 23)

It could be argued that, from the information presented, that the baby’s health needs were not best met by its mother. However, the CSO who was to investigate the case, expressed (in conversation with me) concern that there might be better ways to deal with this situation, rather than as alleged “neglect”. She had spoken with the hospital social worker who had said that the baby was “very sick” and had “complex medical needs” and that, up to now, the mother had “coped very well”. The dilemma for the CSO was that she could investigate, use the tools and ‘substantiate’ the case but what she felt was really needed was more support for the mother to care for the baby when it was discharged from hospital. Intervention by the Department would probably not lead to this, as it was more likely that the baby would be assessed as ‘requiring protection’ as it was ‘unsafe’ and it would be removed from the care of the mother.

At the other extreme, COSs also had difficulty screening in what they considered to be cases of potential child maltreatment and this concurs with statements made by participants in Chapters Five and Six about their concern that the SDM tools did not deal with the complexity and the diversity of the situations they faced. The following example was brought to my attention by a Team Leader, her dilemma was that she wanted to screen the case in as a notification but none of the tick boxes in the Screening tool seemed appropriate:
Notifier advised:

(Psychiatric Hospital social worker) is continuing to have weekly visits with mother and 7 month old baby however they have had to discontinue the intensive Family Support work and they cannot continue to monitor her at the level she was previously receiving.

The mother no longer has the extended family network staying with her and is now having time alone with the baby. They are still waiting for a referral to the (mother and child intensive assessment) Centre.

The mother is presenting as being very anxious and at times is very negative towards the baby.

The mother was previously staying with the "in-Laws" however this had to stop and the family are travelling overseas.

The nanna was staying with her but the nanna has now returned back home overseas.

The only support is the sister in law who visits on Thursdays.

Concern is held for the mother’s ability to be able to appropriately manage the care of the baby now that her supports are no longer in the home.

Previous concerns recorded as a CCR

Mother is in a distressed state and says that she is finding it difficult to cope with her baby. She has been treated by her general practitioner for depression but has not found it successful. Mother is also seeing a psychiatrist and is on medication.

The baby cries all the time. Mother states that she frequently has feelings of not coping and yells and screams at him which makes him cry more. She says that she doesn't want to go home to him or be around him. She has been having thoughts of harming him and herself.

Mother states that she has slapped the baby before. She feels remorseful about what’s happening.

Mother's mother died last year and she feels her loss. Her mother-in-law is not supportive and her husband works full-time.
Mother was taken to Mental Health service today for assessment and support.

Mother states that she cannot settle her baby boy. She is not coping with the baby and fears that she could harm him.

Mother has little support.

(Case file 35)

The Team Leader explained to me that, in a nutshell, the mother of this baby was suffering from “serious depression and suicidal thoughts” but had been successfully supported at home after a brief hospital admission by an intensive family support service funded by the hospital while they waited for a bed in a specialist service that would assess and assist the mother to care for her baby. The problem now was that the hospital had no more funding for the intensive support and hospital staff were concerned that when the support stopped, the baby would be in danger. The Team Leader ticked the box next to ‘Inadequate basic care’ as the closest approximation, but was concerned that inexperienced practitioners might have screened the case out since there was no obvious ‘fit’ between the tool and the baby’s circumstances. This also illustrates that applying the definitions within the tools is not straightforward as it involves a process of interpretation.

Restricted information and its interpretation

In previous Chapters, it has been described how some COSs, particularly at the intake stage, felt that they could not go beyond the information presented to them when making a decision and that they were limited in the inferences they were permitted to draw. The following case is an example of how it might have been inferred that a child was suffering harm, but, since there was no direct reference to
this, the case was not accepted as a notification. The following rationale was recorded as to why the contact was not recorded as a notification:

The information provided by the notifier does not indicate that the SChn [subject children] are experiencing any physical or emotional harms from the DV. There is little information as to the Mother's response to the Father during possible DV situations, the location of the SChn during and after the DV incidents, how frequently the DV incidents occur, or Mother's ability to protect the SChn from the DV incidents.

The information does not state that the SChn are or have been significantly physically or emotionally harmed by the DV. There is no evidence to suggest that this DV incident is not an isolated event, and no information to support Mother's report of "escalating" DV from the Father. There is no CP history for the SCN.

The notified concerns do not screen in as a notification as defined by DChS policy and practices.

(Case file 6)

This excerpt is also an example of how the Screening tool can be used to exclude contacts and therefore defend a CSSC that is 'under siege'. However, it is highly questionable whether decisions can be based on a lack of information or evidence, rather than making attempts to find out, for example, what effect the domestic violence might be having on the functioning of the family and the wellbeing of a child.

The following example shows how the intake worker restricted the information used to make a decision about a contact by focussing only on the present, without any recourse to what may have happened in the past or what other information might have existed. The following excerpt is the rationale for recording a contact as a Child Concern Report:

Police were called to a DV incident on date at approximately 10pm.

Father has returned home after a 13 hour shift at work. Mother was upset about the amount of time he spent away from the family home and they had a verbal argument over family and personal matters. Father reportedly became aggressive and grabbed mother with two hands and pushed and shoved her. Mother then attempted to call police at which time father pulled the phone out of the wall. Father then pushed the tv off the tv cabinet causing minor damage to the tv. Mother left the home and went to a
friend's place as she was scared for her safety.

The children were asleep in their beds throughout the entire incident and were unaware of the incident taking place.

The children were in bed asleep during a domestic violence incident between their parents. They were not placed at any risk of significant harm as a result of this incident.

(Case file 17)

As mentioned in previous Chapters, practices concerning conducting ‘pre-notification checks’ to gain further information about a child’s situation differed from one CSSC to another. Some intake workers reported that they would conduct checks with, for example, schools, General Practitioners and Community Agencies before applying the Screening tool, others said they would if the Screening tool indicated that the case should be accepted as a notification. The following case demonstrates how checks with other agencies could affect the decision to screen in a contact as a notification. It also demonstrates how pre-notification checks were more likely to be made if the intake worker has already decided that the contact should be ‘screened in’.

The first excerpt is taken from a contact that was screened out as a CCR:

Notifier been advised by another person that child is living in a home where there is considerable verbal abuse, which comes from his mother and stepfather as well as a lack of food (no further information given). Notifier was also advised by the same person, that the house is in a filthy state (no further information given).

Notifier said that there are concerns in relation to child’s medication as it is believed that he is not getting his daily medication at home before going to school. Notifier stated that the school does have some medication that is provided to child daily, but there is a concern that when exhorted that there may not be a new supply from home.
The above information has been assessed as a Child Concern Report due to the following reasons:

There is no information to suggest that the child has been harmed or at risk of harm;

Concerns indicate that both parents are verbally abusive to child, however there is no information to suggest that child is being significantly harmed;

Concerns indicate that the home environment is filthy, however there is no information to suggest that the living conditions are hazardous to the child's health or safety;

There are concerns that child is not receiving his medication, however it shows that the school has a supply of medication and is providing child with this medication daily;

The information received was from a third person;

Child attends school were he is able to be monitored on a regular basis.

(Case file 31)

A few months later, the same case was ‘screened in’ based on the information in the following excerpt, which includes a ‘pre-notification check’. The allegations about the way that the child’s mother spoke to him and the descriptions of the home living conditions are also more detailed and graphic, and appear to have come from more than one source:

Notifier 1 provided the following information:

- On date child’s mother stood out the front of the house and screamed at child to leave. She told him he was a “fucking useless cunt maggot” and that he was an “oxygen thief”.
- Mother throws child out of house approximately twice a week
- Child sometimes does not return home for a day or two
- Mother screams and swears at children every day
- Continual DV problems between mother and father/step-father
- Not enough food in house on occasion – money spent on non-essentials
- House smells of rotting food and has cockroaches dropping out of cupboards
- Child has been suspended from school a lot.
- Woman from next door has moved into the family residence
- Father has not been sighted in last few days

On (date) notifier two provided the following information:
• Notifier is concerned for the children who reside in home.
• The children are often sworn at and left outside to look after themselves.
• Mother and father fight all of the time and the police come to the home regularly.
• The house is dirty (notifier was inside the home four months ago and sighted dirty dishes in the kitchen) and the house smells.
• The mother is on drugs - notifier stated that they know this because the mother wears long sleeves.
• She has observed the oldest child be hit in the head by the mother. The child hung his head down after being hit.
• The mother has Aboriginal people come to the home.
• The family is not Aboriginal.
• The family rent the house - they do not own it.
• The children look dirty.

Pre-notification checks:

Phone call to State School:

• Child’s two younger siblings are:
• Sister is "mousy, depressed, loner, isolated" and is bullied by other students. She lacks resilience
• Sister is often dirty
• Brother has difficulty with routines and settling in mornings
• Brother is developmentally delayed
• Brother is very clingy with mother and withdrawn
• Brother told teacher this morning that Mum is pregnant – Mum confirmed she is 12 weeks pregnant. Father was apparently verbally abusive over phone to mother re pregnancy.
• Father’s whereabouts unknown – parents are separated
• Child has been suspended for large part of the term
• There have been some incidences of violent behaviour
• Child displays sexually inappropriate behaviour (mainly verbal) toward other students
• His attention-seeking behaviour results in him being bullied
• Medication for ADHD is not managed well and he often presents at school without having taken his medication

(The case file 31)

The process of using the Screening tool is merely a matter of ticking any one of the boxes in the tool. The information contained in a contact has to be ‘recoded’ with reference to the definitions of abuse and neglect attached to the SDM tools. This case shows how the information in the second contact triggered the intake worker to tick a box in the Screening tool. In addition to the more graphic information in the second contact and the inclusion of a ‘pre-notification check’, another factor which
influenced the decision making of the intake worker might have been that this was the second contact though this is not recorded as a rationale. Interestingly, the pre-notification check in the second contact was made with the same school that made the first contact (see first excerpt above).

Another example of the use of restricted information and its effects on decision making is contained in the following case file:

**September** – emotional harm ‘substantiated’ but child assessed as not needing further protection. Case opened for ‘Intervention with Parental Agreement’. FRET completed with outcome of ‘very high’. Case only ‘substantiated’ and opened for one of five siblings:

The outcome for the notification dated (August) will be recorded as Substantiated emotional harm to child- CNINOP [child not in need of protection] with mother and father recorded as the parents responsible. The outcome in relation to subject children child, sibling, sibling and sibling will be recorded as unsubstantiated - CNINOP. The rationale for this is as follows: There was clear evidence obtained during the course of the investigation that would indicate that subject child has experienced serious emotional harm of a detrimental nature. There was no single episode that could solely attribute for his current emotional state, rather it is a composite of numerous factors outlined above. His parents are seeking to make some beneficial changes but further support, education and intervention is an appropriate response to reduce the likelihood of future harm to subject child and his siblings.

**October** – screened out as a CCR:

Notified concerns received on the date.

Notifier stated the following:

Mother was charged today with a minor drink driving charge and unlicensed driving.

Three children were in the car.
Notifier states that mother was driving recklessly (accelerating rapidly) in a car park.

Child did not appear too phased by the situation. Notifier stated that she appeared as if this kind of behaviour was not uncommon.

No injuries were sustained by any person.

Mother stated that she was 'on a bender' last night and was still affected by alcohol the next morning.

**CHILD PROTECTION HISTORY:**

Investigation and assessment completed this month. Outcome: Unsubstantiated CNINOP.

Assessed that there is a need for mother and father to increase their parenting skills (boundary setting etc).

Department aware of alcohol abuse issues.

Father and mother agreeable to Intervention with Parental Agreement.

Assessment of concerns:

From assessment of the notified concerns and review of the child protection history, it is assessed that this information does not reach the threshold for a notification.

An investigation has recently been completed and it is assessed that ongoing intervention is warranted.

Thus, although this incident alone does not meet the threshold for a notification, the Department is aware of ongoing concerns regarding alcohol misuse and inadequate parenting skills which need to be addressed.

**November** – *all five children removed from the care of their parents. Case ‘substantiated’ for emotional abuse and neglect and all children considered to be ‘in need of protection’.*

(Case file 51)
What is notable about this case is how previous case records appear to have been ignored. When the case was closed in September, after a period of voluntary involvement during which it was substantiated that one the children had suffered emotional harm, the FRET indicated a very high risk of future harm. This appears to have been ignored when a contact was made in October and screened out as a CCR. The children were renotified in November, assessed as ‘unsafe’ and immediately removed from the care of their parents, amid many concerns about their well-being. Reading the file, it was difficult to understand how the contact in October could have been screened out as a CCR, given the previous information contained in the file about the recent voluntary involvement with the family. It was also difficult to understand how a situation could change from ‘safe’ to ‘very unsafe’ in a matter of weeks.

This case is also notable as it was mentioned by the team and the COSs concerned as a ‘very serious case’ and one which had been very challenging for them. It supports the statements made by participants that the tools are only as good as the information that is used when applying them. It also shows that the tools do not necessarily point COSs to gaining further information, or considering information that is already on file (even though there is reference to having done so).

**Thresholds**

Reading the case files showed not only what information was recorded as included or excluded in the decision making process but also how information was processed and this was particularly so in relation to thresholds for intervention. As noted in previous Chapters, participants reported that the thresholds for accepting referrals as notifications differed from one CSSC to another and was dependent on how busy the CSSC was perceived to be by the intake worker (and their Team leader). There were some clear examples of this phenomenon in the case files. The following is an example of how a case was closed at one CSSC with a rationale and then accepted as a notification within weeks at another CSSC as the family had moved house.
The first (abridged) excerpt is taken from the closure of the case by the first CSSC.

**RISK FACTORS:**
- Mother displayed violence and aggression to subject child and police
- Mother utilises inappropriate discipline
- Mother exhibits alcohol dependency
- Mother fails to engage with alcohol rehabilitation / mental health program for herself
- Mother exhibits lack of parenting skills
- Mother fails to adequately supervise subject children
- Family confront cultural and language barriers
- Subject child is scapegoated by Mother
- Subject children state their preference for alternative care
- Subject child increased vulnerability due to young age: 28 months old

**PROTECTIVE FACTORS:**
- Mother and subject children are supported by family friends who live locally
- Local family friends provide respite care and accommodation support for family
- Subject child demonstrates ability to adopt culturally appropriate parental role supporting other subject children’s protective and care needs
- Mother engages with multicultural support service
- Mother is medicated to prevent her abuse of alcohol
- Mother is supported by (ethnic minority) community members

The outcome of the investigation is recorded as UNSUBSTANTIATED – child not in need of protection. The risk of harm to the subject children is mitigated by the protective influence of external agencies, and the eldest subject child.

It is assessed that the mother’s ability to care for and protect the subject children is impaired by her lack of parenting skills and/or her abuse of alcohol. This is evidenced by:
- the violent and aggressive assault by the mother of the subject child, while the mother was under the influence of alcohol
- that the mother’s actions warranted being subdued by force and arrested by attending police
- the mother’s habitual abuse of alcohol
- the subject children being disciplined by the mother with a broom handle
- the ambivalent attachment evidenced by the subject children to the mother, and mother’s failure to demonstrate attachment, engagement and parenting skill during supervised contact with subject children.

*** NOTE THAT despite the unsubstantiated outcome it is assessed that the notified incidents did occur as alleged, although these did not result in significant harm to the subject children, and that the subject children are not at unacceptable risk of harm nor in need of protection because of the support
The above excerpt contains many contradictions and much could be said about what the worker who wrote it regards as significant harm to children and what might be predictive of future harm, but the main point is that, despite all the 'risk factors' identified, the case was still ‘unsubstantiated’, the children assessed as ‘safe’ and the case closed. The FRET had been completed for both neglect and abuse and the score was 3 and 4 respectively which equated to a risk level of ‘moderate' (therefore, according to the Practice Manual not requiring further intervention). This could have been an example, as described in Chapter Six, of the FRET being manipulated to give the desired outcome, especially given the list of ‘risk factors' in the rationale.

The following excerpt is taken from the Intake document from the same case file at another CSSC a few weeks later. The case was accepted as a notification (with ‘inadequate supervision' ticked in the Screening tool and given a ten day response priority).

-- Mother has limited English skills and receives extensive support parenting and with life skills, in her home.

-- Supports include her eldest son; community members; Multicultural Development Assoc. workers; and the family friend and members of that friends' own network.

-- The subject child provides parenting and life-skills support to the mother, including ensuring subject child receives his tuberculosis medication.

-- The family friend's support includes respite care of various subject children by arrangement.

-- Subject children have walked or been sent to the family friend's home at least five times in the past month, for respite care, without prior arrangement by the
Notifier is aware that on date:
-- A local family friend had 2 eldest subject children over for lunch, by arrangement with mother.

-- Mother had gone to another town for lunch with the other subject children. Later she called the family friend saying she and her four youngest children was not coming home that night.

-- The family friend suggested they care for (two of the children) overnight, in city.

-- A man took subject child from regional town, and left him at the mother's house on date.

-- Family friend has just been to the house and it appears the mother has moved out as the furniture and all the children's clothes were gone and the house was "a huge mess".

-- Subject child (eldest) was unaware of an imminent move.

-- Subject child (eldest) states his mother had been very transient while the family lived in (overseas country).

-- The mother is now living in (town), and requested the subject children go to (town) to join her.

(Case file 36)

Superficially, the information contained in this notification would appear to be far less grave than in the assessment of the previous CSO who closed the case. Discussion with the CSO who accepted this notification revealed that she had considered the ‘case history’ and noted the concerns of the previous CSO who had dealt with the family, even though the case summary had indicated that the children were considered ‘safe’ and at ‘moderate risk’. She explained that some COSs might not look beyond the summary provided by the ICMS, which, in this case, indicated that there was an ‘event’ with an outcome of ‘unsubstantiated: child not in need of protection’. Hence the outcomes of using the tools, as they are recorded on the case files in the form of summaries, might serve to restrict the information used to make future decisions, unless the CSO goes beyond them and reads the whole case file. The unstated condition that can be inferred from this is that the outcomes of the
tools, as they are presented within the ICMS in summary form, can, for some COSs, be misleading and more detailed information needs to be sought from the file.

The following case file excerpt illustrates a different threshold between the Child Safety After Hours Service Centre and the CSSC. My notes on the file, as recorded in the Field Diary are in italics.

3 year old girl:

Family residence is 'filthy' with discarded decaying food within child’s reach and piles of clothing throughout. Subject child has decaying teeth and is 'filthy' in appearance'.

Mother drinks daily. This afternoon father informed notifier he had never seen mother so heavily intoxicated.

Alcohol and cigarettes are left within reach of child.

*Screened in as ‘Neglect - Inadequate basic care (food/nutrition, shelter, medical/mental health care, clothing/hygiene)’. Notified by ambulance service to after-hours service – no further details, except mention of previous CCR (see below)*:

CCR date: neglect: child has delayed speech: dirty clothing and decaying teeth - parents not responsive to advice/support;

*Given a response priority of ten days but would have been less if workers had ticked (in the response priority tool) :

' Are drug or alcohol misuse issues or parental incapacity issues present?"
But the CSO completely missed this for some reason and there is no rationale.

Previous contact recorded by CSSC (rather than after hours service) as a CCR:

Notified concerns (from child care centre):

Caller concerned about neglect. Child has been attending since (date) this year.

Child has no language- have suggested an assessment but parents have not followed up on this. Mother said that she can't read so she will not be reading her stories. Caller has tried to address concerns with father but he does not think child has a speech problem. Mother did say that child has learned to swear and that her uncle swears at her and hits her (unknown how uncle hits her) Child can't do puzzles. Father said child "just needs a kick along" Parents have said they attend the (Name) Medical Centre. Child’s teeth are "black". Mother laughed when this was brought to her attention - she said she would not be taking her to the dentist.

Child looks for hugs and love- mother does not interact with her

When child first attended her clothing was dirty and staff had to wash her clothes- this has improved. Child looks as thought she is getting enough food. Parents have responded to suggestions about healthier food for lunch. Parents present as "dirty" themselves and "slow learners" according to caller

Assessment of concerns:

Information from caller indicates child may have experienced a level of neglect - this harm not assessed to be serious at this point as family have responded to suggestions in the past by caller to improve care of the child. Caller asked to recontact if family do not follow concerns about language delay and dental treatment

(Case file 40)
Outcomes and rationales

In all of the CSSCs visited, there were discussions between COSs and Team Leaders about what the outcomes of investigations should be. There were two decisions to be made during these discussions, firstly whether to ‘substantiate’ the case and secondly whether the child was assessed as ‘in need of protection’. The outcomes of having used the FRET and the Safety Assessment were bound up in these discussions. From the discussions that I observed, it became clear that COSs were not clear about what they were required to ‘substantiate’ – harm and/or risk of harm. The understanding of some Team Leaders and COSs was that ‘risk’ could be ‘substantiated’, in line with the FRET outcome, but were then not clear about whether this was ‘future risk’ or ‘past risk’. Past risk was defined for me by one participants as being substantiated when a child had been subjected to risk but no harm had occurred, an example was of a mother leaving a young child unsupervised but nothing untoward happening. Some felt that it was any ‘risk’ that could be substantiated and that no distinction needed to be made between past and future. This confusion about the concepts of risk is exemplified in the following excerpt from a case file:

Assessment of Risk of harm
It is further assessed that subject children have been exposed to significant risk of future probable harm of a detrimental nature: (Case file 51)

In the following excerpt, the child was assessed as not having suffered significant harm, as not in need of further protection, but the case was ‘substantiated’ and referred to the Intervention with Parental Agreement Team. The FRET outcome was ‘very high’.

RATIONALE FOR OUTCOME
My professional rationale for this outcome is as follows:
- child is assessed as not having experienced physical, emotional or psychological harm of a significant nature.
- child is assessed, at this time, as being at an unacceptable risk of harm in the
- Child is assessed at this immediate time, as having a parent who is willing and able to protect her. Mother has demonstrated a willingness and ability to provide for the care and protective needs of child and has consented to work with the Department on an ongoing basis to ensure that child's care and protective needs are met.

The information pertained in the notification was assessed and the following outcomes will be recorded:
- substantiated, child not in need of protection.

**RATIONALE FOR ONGOING INTERVENTION**

Given the high risk to child and her very young age, after consultation with Team Leader, a decision has been made to recommend that this be referred for an Intervention with Parental Agreement. Although a support service may be suitable, concerns would be held that without more intensive intervention from the Department, child may be placed at an increased risk of harm. Mother has consented to work with the Department on an ongoing basis in terms of an IPA case and referrals have been made and accepted to the Community Health Nurse Visiting Program and the Family Centre, Intensive Parenting Program.

Father is currently residing at (name) Drug Rehabilitation Program and has had limited involvement with the Department and child. It may be necessary to assess father's willingness and ability to provide for the care and protective needs of child once his treatment has been completed.

(Case file 5)

While it was beyond the scope of this research to quantify the number of cases in which the decision was ‘no further action’ despite a ‘high’ or ‘very high’ FRET score, there was ample evidence of this in the case files. This finding concurs with the statements made by participants about the FRET in Chapter Seven. This finding also highlights a disjuncture between the ‘official’ and ‘unofficial’ versions of practice. As the *Practice Manual* explains:
The assessment of the CSO must be informed and challenged by the outcome of the family risk evaluation tool, which estimates the probability of a future abuse or neglect incident, which may result in harm to a child occurring in the family in the following 12-24 months. It will be relatively rare that a CSO assesses that there is no risk of future harm to a child when the outcome of the family risk evaluation is ‘high’ or ‘very high’. (page 75)

But while the FRET outcome was not followed in relation to the Practice Manual, there was evidence that it did prompt COSs and Team Leaders to articulate the reasons for their decisions. Some of the rationales provided in the case files were very detailed and lengthy. The following example, which is 774 words long, exemplifies this:

Rationale of outcome.

The outcome for the assessment for child and child is Substantiated-child not in need of protection Emotional harm, naming both father and mother as person’s responsible.

When Child Safety Officers first sighted and interviewed child and child, both children presented as distressed and fearful of the current family unit. Father and mother are separated and currently applying for custody through the family law court. Father has been granted full-time interim custody of both children until final orders are heard and granted. Mother has visitation with [one] child every second weekend and on Wednesday on the alternate week, however [other] child chooses not to have contact with her mother.

Child presented to Child Safety Officers as quite distressed and fearful of returning to father’s residence. Child disclosed that two nights earlier, her father “slapped, punched and kicked“ her repeatedly. Child further disclosed that her father had made her sit naked on the floor as a form of punishment and threatened to make her shower outside in the rain. Child disclosed emotional abuse for example her father stating that he does not love her anymore, and that she was selfish “like your mother”.

However when [other] child was interviewed child stated that there was only a minor fight between her father and sibling on that night and he did not punch, slap or kick her. Child further disclosed that she does not have contact with her mother due to physical abuse from two years ago. Child stated that their mother tells sibling to “make up stories” about her father and to misbehave for him. Child also presented to Child safety Officers as quite distressed and fearful
however she appeared fearful of her mother and at the thought that sibling may live with their mother.

When Mother was interviewed she stated that there was previous domestic violence between herself and father, however there is no further information to support these allegations. There is no Departmental history to suggest domestic violence, police never attended any domestic dispute between the parents, and the children did not disclose that there was domestic violence in the home.

Father presented plausible explanations for the allegations and concerns and believed child was acting out due to the influence of her mother. During the interview process Child safety officers observed an interaction between child and her father, and whilst she began to cry when he initially approached her, she immediately calmed down and not only conversed with him but engaged and instigated conversation.

Child has previously stated that either her mother, father, or step-mother has physically or emotionally abused her however has retracted the statements stating that the other parent “made her do it”. Child has also previously disclosed to her CYMHS caseworker that her mother tells her to make up these stories about her father. Due to her fear and distress, father signed a voluntary care assessment order and child was placed in foster care. After all information was gathered it was decided that their was no further information to support child’s allegations, there was bruising however child had stated that she receive this while at her mother’s house from falling off her skateboard. As a result the Department returned child to her father and step-mother.

Information gathered suggests that there is a lengthy and intense family law court process, and as a result the children are being emotionally harmed by being placed in the middle. Children presented as significantly affected by the current family conflict and they are in a sense fighting the battle alongside their respective parents and the conflict between the parents has transferred on to the children.

Assessment summary

In applying the departmental safety assessment framework it was assessed that child and child were safe within the current family environment. In the outcome of applying the departmental family risk evaluation framework is that the subject children are assessed to be at moderate risk of future allegations of harm.

Analysis of Risk Factors.

Mother and Father are currently in a lengthy and intense Family Law Court battle. Mother and Father each have new partners and therefore there are blended family issues as well. There is Departmental history on the family, a number of CCR’s and one Substantiated physical naming the Maternal Grandmother as responsible.
Analysis of Protective Factors.

Both children are of an age where they can somewhat self-protect. Both Children attend school and therefore their care and protection can be monitored on a daily basis. There is extended family that offers support. Child is currently seeking counselling and support from CYMHS. Mother and Father engaged openly with Child Safety Officers.

(Case file 28)

It was explained to me that the process of balancing ‘risk factors’ and ‘protective factors’ in providing a rationale for a particular assessment was a practice that had started long before the implementation of the SDM tools. This was the process that was used to justify closing cases where the FRET had indicated that a child was at ‘high’ or ‘very high’ risk of future harm. It could be argued that this practice coincides with the Departmental expectation that the FRET should be used to challenge the assessments made by COSs and that the process of making this decision should combine:

- completion of safety assessment
- the assessment of harm and risk for a child that is caused by abuse or neglect
- professional judgement about whether a child in ‘in need of protection’

(Practice Manual, page 75).

So, while outcomes of ‘high’ and ‘very high’ using the FRET may not have been reacted to according to the Practice Manual by opening a case for further intervention, these outcomes were not completely disregarded, as the statements of the participants in Chapter Seven might suggest. The rationale for taking no further action in such cases was created with direct reference to the outcome of the FRET and invoked the articulation of ‘professional judgement’, as mentioned in the Practice Manual.
Studying the rationales provided by COSs also showed that, despite the direction of the *Practice Manual* (as shown above), some COSs had their own beliefs about what they thought the FRET could predict:

<table>
<thead>
<tr>
<th>The outcome of applying the departmental family risk evaluation framework is that the subject children are assessed to be at moderate risk of future allegations of harm.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Case file 29)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The outcome of applying the departmental family risk evaluation framework is that the subject child is assessed to be at high risk of future allegations of harm.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Case file 25)</td>
</tr>
</tbody>
</table>

It was also difficult to understand the rationales for decisions in some case files as COSs appeared to struggle with using the lexicon of SDM to explain their decision, as in the following examples where the FRET outcome was ‘very high’:

<table>
<thead>
<tr>
<th>The outcome of the investigation and assessment is recorded as unsubstantiated - child not in need of protection. That is to say that the children have not been harmed, that there is an unacceptable risk of future harm, but that with the support and assistance of maternal grandmother this risk is reduced.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Case file 44)</td>
</tr>
</tbody>
</table>

**Assessment of Risk of harm**

It is further assessed that subject children have been exposed to significant risk of future probable harm of a detrimental nature:
The practice of providing rationales for decisions was not limited to decisions at the end of investigations, nor was it restricted to occasions when the CSO or Team Leader wanted to record their dissent with the outcome of an SDM tool. An unstated condition appeared to be that decisions could not be made and justified by, for example, just ticking (or not ticking) a box in the Screening tool. The following excerpts illustrate this practice:

It is assessed that the concerns are in relation to a FLC dispute occurring between the Mother and the Father. Prior to August 2007, no concerns were raised in relation to the Mother or the Father’s care of the SChn. Since August 2007, this is the 4th CCR recorded in relation to custody or access. The concerns raised by the present notifiers, are all in relation to incidents and events that occurred over 2 months ago, prior to the commencement of the recorded CCR’s. The same notifiers continue to contact the Department. There is not enough information to indicate the notified concerns demonstrate significant and detrimental harm or risk of harm to the SChn. The notified concerns do not screen in as a notification at this time.

(The Case file 7)

The information received indicates that the subject children have not been physically harmed. The information details DV incidents between the mother and the father/stepfather, none of which occurred while the subject children were present. There is not information to indicate that the subject children have been significantly harmed because of the DV between the parents. The mother appears to be acting protectively of the subject children by applying for a protection order on behalf of the subject children and demonstrating that she has notified police in relation to previous DV incidents.

This information does not screen in as a child protection notification and has been recorded as a child concern report to identify a pattern of concerning behaviour should it develop.

(The Case file 9)

The information provided indicates that the notifier has given inaccurate information to DChS regarding the subject child’s disclosures. The notifier stated
that the subject child said, "My father touched me" and grabbed his genitals while in the doctor's office with the doctor present. The Doctor has not corroborated these events. There is no further information to indicate that the subject child has been sexually abused. The mother has sought out counselling for the subject child from a psychologist who will notify DChS if any disclosures or concerning behaviours are evident in the future.

This information does not screen in according to SDM criteria and has been recorded as a child concern report to identify a pattern of concerning behaviour should it develop

(Case file 13)

RATIONALE FOR RESPONSE:

These concerns meet the threshold for a notification, given the following:

The information received indicates that the children are placed in an environment where there is an unacceptable risk of harm to the children (i.e. exposure to drug labs, used syringes, dangerous chemicals).

It is reasonable to believe that the parents alleged drug use is impacting on their ability to adequately care for and supervise their children.

Criminal history checks indicate that both parents have a history of drug offences, thus suggesting a pattern of drug use.

There is child protection history dating back to 2000, primarily pertaining to neglect and domestic violence.

(Case file 43)

That the rationales were constructed with reference to both the process of using and the outcomes of SDM tools was also evident in some files, as in the following examples:

This information does not screen in as a child protection notification according to SDM criteria and has been recorded as a child protection concern to identify a pattern of concerning behaviour should it develop.
This information does not screen in according to SDM criteria and has been recorded as a child concern report to identify a pattern of concerning behaviour should it develop.

FRET was 'very high'.

Family Risk Evaluation:
Child has had no prior involvement with DChS.
Child did not suffer childhood abuse.
No mental health problem.
Has had a previous drug problem.
Has had a criminal history but has never been charged, to do with drugs

Assessment summary

In applying the departmental safety assessment framework it was assessed that child and child were conditionally safe within the current family environment. The outcome of applying the departmental family risk evaluation framework is that the subject child is assessed to be at high risk of future allegations of harm.

Family Risk Evaluation tool
The outcome reported with VERY HIGH based on mother's previous involvement with the Department and father's drug misuse issues.
The examples above go beyond using the SDM tools as reference points and provide a form of commentary on how the tools were used and their outcomes considered. This commentary appears to be used in some instances to articulate dissent with the outcomes of using the tools.

**Ideology**

As argued in Chapter One, identifying the ideologies that operate in the minds of practitioners and which shape the context for practice can be useful when trying to understand why certain decisions are made and actions taken, particularly when reading case files (see Gillingham and Bromfield, 2008). The following case was brought to my attention by the CSO involved as an example of how the definitions within SDM require interpretation and how this process can differ from one practitioner to another, leading, at times, to conflict between COSs and their Team Leaders. This case file was also a particularly good example of how ideology, as “systems of ideas, values and beliefs” (Sinclair, 2005, p. 228) that operate in the minds of practitioners, structures and shapes what is considered to be child maltreatment and the action taken by (or not) by child protection services.

Unlike many other case files, I was able to discuss this case with the CSO involved and it was this discussion that alerted me to how ideology was operating in the creation of the case file. In particular, this case file and the discussion with the CSO, showed how the debate (or disagreement) between the CSO and her Team Leader was constructed with reference to a particular form of ideology. Again, my notes, as recorded in the Field Diary are included in italics.

**Screened in as ’failure to protect’ with following rationale:**

The Child Protection Concerns meet the SDM Criteria for a Child Protection Notification under Neglect -

The subject child’s basic necessities of life are unmet by his mother to such an extent
that the child's health and development are affected, causing harm. The subject child sustained a serious head injury on (date) which required him to be hospitalised. The subject child was involved in stealing a motor vehicle and was a passenger in the vehicle when it crashed. It was initially believed he would not survive. Child was released from the Royal Children's Hospital on date. Mother was not aware of the child's whereabouts on the date of the accident.

(Failure to Protect) -

Reported concerns indicate the mother is not able to protect the child from harm. The mother suffered an aneurysm approximately four years ago, and this has led to her experiencing short term memory problems, fatigue, headaches and chest pain. Police and Social Workers have expressed concerns for the mother's ability to protect the child from his high risk behaviours, as she has little to no control over him. The subject child has returned to reside with his mother approximately five months ago, and during this period he has attracted police attention for criminal offences wilful damage, tainted property and shop stealing. Subject child has also been involved with police on date, when he 'ran away from home'. Police are currently investigating the incident of the car theft and subsequent accident, which resulted in the child's serious head injury. The child’s high risk behaviours are causing him serious physical harm (serious head injury), AND the mother is not able to take actions to protect the child. This does not simply refer to parental willingness to take action, but to the effectiveness of the attempted action to sufficiently protect the child. Mother has been named as a person responsible for harm to children in previous Child Protection Notifications, therefore the risk of future harm is also considered probable.

Team leader subsequently changed Intake worker’s rationale, see below. Point is that this is an example of the inability of sdm to standardise things. If it were not open to interpretation by individuals then there would be no disagreement between the worker and the team leader. See interview with participant on (date).

The Team leader unticked a box in the Screening Tool to record it as a Child Concern Report, and directed the intake worker to record the following rationale:

After consultations with Team Leader, it was determined that the above concerns do not meet the SDM criteria for a Child Protection Notification, as there is insufficient information to indicate that parental incapacities led to the subject child subsequently suffering a serious head injury. Nil police SCAN referral received, which further indicates that police officers were not able to identify child protection issues during their investigations, rather investigations by police pertain to criminal activity/involvegence. The child's injuries are a result of his involvement with criminal activities, not as a result of neglect, physical abuse or emotional abuse.

(Case file 14)
Clearly the child had been injured and the point of disagreement was about whether the Department should become involved. It is not only the structure of the debate but also the language that was used in the exchange between the Team Leader and the CSO that indicated what forms of ideology were operating in their minds. The debate was about whether the harm suffered by the child was attributable to his mother’s ‘inability to protect’ him and whether they were attributable to ‘neglect, physical abuse or emotional abuse’. During discussion, the CSO explained to me that she felt that the case should be accepted as a notification as it was clear to her that the mother needed help with parenting her son, help that she would not receive if the case were recorded as a CCR. This verbal explanation was grounded in an ideology of ‘family support’ and this was in stark contrast to the language and rhetoric of ‘child rescue’ she used to build her argument in the case file. The exchange between the Team Leader and the CSO was structured and shaped by an ideology of ‘child rescue’, which is consistent with findings presented in earlier Chapters about the context for practice in the Department. There was no mention of or discussion about whether Youth Justice should become involved with the child.

Chapter summary

In summary, reading the case files demonstrated how the SDM tools were used to ‘recode’ the experiences of children and construct them as child protection cases (or not) from the decision about whether a contact should be recorded as a notification through to decisions about substantiation and whether further intervention was required. As other studies have shown (for example, Munro, 1999; Reder et al., 1993), the case files also revealed how the information used by practitioners to make decisions was restricted. For some practitioners, use of the SDM tools appeared to be more important than seeking appropriate information on which to base a decision and it did not appear that use of the tools prompted them to seek further information. The case files also illustrated the differences in thresholds for investigation between different CSSCs and the lack of consistency in response between them. Reading the case files also demonstrated how the ideology of ‘child rescue’ was operating in the minds of practitioners as they recorded and recoded the experiences of children and
parents, though the inconsistency in response suggests that this varied between practitioners and Team Leaders.

A significant finding, at a more general level, is that, in the context of the Department, use of the SDM tools has not led to any streamlining in terms of how records about clients are created by practitioners. Aas (2004) suggests that the move to electronic databases and the use of risk assessment tools for recording information about offenders has changed the kind of information that is recorded and reduced the ‘narrative’ content of case files. Similarly, Parton (2008) describes how knowledge about clients in social work has been transformed by the introduction of ICT’s from the ‘social’ to the ‘informational’. The key task has become the gathering, sharing and monitoring of information rather than the construction of a narrative which attends to the relational and social aspects of the tasks of social work. This does not appear to be the case in Queensland, where, in addition to filling out the SDM forms, practitioners also provide quite detailed, and sometimes lengthy, rationales for their decisions. As mentioned earlier, some of the case notes about interviews with clients are also very long and represent attempts to ‘record everything’ and construct a narrative about a particular child. So, while the SDM tools, embedded in the electronic ICMS, are requiring practitioners to act in ‘informational’ ways to collect and manage information, this is in addition to rather than instead of recording information in a more ‘social’ way in some instances.

But while the case files supported the inference drawn in previous Chapters that many COSs and Team Leaders did not rely on the SDM tools to guide their decision making, they also showed how the SDM tools were the main reference point for justifying decisions. So, while, as argued above, practitioners may be still be recording knowledge about clients in a ‘social’ way by constructing narratives, how the narratives are constructed has changed with the introduction of SDM and the ICMS. The narratives are constructed with reference to the informational characteristics of SDM rather than with reference to psychological and sociological understandings about human behaviour and motivation, as Parton (2008) argues they were before the introduction of ICT’s. Considering that many COSs might only
have a limited, or no, understanding of how social work theory draws from a range of disciplines to provide guidance about understanding and intervening in the lives of clients, this is perhaps not surprising. For many of the participants in this research, their only theoretical framework in relation to their practice was the SDM tools. Hence an important theme that emerges from the case files concerns how the process of justification is closely linked to the processes and outcomes of using the SDM tools, in that rationales for decisions are constructed using the lexicon of SDM. This ‘recoding’ of information about children and parents (Hall et al., 2006) points to another unstated condition being that the SDM tools operated like a cipher machine. A cipher is defined as “a secret or disguised manner of writing” (Oxford English Dictionary). A cipher machine, like the ‘Enigma’ machine used by the German Navy in World War Two (Singh, 2000), is used to encode or decode information, using a ‘key’. The ‘keys’, in this instance, were the SDM tools. This theme is discussed more fully in the next Chapter.

In Chapter Five, accountability was identified as an important element of the context for practice in Queensland and in Chapter Six, participants identified that use of the SDM tools, and filling in the forms on ICMS, was an important part of this accountability. The inclusion of the rationales for decision making in the case files would suggest that accountability is demonstrated only partly through completing the SDM forms. This may be attributable to the emphasis on the need for “professional judgement” to be combined with the application of the tools, as mentioned in the Practice Manual (page 76). It may also be an example of Craddock’s view that “the question of what constitutes too much risk cannot be divined by means of assessments themselves. Rather, while assessment categories structure and focus child protection inquiries, the question of what constitutes too much risk remains at its root a subjective process” (2001, p. 14, quoted in Webb, 2006, p. 154).

The rationales contained in the case files emerge not only as a defence for disregarding FRET outcomes (and the Practice Manual) but also as a commentary on how the SDM tools were applied (for example why certain boxes were ticked and why certain scores on the FRET were achieved). This supports the finding there was
a specific unstated condition about the FRET (see Chapter Seven) that its outcomes could be disregarded. This does not necessarily undermine the other finding in Chapter Six that the tools were used as accountability tools. It suggests that the tools were considered as only one of the mechanisms used within the Department to ensure accountability, as suggested in Chapter Five. That practitioners considered use of the tools as only partially meeting the requirements for accountability is indicative of the importance of accountability as part of the culture of the Department.

In summary, the themes that emerge from analysing the case files support and expand on the themes identified in the interviews, as presented in previous Chapters. A theme that perhaps emerges more strongly from an analysis of the case files is the importance of accountability in providing justifications for decisions. The findings from the case files support findings about unstated conditions in Chapter Six that the tools were used as accountability tools and in Chapter Seven that It’s OK to manipulate/ignore outcomes. A particular theme that emerges from the case files is that the tools operated like a cipher machine.

In the next Chapter, themes and unstated conditions identified as emerging from the data from the observations made of practice in the Department, the interviews with practitioners and the case files are drawn together and discussed further.
Chapter Nine: Discussion

Introduction

The aim of this research has been to explore the unstated conditions (Garfinkel, 1967) that underpinned the use of the SDM tools in the intake and investigation stages of child protection in the Department of Child Safety. The broader aim has been to address a gap in the literature about how assessment tools are used by practitioners and to contribute to debates about their future development. In this Chapter the main findings of this research are summarised and the unstated conditions that emerge are made explicit. The contribution of this research to existing knowledge about decision making, risk assessment and the use of tools in child protection practice is then identified. Throughout this research I have used ‘ideology’ as a conceptual tool to understand and interpret policy and practice in child protection. In this Chapter, the utility of applying ideology as a conceptual tool is explored further with reference to the findings of this research. The limitations of this research are also identified and suggestions for future research are made. The Chapter begins with a summary of the findings of this research.

The findings – a summary

In Chapter Five, the findings of this research in relation to the context for practice within the Department of Child Safety were presented. Exploring and understanding the context for practice, was, in ethnomethodological terms, important to the process of becoming a ‘member’ and gaining ‘membership’ knowledge. This ‘insider view’ revealed that practitioners within the Department had been challenged by the pace and scope of organisational change. Staff numbers had increased and the Department had recruited staff with little experience of, or qualification for, working with children and families. Many qualified social workers and more experienced child protection practitioners had left the Department and there was ambivalence about what the social work profession might contribute to practice. Significant changes in the organisation of practice had been the introduction and continued development of the Practice Manual, the ICMS and the SDM tools. All of these developments were
connected to the increased importance of accountability for actions and decisions and pressure to meet ‘Key Performance Indicators’ in relation to processing cases. The emphasis for practice had shifted from working with families to meeting increased administrative demands, particularly in relation to accountability. It was clear that a managerialist rather than social work ideology (Lonne & Thompson, 2005) was driving the work of the Department.

It also emerged through the statements made by the participants and my observations of their practice that it was a child rescue rather than family support ideology (see Tilbury, 2005) that underpinned practice within the Department. Some participants reported that it appeared that more children were removed from the care of their parents and resources were directed more to supporting foster carers to care for children than natural parents. Participants also commented on the lack of support services to which they could refer children and families.

In Chapter Six, data was presented from the interviews about how participants regarded the SDM tools generally. SDM was introduced to practitioners as a framework for practice that would assist in decision making and promote some consistency in practice. For less experienced staff the SDM tools had become central to their practice and they felt they relied on them. More experienced participants were concerned about this apparent reliance on the tools but acknowledged that, as a framework for practice, SDM has potential as a learning tool for inexperienced staff. Some participants reflected that the ‘tick and flick’ nature of the SDM tools tended to oversimplify the complexities of the situations they faced and tended to restrict their practice. Some reported that there were difficulties in applying the tools as the definitions within them required much interpretation. There was also the sense that use of the tools over time led to practitioners becoming disenchanted with them as their shortcomings emerged.

Participants also reported that frequently they had already made their decision about a case before they used the tools and some described how they could manipulate
the tools to give the outcome they wanted. Others were less concerned about the outcome of the application of the tools and disregarded it, though they did provide a rationale for doing so. More experienced participants described how they used the tools as a ‘checklist’ after they had already made a decision. Participants also reported that the tools were used differently by individuals, teams and CSSCs, according to levels of experience and qualification, personality and attitude. Consequently, the promise that the tools would promote consistency had not been met. For some participants, SDM was considered as an accountability tool rather than a decision making tool. Participants described how they would be held accountable for whether the tools had been used and how they had been used. The SDM tools, embedded in the ICMS, were another set of forms to be filled in and, as such were an administrative burden.

In Chapter Seven, data was presented from the interviews which focussed on how particular tools were used by participants. The Screening tool, while initially promising when it was introduced, tended to restrict the type and amount of information that was used to decide whether a contact was accepted as a notification or ‘screened out’ as a CCR or a contact. Participants found the definitions within the tool difficult to apply to the lives of the children and families they were dealing with as they required a certain level of interpretation, which led to a process of negotiation between CSSO’s and Team Leaders. Consequently, the Screening tool was used differently between CSSCs, particularly in terms of how thresholds for intervention were set. An important factor which did affect how thresholds for intervention were set was how busy a particular CSSC was. It would appear that implementing the Screening tool to promote consistency between CSSCs in order to target the children most in need had not been successful.

Consistency in terms of time of response also had not been achieved through the implementation of the Response Priority tool. Practitioners in different CSSCs, using the same tool on the same notifications, were found to produce very different results in terms of the priority given. Again this appeared to be affected by how busy a particular CSSC was and by a concern to achieve the statistical goals set by ‘Key
Performance Indicators’ about starting investigations within assigned time periods. Practitioners also deliberately manipulated this tool to achieve the outcome that they wanted.

The Safety Assessment tool was initially seen as a useful tool and some participants commented that the concepts and constructs of safety that it contains may have found their way into practice through becoming embedded in the minds of practitioners. Given its location in the ICMS, though, it was most likely to be used ‘after the event’, that is, after the CSO had returned from an investigation and so its utility was limited to a ‘checklist’ to ensure that nothing had been missed in the investigation. As some participants mentioned, it would have been more useful if it could have been used with families. Similar statements were made in relation to the Safety Plan that forms part of the Safety Assessment tool (if required) which also appeared to have become a tool to ensure accountability. From the example given, it also appeared to be a tool that was used to confirm the accountability of parents to ensure the protection of children by instructing them how to ‘act protectively’ - or risk having their children removed.

The purpose of applying the FRET at the end of an investigation is to assign a risk level, which then assists in the decision about whether to keep a case open for further involvement or close it. It did not appear to be used by COSs and Team Leaders for this purpose. Frequently, it was not filled in until long after the investigation had been completed, and then perhaps only with limited information. Sometimes the FRET was deliberately manipulated to provide the desired outcome. Even when it was not manipulated the outcomes were frequently ignored as the widespread perception was that it tended to assign overly high risk levels that did not reflect the particular circumstances of a case. While participants could articulate how the other three tools could be, but not necessarily were, used in positive ways to enhance their practice, none could be articulated for the FRET. Indeed attitudes toward the tool were overwhelmingly negative. It appeared to have become another form to fill in when the case was to be transferred to another team or closed.
In Chapter Eight, data was presented from the case files about how the SDM tools were used. The case files demonstrated how the tools, and particularly the lexicon of SDM, were used to ‘recode’ the experiences of children. Again the themes of ‘restricted information’ that were used to make decisions and the lack of consistency between CSSCs in terms of thresholds for investigation surfaced. A significant finding, at a more general level, was that, in the context of the Department, the use of the SDM tools had not led to any streamlining in terms of how records about clients were created by practitioners. Case notes were very lengthy and significant amounts of time and effort was expended on creating them. The length of case notes was linked to the importance of accountability for decisions and actions, as mentioned by the participants, especially when providing rationales for disregarding the outcomes of the SDM tools. These rationales were structured using the lexicon of SDM and individual tools as a reference point. Filling in the SDM screens on the ICMS, without providing a (sometimes lengthy) rationale, did not appear to be sufficient to demonstrate accountability for decisions.

The unstated conditions that emerge from the findings presented in these Chapters are discussed in the next section.

**Disjunctures and unstated conditions**

The aim of this research has been to articulate the unstated conditions (Garfinkel, 1967) which underpin practitioners’ use of the SDM tools through the exploration of the disjunctures between the ‘official’ and ‘unofficial’ versions of practice (de Montigny, 2007; Buckley, 2003). In keeping with other ethnomethodological studies, the findings of this research have been presented as richly detailed descriptions of work practices (de Montigny, 1995) that aim to articulate the “sequential production of what it is that practitioners of esoteric competencies distinctively and in detail do” (Katz, 2001), p. 333). Ethnomethodology, as an approach to research and practice, re-emphasises the importance of understanding how individuals make sense of their world (de Montigny, 2007). The process of developing this understanding, of becoming a ‘member’ (ten Have, 2002), entails addressing questions about ‘why’ as
well as ‘how’. Therefore the articulation of the unstated conditions of any activity
provides explanation as well as description. In this research, the explanatory part of
the unstated conditions of the use of the SDM will be used to theorise about the use
of the tools and their future development in this Chapter and Chapter Ten. Firstly,
though the unstated conditions that emerged from this research can be summarised
as follows.

**Accountability tools and the cipher machine**

There were two general unstated conditions about the use of the SDM tools that
emerged from this research, both of which were generalisable across the CSSCs
visited for this research. The first unstated condition concerned the connection made
by participants between the tools and the emphasis on accountability within the
Department. As discussed above, participants described how accountability for
actions and decisions was a very important part of the culture of the Department.
The ‘official’ version of practice describes how the SDM tools are to be used to assist
decision making, but the ‘unofficial’ version was that they were considered by
practitioners as a mechanism to demonstrate accountability. Consequently, an
unstated condition that guided practitioners in how the tools were used was that the
SDM tools are to be used as *accountability* tools, rather than to assist decision
making. But, as shown by the sometimes lengthy rationales in the case files, the
completion of the SDM tool screens on the ICMS was not sufficient, in itself, to
demonstrate accountability for a decision. The SDM tools were, therefore just one
mechanism by which the need for accountability was manifested within the
organisation.

The second general unstated condition concerned the way that practitioners
demonstrated accountability and it emerged from both the case files and discussions
about cases. This unstated condition was that when the tools were used, they
operated like a *cipher machine*. As mentioned in Chapter Eight, a cipher machine is
a device which can be used to encode or decode information, using a ‘key’. Use of
the SDM tools (used as the ‘keys’) ‘recoded’ information about children and parents
according to organisational schema (Hall et al., 2006). For some of the less experienced practitioners, the SDM tools were their main and perhaps only practice framework and their main frame of reference for discussing or recording information. Experienced practitioners had to engage with the tools, though they might consider them as just another screen on the ICMS that had to be completed to move cases through the system. This ‘recoding’ was best exemplified in the case files where rationales for decisions were constructed with reference to, and using the lexicon of the tools, whether the outcomes of applying them were accepted or rejected. As such, the SDM tools were used as rhetorical and accounting devices in the construction of rationales for decisions (Maynard and Clayman, 1991; Hall et al., 2006).

Normally, a cipher machine, would use a ‘key’ to encode and decode information in a way that leaves the information unchanged. The SDM tools, however, do change the information when they act like ‘keys’ in a cipher machine, as they recode information. As presented in Chapter Six, participants stated that: the tools tended to ‘restrict’ practice; there was a ‘lack of fit’ between them and the situations they faced; and the tools could not deal with the ‘complexity’ of the lives of children (see Chapter Six). To illustrate this point, it is worth repeating the following statement from a participant, quoted in Chapter Six in relation to the theme of ‘restricted practice’, which suggests how the tools tend to change information about children and parents:

SDM is too specific, too focussed, everything has to be considered as abuse or not when family life is far more complicated than that and it cannot be reduced - danger is that workers seem to think it can because they have this tool that tells them that it can. (Interview 10)

In contrast to how a cipher machine would normally be used, information about children and parents is never decoded, but is recorded on the ICMS in its changed, recoded, form. Children are recorded permanently as being safe, conditionally safe or unsafe and/or as being at differing levels of risk.
These two unstated conditions that relate to the use of the SDM tools by practitioners appear to coincide with the organisational aims of implementing SDM as a practice framework. As stated in Chapter Two, the Blueprint (2004) acknowledged the need for an increased level of accountability for decision making and consistency in decision making. Implementing the SDM tools has resulted in an increased sense of the need for accountability for decision making, along with the introduction of the ICMS and the Practice Manual. The use of the tools, operating like keys in a cipher machine to process information about children and parents, though, has not led to greater consistency in decision making, a point which is discussed further in the final Chapter.

Further unstated conditions

There were some unstated conditions that emerged that differed from the two more general unstated conditions mentioned above in terms of how pervasive they were in the different CSSCs visited in this research. These unstated conditions existed at the level of individual practitioners and teams to a greater or lesser extent, though they were more generalisable with reference to the FRET. One was related to the general notion mentioned above that the tools were accountability tools. At the level of practitioners, this emerged as an unstated condition that having to fill in the screens that contain the SDM forms on the ICMS was an administrative task that met bureaucratic rather than practice needs. From the comments by participants that “the SDM forms were just another form to be filled in”, the unstated condition might be best summarised as practitioners considering the tools as an administrative burden.

Related to this a further unstated condition was that the tools were not really helpful when it came to making decisions and so it was acceptable to manipulate them to get the desired outcome, having already made a decision. It was also acceptable to disregard the outcomes of applying the tools. This was underlined by the infrequency with which the ‘administrative over-ride’ function within the ICMS was used (or
mentoined) by the participants in this research. The unstated condition that emerges from this finding was that *It’s OK to manipulate/ignore outcomes.*

A further unstated condition about how the tools were used is related to the findings about how the Screening tool, the Response Priority tool and the FRET were used. Each of these tools were manipulated or, in the case of the FRET ignored, and the extent to which this occurred was affected by how busy a particular team or CSSC was. Contacts were sometimes accepted as notifications and response times for investigations were set by COSs according to how many other investigations were required at the time, with a view to meeting the required ‘key performance indicators’ for starting investigations within a certain time (see Chapter Six). Cases which were assessed as ‘high risk’ by the FRET were not all opened for further intervention because of a lack of resources. The unstated condition that existed in the minds of practitioners and which affected how they used the tools can be framed as the question, *How busy are we?* Expressed as a rule which guided how the tools were used, the unstated condition becomes *according to the pressure of demand.*

**Expertise and use of the tools**

The identification of the unstated conditions about the use of the SDM tools provided a general view of how they were used but they could not be applied to predict accurately how particular individuals might use a particular tool in a particular context. At the level of individual practitioners, the research has shown that there was a range of ways that practitioners used the tools and there was little consistency in the way that they were used from practitioner to practitioner, team to team and CSSC to CSSC. This lack of consistency in how the tools were used prevents the articulation of a clear set of specific unstated conditions or an ‘unofficial’ version of practice that could be presented in the same way that the ‘official’ version of practice (Buckley, 2003) is presented in the *Practice Manual.* But while the picture that emerges about how the SDM tools were used is complex, one factor did emerge that was associated with how an individual might use the tools.
The level of expertise (defined as knowledge, skills and experience (Fook, Ryan & Hawkins, 2000) of a practitioner was found in this research to be associated with how they might use the SDM tools (as described in Chapter Six). Less experienced practitioners described their reliance on the tools but also highlighted the need for a certain level of knowledge required to interpret the definitions within the tools. They were most likely to need to use the tools, but least likely to be able to. More experienced practitioners described how they had soon become disenchanted with using the tools as difficulties emerged. It was the most experienced practitioners who described how they used the tools as a checklist, but who were also most likely to say that their practice would not change if using the tools was stopped the next day. This group of practitioners were most likely to be able to use the tools in creative ways, but least likely to perceive that they needed to do so to enhance their practice.

The findings about expertise mirror the conceptualisation of professional expertise and its development by Fook, Ryan and Hawkins (2000) who argue that “novices” are more likely to follow rules and “experts” are more likely to engage in a “critically reflective process” (p. 189) when interpreting information and making decisions. They also align with Dreyfus and Dreyfus’ (1986) model of skill acquisition in which there are five stages from novice through advanced beginner to competent, proficient and finally expert practitioner. According to their model, novices tend to use analytical reasoning, with reference to sources of information external to them (in this case, the SDM tools), to make decisions. Experts tend to use intuitive reasoning and sources of information that reside internally in the form of previous experience of similar situations and pertinent knowledge.

The significance of the findings about expertise emerges from the statements made by some of the participants (see Chapter Six) about the SDM tools being used and considered as a replacement for expertise, to the detriment of good decision making and practice with children and families. This point leads to the conclusion that tools should not be used to replace expertise, as Wald and Woolverton (1990), Blaug (1995) and Spratt and Houston (1999) argue. Expertise and use of the tools is
discussed below as a topic for further research and in Chapter Ten in terms of its implications for policy and practice.

In summary, the two general unstated conditions that emerged from the findings of this research were that the SDM tools were used as accountability tools and operated like a cipher machine to encode and recode practice. At the level of individuals and teams, less generalisable unstated conditions were that the tools were an administrative burden and that it was OK to manipulate/ignore outcomes. The tools were also used according to the pressure of demand. Identifying the unstated conditions provided a general view of how the tools were used but the unstated conditions could not be employed to predict how particular individuals might use the tools. The research did identify that expertise was an important factor about individuals that impacted on how the tools might be used.

**Contribution to existing literature**

The identification of the unstated conditions about the use of the SDM tools provided additional insights that relate to existing literature and research about decision making, risk assessment and the use of tools in child protection practice. In this section, the specific contributions of this research to these fields of research are discussed.

**Decision making**

The focus of this research was not specifically on how practitioners make decisions in practice but the findings both confirm and contradict previous research about decision making that highlights the range of influences that affect how individual practitioners make decisions in practice. For example, Dingwall et al.’s (1983) concept of ‘defensible decision making’ emerged strongly in relation the unstated condition about how the SDM tools were used as accountability tools. Decisions made with ‘restricted information’ (Reder et al., 1993) also emerged strongly as a theme, though the participants in this research considered that it was the SDM tools
that promoted this rather than their own practices. Contextual factors such as high case loads, the nature of the work as ‘emotion laden’ and a limited range of service options (Proctor, 2002) were also found to be important influences on how and what decisions were made (see Chapter Five). Practitioners and Team Leaders were also slow to revise their decisions in the light of new information about a family or an assessment that contradicted their view, particularly the outcomes of applying the SDM tools (Munro, 1999). It was also found that practitioners tended not to make decisions in isolation, but through discussion with others, particularly their Team Leaders (Howarth, 2005).

Dingwall et al.’s (1983) observation that practitioners seemed to be influenced by a ‘rule of optimism’ with respect to parents was not applicable in this research, indeed the opposite was found in some instances. ‘Groupthink’ (Janis, 1982) appeared to be operating in the SCAN meetings, according to the participants, but the consensus sought was, according the participants, limited in that it did not include Departmental representatives. The SCAN meeting participants also did not appear to be demonstrating the ‘certainty effect’. They appeared to demonstrate quite the opposite, as the decisions made appeared to be ‘risk averse’ rather than ‘risk seeking’ (Kelly & Millner, 1996).

The apparent contradictions between the findings of this research and previous research about decision making are perhaps better considered as ‘variations on themes’ as the contexts for research differ greatly in both time and geographic location. Direct comparison is therefore not appropriate. It cannot be argued that the ‘variations on themes’ found in this research meant that decision making in this research was better. Considering the unstated conditions that were distilled from the findings of this research, it would appear that many of the “common errors of reasoning” (Munro, 1999) identified in previous research about decision making were found in this research despite the implementation of a tool that was specifically designed to correct them.
As discussed in Chapter One, Munro (2008) explains how both intuitive and analytic forms of reasoning are used by practitioners and how they can be combined to improve decision making. This is reflected in the *Practice Manual*'s emphasis on the need for practitioners to combine ‘professional judgement’ with use of the SDM tools to make decisions. It emerged in this research that some of the participants appeared to choose either one form of reasoning or the other. Some participants described their reliance on the SDM tools to guide their decision making, others described how they had already made their decision before they used a particular tool. It was only the more experienced practitioners who described how they could combine intuitive reasoning (their professional judgement) with use of the tools (as a form of analytic reasoning) to enhance their decision making.

Perhaps one way that the SDM tools may have contributed to improving decision making emerges from the findings presented in Chapter Eight about the case files, and the unstated conditions that the SDM tools were used as *accountability* tools and operated like a *cipher machine*. The case files revealed that, even if practitioners did not use the tools to assist their decision making, and perhaps chose to disregard the outcomes of the tools, particularly the FRET, their rationale for a particular decision was constructed and recorded with reference to the SDM tools. From this finding, it could be argued that the SDM tools were, perhaps even at an unconscious level, providing a checking mechanism for decision making. This might suggest that the SDM tools were used as a form of analytic reasoning to complement the intuitive reasoning of practitioners, as Munro (2008) suggests, or that professional judgement was combined with use of the tools, as prescribed by the *Practice Manual*.

It could also be argued that the process of constructing the rationales perhaps provided the opportunity for ‘reflective evaluation’ (Holland, 1999). In suggesting this, though, it has to be remembered that the case files are, as Garfinkel (1967) suggests, an ‘after the event’ account of the process of decision making in which information is arranged to support, rather than critique, a decision that has already been made. Also, as Chapter Eight shows, the quality of rationales between case files, and presumably practitioners, differed greatly, with some making little sense,
and so any inference that can be drawn about the contribution of the SDM tools to decision making in relation to the construction of rationales can only be tentative at best.

The inference that the SDM tools were acting as a ‘checking mechanism’ or a complementary form of analytic reasoning for some is also undermined by the unstated conditions found in this research that the tools are an *administrative burden* and, for some practitioners, *It’s OK to manipulate/ignore outcomes*. The general unwillingness of practitioners to revise their decisions when new information becomes available (Munro, 1999) may, in part, explain the second of these unstated conditions. In this research, there may have been a further reason as the participants made it clear that they had little confidence in the outcomes of applying the tools, in particular the risk levels assigned to cases by the FRET.

In the above discussion, the speculation that the SDM tools might have been used constructively by practitioners in the process of using them as *reference* and *accountability* tools appears to be contradicted by the findings of this research about how the tools were actually used. This speculation is useful as it does point to ways that the tools could be used to improve decision making in the future, a point which is discussed further in a later section and Chapter Ten.

**Risk Assessment**

As described in Chapter One, forms of risk assessment have been increasingly implemented as the focus of assessment in child protection practice. In focussing on how a particular set of tools is actually used by practitioners, this research adds a new perspective to debates about risk assessment. In particular, this research demonstrates how some of the problems identified in the literature about the design of such tools translate into difficulties in practice. For example, critics of risk assessment point to the limitations of the use of child protection populations to derive the risk factors used in actuarial tools, without consideration as to whether such factors exist in the general population (Parton et al., 1997). In this research, participants commented that many of the factors that were used in the FRET to
calculate risk were present in their own lives and their own families and so questioned how predictive these factors might be. Participants commented that the FRET tended to overestimate risk and this led them to disregard, or manipulate, the outcomes of applying the tool.

Critics of risk assessment also point to the way that the use of risk assessment tools moves the focus from working with children and families to collecting certain types of information and managing abstractions (see Goddard et al., 1999; Parton, 1998; Reder et al., 1993). Participants described the difficulty of applying the generalised concepts within the SDM tools (in particular the definitions) to the situation of individual children and families (see Reder et al., 1993). They also commented that use of the SDM tools tended to restrict their practice by emphasising assessment rather than intervention (see Chapter Six), leading to a pre-occupation with risk (see Spratt, 2000). Participants were also concerned that proficiency with use of the SDM tools had become more highly regarded in the Department than the expertise required to work with children and families.

It has been argued that actuarial risk assessment can be more reliable than clinical judgement but only if practitioners are adequately trained in their use (Munro, 2008; Rycus & Hughes, 2003). In this research, participants reported that the training they had received about SDM had been inadequate and, while there had been some stimulating debate following its implementation, this had subsided over time and there had been no subsequent training. Considering this within the context of the findings of this research, this does not necessarily mean that better and more training would have affected how practitioners use the SDM tools. Participants described how, despite a lack of training, they became proficient at using the tools but ‘outgrew’ them as the limitations became apparent (see Chapter Six).

The reliability of risk assessment tools is also dependent on whether practitioners use the tools in the way that they were intended to be used by their designers. This research has shown that practitioners do not necessarily use risk assessment tools
in the way that they were intended to be used. This research has extended the observation by Lyle and Graham (2000) that practitioners may manipulate the outcomes of tools so that they reflect their own desired outcomes. It has also expanded on Kang and Poertner’s (2006) research that demonstrated problems with the inter-rater reliability of risk assessment tools by providing a detailed account of both how and why practitioners might manipulate risk assessment tools or disregard their outcomes.

In summary, this research confirms and extends some of the more speculative points raised in the literature about the limitations of risk assessment tools as they might be used in practice. In particular, it has revealed two significant disjunctures between the ‘official’ and ‘unofficial’ versions of practice (Buckley, 2003). Firstly it has revealed a disjuncture between how the FRET (in particular) is promoted within the organisation and how it is regarded by those who have to use it. Secondly, it has revealed a disjuncture between how it is intended to be used and how it is actually used. These findings are significant in that they contribute to debates about how risk assessment tools might be used by practitioners (discussed further in the next section). Their significance also highlights the importance of research that focuses on how practitioners use tools, from their perspective. Both of the disjunctures identified would remain hidden in other forms of inquiry, given that practitioners are completing the SDM screens within the ICMS and thereby appearing to have used the tools to make decisions.

**The use of tools in child protection**

This is the first independent research that has considered how practitioners use the SDM tools and so it makes a contribution to filling a specific gap in the literature. More generally, this research found that the SDM tools were not used by practitioners in the way they were intended to be used or for the purpose they were intended for. In particular the research contributes to debates about whether the development of tools to improve child protection practice should be continued and, if so, how. While, as discussed in Chapter One, there has been considerable debate
about the efficacy of the use of risk assessment tools at a theoretical level and research about outcomes at a systems level, this research demonstrates at a practice level that we cannot assume that practitioners will use tools in the ways that were intended. As Sheppard et al. (2000) argue, ‘human agency’ makes the use of any tool or form of knowledge in practice a less than straightforward process. This research has confirmed the view that it is not possible to predict how a tool might be used by a particular individual, though it has identified individual and contextual factors that affect how it might be used.

The focus of this research on how the tools were used has revealed the pragmatism of practitioners in their approach to the use of tools. Participants distinguished between the different tools in terms of their utility. The research has demonstrated that however much the use of a particular tool may be prioritised, promoted and mandated at an organisational level, ultimately it is the practitioners who have to use it who decide how it is actually used. Therefore, the views of practitioners about what they find useful have to be incorporated into the future design of tools. As Munro (2005b) argues, the design of any tools to assist practitioners should be ‘user-centred’ and address the areas of practice that the ‘users’ find most problematic.

After the completion of the fieldwork and data analysis, ethnographic research about the use of ICT systems and assessment tools embedded in ICT systems in the UK was published. The findings of the UK research resonate with the findings of this research. Peckover, White and Hall (2008), in their study of how practitioners used the ContactPoint database, emphasize the need for ethnographic engagement with practitioners so that the design of ICT systems is ‘user centred’. Their findings also point to differences between the intended aims of implementing the system and the reality of how it was perceived and used by practitioners. Similarly, Broadhurst et al. (2009), from their research about the Initial Assessment System (IAS), an ICT system being used some UK jurisdictions, conclude that although its implementation aimed to improve safety for children and improve the decision making of social workers, it may have had the opposite effect. They also illustrate how the IAS, like many other ICT systems, may contain “latent conditions for error” that serve to
undermine the decision making of practitioners. In a study of how practitioners used the Common Assessment Framework (CAF) in the UK, White, Hall and Peckover (2008) illustrate the impacts of the use of this particular tool on practice. In particular, they highlight the interpretive demands of the forms in the CAF, which require that information that practitioners have about clients be re-ordered as “...the CAF disrupts the temporal and narrative display of information” (p. 10).

This research has focussed on how a particular set of tools was used by practitioners and the extent to which the findings can be generalised to other risk assessment tools is limited. The findings are, however, consistent with recent research findings from the UK, as mentioned above, and do have a contribution to make to debates about the development of tools to enhance practice in child protection. In Chapter One, arguments were presented that the application of instrumental reason (Blaug, 1995) or technocratic ideology (Spratt & Houston, 1999) should be resisted in the domain of providing services to children in deference to strategies based on communicative reason. These arguments articulate the inappropriateness of applying instrumental reason and technocratic ideology, which lead to the development of tools to address personal and social problems, and suggest that a ‘wrong turn’ has been taken in the development of services. A key question was raised in Chapter One about how this ‘wrong turn’ might manifest in how practitioners use the SDM tools. From the statements made by participants, evidence of the ‘wrong turn’ emerges in this research in the following ways. Participants mentioned the difficulties they had in applying the general definitions within the SDM tools to the specific lives of the children and families they were dealing with and described how the tools tended to oversimplify the situations they faced. There was a lack of ‘fit’ between the tools and the complexity of the situations they were expected to deal with. The tools also tended to restrict practice and participants described how they had to go beyond the tools to understand and intervene in situations. In general, the tools were considered as serving the organisational or bureaucratic need for accountability rather than practitioners’ needs for assistance in making decisions.
In particular, the findings of this research support Blaug (1995) and Spratt and Houston’s (1999) contention that the development of tools cannot be used to replace practitioner expertise. As Wald and Wolverton (1990) argued nearly twenty years ago: “The use of risk assessment procedures, however, cannot adequately compensate for inadequate staff or other resources” (p. 504). But the evidence for the ‘wrong turn’ has to be balanced by the more positive findings of this research that suggested that the SDM tools can be used constructively. As mentioned above, more experienced practitioners were able to use the tools to check their decisions - though not necessarily change them - and so the place of tools in practice might ideally be as a form of analytic reasoning to complement the intuitive reasoning of practitioners (Munro, 2008; Corby, 2003). There were also suggestions that the tools could be used to assist the professional development of inexperienced staff (which is discussed further in the final Chapter). This research has shown that this ideal is not generally reflected in practice as it appears that the SDM tools have, in the opinion of some of the participants, been implemented to replace or compensate for a lack of professional expertise rather than to complement or enhance it. The continued implementation of recruitment policies that undermine the importance of expertise by broadening the minimum qualification required to be employed as a CSO (see Chapter Two) support these observations. The findings of this research suggest that rather than choosing between approaches to practice that are based in instrumental reason and technocratic ideology and approaches that are based in communicative reason, we perhaps need to consider how they can be used to complement each other. This coincides with Munro’s (2008) view that intuitive and analytic forms of reasoning need to be combined to improve decision making in child protection practice.

In summary, the findings of this research suggest that there is a place for decision making tools in child protection practice, particularly in providing the analytical form of reasoning proposed by Munro (2008) and to complement the intuitive forms of reason used by decision makers. The key point is that the role of tools must be clearly understood, they may be implemented to assist or complement professional expertise, but they should not be used to replace it (see also Corby, 2003). This research has only considered how a subset of the SDM tools were used by
practitioners but it has shown that the type of tool used, in terms of its usefulness to practitioners, is an important consideration in how we might develop them in the future. It has also demonstrated that, however much the use of a tool is promoted and mandated within an organisation, practitioners will resist using it if they do not find it helpful. Consequently, the future development of tools, as complementary to professional expertise, should be guided by the perspectives and needs of the practitioners who will be required to use them, rather than organisational needs for consistency and accountability.

The use of ‘ideology’ to understand practice, policy and context

Throughout this research, I have used the concept of ‘ideology’ to analyse and interpret practice, policy and the context for child protection in Queensland. I have applied Therborn’s (1980) (cited in Sinclair, 2005, p. 227-8) definition of ideology as a “conceptual and analytical tool to explore a range of prevailing ideological discourses that have an effect on systemic child protection practice”. At a more individual level, I have applied Sinclair’s (2005) definition of ideology as “systems of ideas, values and beliefs” (p. 228). I have also drawn from the work of Carter (1974), Parton (1985), Smith (1991), de Montigny (1995), Blaug (1995), Spratt and Houston (1999), Tilbury (2005), Lonne and Thompson (2005), Pelton (2008) and my own work (Gillingham & Bromfield, 2008) to develop and apply ‘ideology’ as a conceptual tool.

Applying ideology as a conceptual tool was particularly useful, as mentioned in Chapters One, Two and Five, for understanding and interpreting the context for practice in the Department. That is, how the problems in the former Department of Families were conceptualised (see CMC 2004) and responded to (see Blueprint 2004). An analysis of the prevailing ideologies that shaped the CMC’s inquiry and the Department’s response provided insight into how SDM came to be chosen and implemented as part of the solution to identified problems. Problems were conceptualised by applying managerialist and bureaucratic ideologies, and technocratic ideology was used to conceptualise the solutions. Child rescue ideology
was identified as underpinning the philosophy of the new Department of Child Safety and the creation of the Practice Manual and, in this research, has emerged as underpinning practice at the level of some practitioners in relation to their decisions about clients. SDM, in terms of its stated aims, and as part of the solution to the perceived problems with the Department of Families, was aligned ideologically with both managerialist and bureaucratic ideologies. SDM is also aligned with child rescue ideology, both in terms of its lexicon and its foundation on actuarial risk assessment.

The findings of this research raise significant doubt about whether implementing SDM as a practice framework, as part of a range of initiatives in the new Department, was the best course of action to address the problems identified in the former Department of Families. The findings of this research go further than just suggesting that the wrong tool has been chosen and that there might be a better one that the Department could adopt. These findings question whether an approach to improving practice that was based so extensively on technocratic ideology was appropriate.

Spratt and Houston’s (1999) definition of technocratic ideology, drawing from Carter (1974) and Parton (1985) (see Chapter One), concerns the belief that we need to develop tools to solve problems in the provision of human services. As noted in Chapter Eight, this belief has, more recently, been extended to the need to develop electronically based data (ICT) systems to assist with case recording. Before ICT systems became widespread in human services organisations, tools to assist practice were paper based, for example, the ‘Orange Book’ assessments in the late 1980’s in the UK. Presumably the first projects that involved the SDM tools in the late 1980’s and early 1990’s were also paper based. Some participants in this research recalled that when the SDM tools were trialled and initially implemented across the state, they were paper based as the ICMS had yet to be launched. In Queensland, the SDM tools have been combined with, and embedded within an ICT system (the ICMS). The move to ICT systems for case recording has been criticised for the way that it affects the type of information that is collected about clients and the way that
information is used (Parton, 2008; Aas, 2004) (see Chapter Eight). While the observations of Parton (2008) and Aas (2004) only partially apply to the findings of this research, the effects of embedding the SDM tools in an ICT system do require comment. Perhaps the most important point is that, whereas paper based tools can be ignored and not included in files, the ICMS in Queensland is instrumental in ensuring that practitioners and Team leaders do not ignore the tools. The tools have to be completed and approved before the case can be moved to the next stage. As shown in Chapter Eight, the implementation of the ICMS has also meant that, not only do practitioners have to engage with the SDM tools, but they also feel compelled to type very long descriptive casenotes and rationales for their decisions. It is the ICMS that has made it possible for practitioners to write such long casenotes. Therefore, when considering how technocratic ideology might affect child protection practice, the analysis now needs to include the effects on practice of embedding decision making tools in ICT systems.

The implications of the use of ideology as a conceptual tool in relation to the findings of this research are further applied to child protection practice in Queensland in the Chapter Ten.

**Limitations of the research**

The main limitation of this research is that it has only considered how practitioners used four of the SDM tools in one jurisdiction. Consequently the findings cannot be generalised to other jurisdictions and other forms of risk assessment tools. Even within the Department of Child Safety, the generalisability of the findings is limited by the inclusion of only six CSSCs (out of a total of 46) in this research. Selection of the sites, while purposive, was not random and was more a sample of convenience as I was obliged to accept sites as they were offered by the Departmental representative who very kindly and diligently sought the co-operation of CSSC managers. Hence the sample only included managers who wanted their CSSC to be included in the research. This was certainly true in the case of two sites, but in another two, the managers who had agreed to participate in the research had moved on to other
positions before I actually arrived. But, rather than undermine the findings of this research, these limitations illustrate the difference between how qualitative research is theorised and how it is actually carried out in human service organisations (Darlington & Scott, 2002). Ultimately, a balance has to be struck between the ideals presented in theory about research and the demands of practice, in order for any research to be conducted.

This research focussed on how the SDM tools were used by practitioners rather than the outcomes of their use. While a study of how the tools were used can provide some information about the effects on practice at a case level, inferences about the outcomes at an organisational level are limited. In this research, a particular limitation has been the lack of concurrent quantitative data about general trends in the child protection system - such as numbers of notifications, substantiations, children removed from the care of their parents - alongside which the findings could be considered. However, as mentioned above, given that the research shows that the tools were frequently not used to assist decision making, the research has shown that a consideration of outcome, or throughput, data on its own cannot be used to draw inferences about the effects of implementing tools.

While a consideration of the context for practice in Queensland was an important part of this research, context was considered mainly in relation to the use of the tools. The focus on how the tools were used obscures other, perhaps more significant, contextual factors that affected practice. For example, in CSSCs where there were insufficient staff or predominantly staff who had little expertise, use of the SDM tools was not the most important challenge that practitioners faced on a daily basis. Participants in this research may have been very willing to describe to me how they struggled to use the tools at times and interpret definitions in their interviews with me. My observations were, though, that their main concern was about whether the decisions they had to make about the children and families were correct, rather than how the decisions were made. In short, while my focus as a researcher was on how the tools were used, this was not the main concern for the practitioners I was observing and interviewing.
As explained in Chapter Three, the designers of SDM claim that the tools can be used in any child protection jurisdiction, perhaps with a little adjustment to local conditions and legislative requirements, and that cultural factors are not important. This would appear to be at odds with policies in Queensland and other states that prescribe particular practices for working with, in particular, Indigenous Australians. This research has not engaged with this apparent contradiction. Given the recognised need for ‘culturally competent’ practice with Indigenous Australians, there is a need for further research that explores the extent to which SDM, as a tool to assist decision making, is consistent with culturally competent practice. This is particularly important given the over-representation of Indigenous Australians in every stage of the child protection process (see AIHW, 2007).

**Suggestions for future research**

Following on from the main limitation of this research noted in the previous section, future research about how the tools are used by practitioners in other jurisdictions would provide a useful comparison for this study. In particular, it would provide more insight into the relative importance of the factors identified in this research that affect how the tools are used. Throughout this research, the point has been made that use of the tools in Queensland, particularly in the intake and investigation stages of a case, is not only mandatory but it is also unavoidable. Future research in jurisdictions where use of the tools is discretionary rather than mandatory, might, in comparison with this research, provide useful insights about how and why practitioners use the SDM tools.

The findings of this research suggest that there is a relationship between how the SDM tools are used and the expertise defined as knowledge, skills and experience of particular practitioners. This was a finding rather than the focus of this research and while it appears that use of the SDM tools requires a level of expertise this observation requires further investigation to enhance our understanding of how tools need to be developed in the future. A particular question that arises concerns the
point in the career of a practitioner at which the tools start to become less useful as a framework for practice.

The suggestion was also made by some participants that the SDM tools were useful as learning tools, particularly for less experienced and new staff. How tools might be used to assist in the professional development of new practitioners requires further exploration. Such research would also need to take account of the conclusion drawn in this research that the future development of tools needs to be guided by the practitioners who would use them.

**Chapter summary**

In this Chapter, the findings of this research have been summarised and the unstated conditions of the use of the SDM tools in the intake and investigation stages of child protection practice in Queensland made explicit. The general unstated conditions that emerged from the findings were that the tools were used as accountability tools and operated like a cipher machine. Unstated conditions that differed in applicability across the CSSCs visited for this research were were an administrative burden and that it was OK to manipulate/ignore outcomes. The tools were also used according to the pressure of demand. The identification of the unstated conditions provided a general view of how the tools were used but they could not predict how individuals might use them. The most significant factor identified about individuals that affected how they used the tools was their level of expertise.

The contribution to research about decision making, risk assessment and the use of tools in child protection practice has also been identified. The focus in this research on how the SDM tools were used by practitioners showed that we cannot assume that practitioners will use tools according to organisational mandates and that, ultimately, they decide how they will use tools. This research has made a contribution to debates about the future development of tools to assist with decision
making, specifically that it needs to be guided by and include the perspectives of the practitioners. In doing so, as Munro (2005b) suggests, tools need to address areas of practice that practitioners define as problematic. This research has shown that implementing tools that appear to align with organisational and administrative needs do not assist practitioners, despite, as in the case of SDM, the claims made for them by their designers. Neither do they meet organisational and administrative needs.

Throughout this research I have used ‘ideology’ as a conceptual tool to understand and interpret policy and practice in child protection. In this Chapter, the utility of applying ideology as a conceptual tool to assist in understanding and interpreting practice has been explored further with reference to the findings of this research. The implications of the use of ideology as a conceptual tool in relation to the findings of this research are applied to child protection practice in Queensland in Chapter Ten.

Finally in this Chapter, the limitations of this research have been identified and suggestions made about further research that might further enhance understandings about how practitioners use tools in their practice.

In the final Chapter, the implications of this research are discussed as they relate more specifically to child protection policy and practice in Queensland.
Chapter Ten: Implications for Policy and Practice

Introduction

This Chapter draws from the discussion of the findings in Chapter Nine to explore the implications of this research for child protection policy and practice in Queensland. This discussion is structured by a consideration of the findings as they relate to the stated aims of SDM as a practice framework (see Chapter Three) and the specific goals of implementing them in Queensland (see Chapter Two). In this discussion, the findings of the research (from Chapter Nine) are restated briefly rather than repeated. The discussion from the previous Chapter about the use of ideology as a conceptual tool, as it relates to the Department of Child Safety is then continued. Lastly, the role of social work in relation to child protection practice is considered.

The findings of this research, as presented in this Chapter and Chapter Nine are both pertinent and timely. In November 2008, the Report of the Special Commission of Inquiry into Child Protection Services in New South Wales was released (Wood, 2008). In the Executive Summary and Recommendations, Recommendation 9. 1 is:

DoCS should test the use of Structured Decision Making tools at the Helpline and at CSC’s in relation to assessments and intervention including restoration.

Contact has been made with a representative of DoCS to discuss the findings of this research, as the Department is preparing a “detailed action plan” to be released in March 2009) as a response to the Report (DoCS, 2008).
Implications for policy and practice

In Chapter Three, the claims made for the SDM tools were, briefly, that they assist in decision making and can be used by inexperienced staff in situations where there is high staff turnover. Further that they promote consistency in decision making and action, and can help to target the children most in need of a service. In this section, these claims will be assessed in relation to the findings of this research in order to articulate their implications for future policy and practice in the Department.

To assist decision making and use of the tools by inexperienced staff

Overall, there was little evidence found in this research to suggest that practitioners used the tools to assist with their decision making, and this was particularly so for the FRET.

There is currently a project underway at the Department Head Office which has the following aims:

1. Improving the application and use of the SDM tools
2. Improving the usage and utility of case readings
3. Improving the fusion between professional judgement and the use of SDM (personal email communication, 26/8/2008)

The belief that decision making will be enhanced if practitioners can improve their use of the SDM tools is further evidence that technocratic ideology continues to drive policy and practice in the Department. The findings of this research do not support this strategy to improve decision making and practice more generally. The findings of this research suggest instead that practitioners in the Department, particularly the new recruits, need increased levels of knowledge and skill to deal with the complex situations they face. In particular they need knowledge about the forms and signs of child abuse and neglect and ways to intervene in families to reduce the risk of harm
to children. Point 3, which is about ‘improving the fusion between professional
judgement and the use of SDM’, does coincide with the tentative conclusion drawn in
Chapter Nine (which Munro (2008) also advocates) there may be ways that tools can
be used as a form of analytic reasoning to complement intuitive reasoning.

In Chapter Five, participants described the lack of training for new staff and were
critical of the strategies that did exist (the ‘Verification of Competence’). However,
five participants had completed the Graduate Certificate in Human Services (Child
Protection) at the University of Queensland and were very positive about how this
course had helped them in their work. In 2008, the Department was offering 30
scholarships to three categories of potential applicants to undertake the Certificate at
either James Cook University (15 places) or the University of Queensland (15
places) (DCS, 2008a). The findings of this research suggest that the Department
should consider increasing the number of scholarships for the Certificate rather than
trying to increase compliance with the use of the SDM tools. As suggested in
Chapter Nine, there was some evidence found in this research that the tools could
be developed further as ‘learning tools’, but this would require further research and
needed to be geared to the needs of practitioners, rather than the organisation.

To promote consistency

As discussed in the previous Chapters there was no evidence in the findings of this
research to suggest that the SDM tools promoted consistency in decision making,
action or service delivery. There were clear differences between practitioners, Team
Leaders and CSSCs in terms of what decisions they would make in the same case,
particularly in relation to whether to accept a contact as a notification for
investigation, the timescale of an investigation and when to recommend case closure
or further intervention. While some of the participants argued in favour of the need
for ‘consistency’ (even that CSSCs should be like McDonalds, see Chapter Five), it
could also be argued that the emphasis should be more on tailoring Departmental
responses to what is required to meet the individual protective needs of children.
This tailoring of service response to individual service needs would require flexibility
of response and innovative approaches to dealing with children, families and
communities. It is the opposite of the ‘one size fits all’ response (Waldfogel, 1998;
Barter, 2001) that the notion of consistency tends to invoke. At another level, given the diversity of the population in Queensland, particularly in terms of geographic location and ethnicity, it would be unreasonable to expect consistency in practice between, for example, a CSSC in the inner northern suburbs of Brisbane and a CSSC that covered isolated Indigenous populations in Cape York.

To target the children most in need

According to the CRC documents (see Chapter Two), the FRET, in particular, aims to assist decision makers to identify children who are, because a range of factors that exist in their lives, most likely to come to the attention of a child protection service again at some time in the future. Having identified this group of children, services can then be provided to reduce the likelihood of renotification. The findings of this research were that practitioners were not using the FRET to target the children most in need. The outcomes (risk levels) assigned by the FRET at the conclusion of an investigation were, in many cases manipulated or ignored, as participants did not consider that they were accurate.

There were two significant findings in this research that need to be considered in relation to the targeting of children most in need. One was that participants perceived that the implementation of SDM had led to the prioritising of the ability to assess rather than intervene and work with families. The other perception of some participants and my observation was that there was a lack of services to support families and a lack of knowledge among practitioners about what services that did exist. There were several participants who identified that the key to protecting most of the children they came into contact with was the ability to be able to intervene to support families and that this needed to be re-emphasised in the Department. The need for a shift in emphasis in how child protection is conceptualised is discussed further in the next section.
Ideology in Queensland

Child Rescue Ideology

The identification of child rescue ideology as underpinning much of the practice that I observed during the fieldwork was, as stated in Chapter Five, important to the process of understanding and interpreting the decisions and actions of practitioners. At an individual level, this may have been linked to the lack of experience of many of the COSs and Team Leaders. As Gambrill (2000) argues, less experienced practitioners are more likely to adopt a child rescue position when confronted with harm to a child. At a policy level, it was also a significant finding of the analysis of documents about the reorganisation of child protection services presented in Chapter Two. Tilbury (2005) poses the question of whether the then new Department of Child Safety would be able to avoid the “pitfalls of the ‘pendulum swing’ between child rescue and family support” (p.15-16). The findings of this research suggest that the pendulum has swung very firmly toward child rescue.

The emphasis within such a service system is on ‘rescuing’ children by removing them from the care of their parents and directing parents to take initiative to address problems that are conceptualised as resulting from individual pathology rather than social structures that create inequality (Pelton, 2008). The emphasis is not on supporting parents to improve care of their children, with removal being a last resort. This development in services in Queensland can be considered as the opposite of developments in the UK, referred to as the ‘refocussing debate’ (Corby, 2006; Parton, 1997), and in Victoria with the expansion of family support services in the non-government sector aimed at reducing involvement with child protection services (DHS, 2006). It also runs counter to commentary in the literature that argues for a different approach to child protection (for example, Lonne, Parton, Thompson & Harries, 2008; Scott, 2006a and b; Pelton, 2008; Houston & Griffiths, 2000; Scott & O’Neill, 1996).

The consequences of child rescue ideology, mentioned by some of the participants in this research, were that increasing numbers of children were being removed from
the care of their parents, many for short periods of time, than was the case before
the Department was created (see Chapter Five). The trends in the data from the
Department (presented in Chapter Two) support these observations. The more
recent data from the Queensland Magistrates Courts Annual Reports 2005-06 and
2006-07 (presented in Chapter Two) suggest that this might be the case in some
parts of the state more so than others. The disparity between courts in terms of large
increases and decreases in applications by the Department also suggest that, even
allowing for some reorganisation of the court jurisdictions, that practice from one
CSSC to another was not consistent. Despite the claims made by the Department (in
Chapter Two) that SDM may be having a moderating effect on the increases in
notifications and substantiations, it could be argued that more recent data, and data
over a longer period, would be required to make any assessment of the impact of
implementing SDM. As mentioned in the last Chapter, any inferences drawn from
such data would be undermined by the findings of this research.

If, ultimately, the trend is that increasing numbers of children are being removed from
their parents, then further problems emerge. Firstly, there is the possibility of causing
more harm to children by removing them from their parents: “It is important for child
protection professionals to recognise that there is no such thing as absolute safety,
and that the likely or possible benefits of any intervention - whether or not this
involves removing children from their parents' care - must be weighed against the
likely or possible harm that it might do” (Beckett, 2007, p. 188). Beckett (2007) goes
on to define the harm that children might suffer after being removed from the care of
their parents as resulting from “system abuse”, a particular example being placement
breakdowns and moves. Secondly, there is the demand that this would place on the
out-of-home care system. From my current involvement with the foster care system
in Victoria, it is clear that foster parents are a finite resource in any community (see
also CECFW, 2008). ‘Kinship care’ may not always be a viable alternative for
individual children, nor, more broadly, in developing the out-of-home care system.
Accommodating children in out of home care is also costly: the annual average cost
of accommodating a child in an out of home placement in Queensland is $55 800
(CECFW, 2008, p. 5). So far, the budget for the new Department has increased
annually, but it is reasonable to suggest that ‘child safety’ may not always be the priority it has been in Queensland since 2003 and that this may not continue.

The realisation that supporting parents to care for their children rather than removing them is preferable in most cases, coupled with the practical and financial problems of providing out-of-home care may provide impetus for a change in ideology in Queensland, from child rescue to family support, as has happened in other jurisdictions. There is some indication that this may already be happening in Queensland, with the development of “Referral for Active Intervention” services (DCS, 2008b), which occurred after the fieldwork for this research had been completed. These services are funded by the Department of Communities and are intended for children and parents who are considered to be at risk of entering the child protection system and/or had past involvement with the Department. Despite this initiative appearing to be a way of diverting children away from the child protection system, referrals to the service can only be made by officers of the Department.

Technocratic Ideology

As discussed in Chapter Two, technocratic ideology, that is, the belief that tools and technology can be used to address problems and improve the delivery of services to children and families, shaped both the way that problems in the former Department of Families were conceptualised and addressed. As discussed above, implementing the SDM tools has not solved the problems identified in the CMC Report (2004). The current problems with the ICMS, in particular with its inability to produce reports, have, from my conversations with Head Office staff since the fieldwork was completed, already undermined beliefs about the promises of ICT and perhaps of technocratic ideology more generally.

The findings of this research suggest that the reliance on technocratic ideology was misguided and that too much faith was placed in the development of technical solutions - the implementation of the SDM tools and the ICMS - as a way to improve practice. As stated previously, technological solutions in the form of the SDM tools
might have a place in enhancing practice, but they cannot be used to replace expertise. Rather than focus on the further development of tools, or strategies to increase compliance with their use, the Department may be better advised to focus on the development of expertise in its staff as suggested above. It is also worth noting that some participants referred to the SDM tools as ‘dumbing down’ practice rather than enhancing it.

**Child Protection Practice and Social Work**

The place of professional social work in child protection practice, or perhaps more accurately, its absence, has been a theme throughout this research and relates back to my position as a social worker and my experiences of working in the field. More generally, though, this theme also relates to the way that tools like SDM are being considered by organisations as a way to address a lack of, or even replace, expertise.

As mentioned in the Introduction, throughout my career as a child protection practitioner in Australia and in this research, I have been surprised to find that child protection practice is not necessarily social work practice. Some of the participants in this research considered that there was no need or place for social work in child protection practice, and, more broadly there appears to be ambivalence about what the profession can offer to this field of practice (Healy & Meagher, 2007). My experience and the findings of this research lead me to agree with those participants who argued that child protection practice does need social work. As argued above, strategies to enhance practice should focus more on the development of expertise rather than on the development of tools. Newly qualified social workers may vary in their readiness to practice in child protection, but they do have to have a level of knowledge and skills that assist them to understand and intervene in complex situations, which exceeds that of graduates from more generalist tertiary courses. Additionally, qualified social workers should also have a more developed sense of the ethical dilemmas that working with involuntary clients can pose. More specialist knowledge will be provided by the current development of a statement of specific
child protection curriculum content for all social work qualifying courses (a process in which I am currently involved as a social work educator). And so, rather than seeking to widen the range of qualifications required to work in child protection (as mentioned in Chapter Five), the Department should perhaps consider how it might prioritise the recruitment and retention of qualified social workers.

Chapter summary and conclusion

The findings of this research suggest that the original aims of implementing the SDM tools, at least in the intake and investigation stages of a case, have not been met. The SDM tools have not assisted practitioners to make decisions, they have not promoted consistency in practice and they have not helped to identify the children most in need. The reliance on technocratic ideology to solve the problems identified in the former Department of Families was, based on the findings of this research, misguided. More broadly, the foundation of child protection practice and policy on child rescue ideology has led to the diminution of what has been recognised in other jurisdictions as the most important strategy to protect children from harm, that is, the expertise and resources to support children and parents.

The findings of this research and the implications for policy and practice that have been discussed above have to be considered in the broader context of the recent history of the development of child protection services in Queensland (Tilbury, 2005). As shown in Chapter Two, the redevelopment of child protection services was driven by a particular combination of social and political forces which led to the adoption of what, in the circumstances, appeared to be the most appropriate ideologies to conceptualise and solve the problems identified, most significantly managerialistic, technocratic and child rescue. But as society changes with time, so do attitudes toward child protection (Parton, 1991; Scott & Swain, 2002; Ferguson, 2004) and so the Department will evolve. The social and political conditions that existed in 2004 have already changed as other problems have become priorities. As mentioned in Chapter Five, despite the Department being under continued pressure from both the media and other professional groups and agencies to maintain its focus on child
rescue, there were very positive signs that this was being resisted by some frontline practitioners and senior managers in the Department.

Reflecting on the findings of this research and, in particular, my observations of practice in the Department, change within the Department, as outlined above, is not only possible, but inevitable. The Department and its staff are very used to change as much has changed since its creation in 2004. Though the Department has recruited many new and inexperienced staff, these staff are, as time proceeds, becoming more experienced. The findings of this research suggest that staff become disenchanted with SDM as a practice framework as their experience grows. Some participants in this research were keen to learn more about child protection practice and access further learning materials. As suggested above, the SDM tools might also be used as a learning tool to enhance their knowledge and expertise. If this learning extends beyond the identification of risk of harm to children to how to intervene to support children and families, then the focus of the Department’s work will change.

While the picture that emerges from this research is almost wholly negative with respect to how the SDM tools were used, this should not be read as criticism of the participants in this research or Departmental staff more generally. Certainly I encountered practitioners who had little experience of or knowledge about what they were expected to deal with, but the criticism here is aimed at the strategy for recruiting Child Safety Officers rather than the individuals involved. Most positively, I did meet some very experienced and knowledgeable practitioners, Team Leaders, Senior Practitioners and Managers whose commitment and practice was exemplary - though they were keen to point out that their practice had little, if anything, to do with the SDM tools. As stated in Chapter Nine, tools cannot be used to replace expertise, neither can they be used to replace the dedication of staff to the complex and demanding role of protecting children from harm.
A Final Thought

Throughout this research, there has been, at the back of my mind, a quiet but persistent voice that has reminded me of the adage that ‘a bad craftsperson always blames their tools’. This has been coupled with memories of a woodwork teacher who (successfully) managed to teach me that a good craftsperson would not use bad tools. The relevance of these thoughts has eluded me for much of this research until now. This research has shown what happens when craftsperson (s) - ‘good’ or ‘bad’ - are compelled to use what they mostly consider to be bad tools. While it may appear that such craftspersons are using the bad tools, a closer examination reveals that they are not really using them.

Another lesson that I learned from my woodwork teacher was that good tools do not make a craftsperson, tools are only as good as the person using them. This was borne out in the findings of this research, in particular, that tools, however good they might be, cannot replace expertise.
References


http://www.nccd-crc.org/crc/c_pubs_main.html

http://www.nccd-crc.org/crc/c_pubs_main.html


services. Olympia, WA: Department of Health and Social Services, Office of Children's Administration Research, National Centre on Child Abuse and Neglect Grant No. 90-CA-1456.


http://www.auditor.mo.gov


### Appendix 1: The SDM Screening Tool from Chapter 1 (page 27) of the *Practice Manual*

#### Section 1: Alleged Harm/Risk of Harm

**Neglect:** The child’s basic necessities of life are unmet by his/her parent to such an extent that the child’s health and development are affected, causing harm, or an unacceptable risk of harm, to the child.

- Inadequate supervision
- Inadequate basic care (food/nutrition, shelter, medical/mental health care, clothing/hygiene)
- Abandonment
- Failure to protect
- Child is at risk of neglect following the death of a sibling in suspicious circumstances
- Youth homelessness

**Physical harm:** A child has suffered, or is at an unacceptable risk of suffering, serious physical trauma or injury of a non-accidental nature, due to the actions of his/her parent.

- Non-accidental injury or illness
- Suspicious injury or illness
- Excessively harsh discipline
- Child is at risk of physical harm following the death of a sibling in suspicious circumstances
- Exposure to domestic violence resulting in, or likely to result in, physical harm

**Sexual abuse:** Child sexual abuse refers to any sexual activity or behaviour that is imposed on a child by his/her parent or a household member. It includes the inducement or coercion of a child to engage in, or assist any other person to engage in, sexually explicit conduct or behaviour for the sexual gratification or profit of the person responsible. It also includes circumstances where there is an unacceptable risk that the child may be sexually abused.
Sexual contact or exploitation

Sexual contact or exploitation by another child

Suspicious indicators consistent with abuse

Emotional harm: The child’s social, emotional, cognitive, or intellectual development is impaired or seriously threatened as a direct result of persistent parental behaviour/attitude towards the child. This includes significant emotional deprivation due to persistent rejection and hostility.

The harm to the child may be observable in behaviour such as severe anxiety, depression, withdrawal, self-harming behaviour, or aggressive behaviour towards others.

- Chronic rejection, criticism, scapegoating, ignoring, isolating or terrorising
- Parental conditions/behaviours (other than domestic violence) have led to emotional harm
- Exposure to domestic violence resulting in or likely to result in emotional harm

Unborn child:

- An unborn child is reasonably suspected to be in need of protection after he or she is born, due to neglect, physical or emotional harm or sexual abuse.
Appendix 2: The Safety Assessment tool, from Chapter 2 (page 42) of the Practice Manual

**Section 1: Immediate Harm Indicators**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has the child experienced serious physical harm due to the actions of a parent or other household member; or has a plausible threat to cause serious physical harm to the child been made by a parent/household member?</td>
<td></td>
</tr>
<tr>
<td>2. Is child sexual abuse suspected AND do circumstances suggest that further sexual abuse may occur if action is not taken immediately?</td>
<td></td>
</tr>
<tr>
<td>3. Has a parent failed to protect the child from physical abuse, sexual abuse, emotional abuse, or neglect by others AND this failure to protect the child from abuse or neglect has led or could lead to the child being seriously harmed?</td>
<td></td>
</tr>
<tr>
<td>4. Has the injury to the child been denied or minimised by the parent, or is his/her explanation for the injury questionable or inconsistent with the type of injury, AND the nature of the injury suggests that the child’s safety may be of immediate concern?</td>
<td></td>
</tr>
<tr>
<td>5. Has the parent refused access to the child or hindered the investigation and assessment; OR is there reason to believe that the family is likely to flee to avoid the investigation and assessment?</td>
<td></td>
</tr>
<tr>
<td>6. Are the child’s immediate needs for supervision, food, clothing, and/or medical or mental health care currently unmet by the parent, AND as a result is the child’s health and wellbeing seriously impaired OR are the needs so imminent that action is required today?</td>
<td></td>
</tr>
<tr>
<td>7. Are the physical living conditions hazardous AND pose an immediate threat to the health and/or safety of the child?</td>
<td></td>
</tr>
<tr>
<td>8. Are the child’s immediate protection and care needs currently unmet due to</td>
<td></td>
</tr>
</tbody>
</table>
the parent’s misuse of alcohol or drugs?

9. Does domestic violence exist in the home AND do they pose a danger of serious physical and/or emotional harm to the child?

10. Is the child exhibiting severe behavioural indicators of emotional harm as a result of a parent’s emotionally abusive treatment of the child?

11. Are the child’s immediate protection and care needs currently unmet due to the parent’s emotional instability, intellectual or physical disability or mental health issues?

12. Other (specify):

________________________________________________________

13. If items 1-12 do not apply, is there information that indicates a pattern of escalating threat to the child’s safety?

---

**Section 2: Safety Interventions**

Non-custody Interventions:

1. Intervention or direct services by the Child Safety Officer/Child Safety Support Officer as part of a safety plan.

2. Use of family, neighbours or other individuals as safety resources, including brief overnight stays as arranged by the family if appropriate.

3. Use of community agencies or services as safety resources.

4. A parent who has not harmed the child agrees (and is both able and willing) to protect the child from the person alleged responsible for the harm (in cases of sexual abuse, this intervention may not be used as the only intervention in a safety plan).

5. The person alleged responsible for the harm will leave the home, either voluntarily or involuntarily.

6. The parent who has not harmed the child will move to a safe environment with the child.

7. Legal action planned or initiated – custody remains with the parent.

8. Other (specify):

________________________________________________________

Placement Interventions:

9. The child’s parent agrees to place the child in a departmentally approved
placement (placement with parental consent).

10. The child is placed in custody under an assessment order because no other interventions are available to adequately ensure the child's immediate safety.*

11. The child is placed in custody under a child protection order or interim child protection order because no other interventions are available to adequately ensure the child’s immediate safety.*

* Requires consultation with Team Leader.

Section 3: Safety Decision

1. Safe. No immediate harm indicators are identified at this time. Based on currently available information, there are no children likely to be in immediate danger of serious harm.

2. Conditionally Safe. One or more immediate harm indicators are present, and noncustody safety interventions have been planned or implemented. Based on safety interventions, all children will remain in the home at this time. A safety plan is to be completed with the family.

3. Unsafe. One or more immediate harm indicators are present, and placement is the only safety intervention possible for one or more children. Without placement, one or more children will likely be in immediate danger of serious harm.
### Appendix 3: The FRET reproduced from in Chapter 2 (pages 61-62) of the Practice Manual

**SDM™ Family Risk Evaluation for Abuse/Neglect (Version 3.0)**

Below are the neglect and abuse indices that determine the ‘scored risk level’.

#### NEGLECT

**N1. Current notification alleges neglect**  
- a. No .......................................................................................................................................................... 0  
- b. Yes ....................................................................................................................................................... 2  

**N2. Prior notifications (assign highest score that applies)**  
- a. None ..................................................................................................................................................... -1  
- b. One or more, abuse only ....................................................................................................................... 1  
- c. One or two for neglect .......................................................................................................................... 2  
- d. Three or more for neglect .................................................................................................................... 3  

**N3. An ongoing intervention case has previously been opened with the household**  
- a. No ......................................................................................................................................................... 0  
- b. Yes ....................................................................................................................................................... 3  

**N4. Number of subject children living in the notified household (Number = ___)**  
- a. One, two, or three ............................................................................................................................... 0  
- b. Four or more ....................................................................................................................................... 2  

**N5. Age of youngest child in the home (Age = ___)**  
- a. Two or older ........................................................................................................................................ 0  
- b. Under two ............................................................................................................................................ 1  

**N6. Primary parent provides physical care inconsistent with child needs**  
- a. No ......................................................................................................................................................... 0  
- b. Yes ....................................................................................................................................................... 1  

**N7. Primary parent has a history of abuse or neglect as a child**  
- a. No ......................................................................................................................................................... 0  
- b. Yes ....................................................................................................................................................... 2  

**N8. Primary parent has/had a mental health problem**
<table>
<thead>
<tr>
<th>N9. Primary parent has/had a drug or alcohol problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. None/Not applicable ................................................................. 0</td>
</tr>
<tr>
<td>b. One or more apply................................................................. 2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>a. During the last 12 months AND/OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>At any other time prior to that</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>N10. Primary Parent has criminal history as adult or juvenile</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. No ........................................................................... 0</td>
</tr>
<tr>
<td>b. Yes ........................................................................... 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>N11. Characteristics of children in the household</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Not applicable ................................................................. 0</td>
</tr>
<tr>
<td>b. One or more apply................................................................. 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Developmental or physical disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medically fragile/failure to thrive</td>
</tr>
<tr>
<td>Positive toxicology screen at birth</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>N12. Current housing</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Not applicable ................................................................. 0</td>
</tr>
<tr>
<td>b. One or more apply................................................................. 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physically unsafe AND/OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family homeless</td>
</tr>
</tbody>
</table>

**ABUSE**

<table>
<thead>
<tr>
<th>A1. Current investigation and assessment is substantiated and the harm or risk of harm resulted from physical abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. No ........................................................................... 0</td>
</tr>
<tr>
<td>b. Yes ........................................................................... 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A2. Number of prior notifications alleging abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. None ................................................................. 0</td>
</tr>
<tr>
<td>Question</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>b. One</td>
</tr>
<tr>
<td>c. Two or more</td>
</tr>
<tr>
<td>A3. An ongoing intervention case has previously been opened with the household</td>
</tr>
<tr>
<td>a. No</td>
</tr>
<tr>
<td>b. Yes</td>
</tr>
<tr>
<td>A4. Prior injury to a child resulting from child abuse/neglect</td>
</tr>
<tr>
<td>a. No</td>
</tr>
<tr>
<td>b. Yes</td>
</tr>
<tr>
<td>A5. Primary parent's assessment of incident</td>
</tr>
<tr>
<td>a. Not applicable</td>
</tr>
<tr>
<td>b. One or more apply</td>
</tr>
<tr>
<td>Blames child AND/OR</td>
</tr>
<tr>
<td>Justifies abuse/neglect of a child</td>
</tr>
<tr>
<td>A6. Two or more incidents of domestic violence in the household in the past year</td>
</tr>
<tr>
<td>a. No</td>
</tr>
<tr>
<td>b. Yes</td>
</tr>
<tr>
<td>A7. Primary parent characteristics</td>
</tr>
<tr>
<td>a. Not applicable</td>
</tr>
<tr>
<td>b. One or more apply</td>
</tr>
<tr>
<td>Provides insufficient emotional/psychological support</td>
</tr>
<tr>
<td>Employs excessive/inappropriate discipline</td>
</tr>
<tr>
<td>Domineering parent</td>
</tr>
<tr>
<td>A8. Primary parent has a history of abuse/neglect as a child</td>
</tr>
<tr>
<td>a. No</td>
</tr>
<tr>
<td>b. Yes</td>
</tr>
<tr>
<td>A9. One or more parents have/had alcohol and/or drug problem</td>
</tr>
<tr>
<td>a. No</td>
</tr>
<tr>
<td>Question</td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td>b. Yes (check all applicable) ................................................................. 1</td>
</tr>
<tr>
<td>During the last 12 months: [ ] Primary Parent</td>
</tr>
<tr>
<td>[ ] Secondary Parent</td>
</tr>
<tr>
<td>Any other time prior to that: [ ] Primary Parent</td>
</tr>
<tr>
<td>[ ] Secondary Parent</td>
</tr>
<tr>
<td>A10. Primary parent has a criminal history as adult or juvenile</td>
</tr>
<tr>
<td>a. No ........................................................................................................... 0</td>
</tr>
<tr>
<td>b. Yes ......................................................................................................... 1</td>
</tr>
<tr>
<td>A11. Characteristics of children in household</td>
</tr>
<tr>
<td>a. Not applicable ................................................................................... 0</td>
</tr>
<tr>
<td>b. One or more apply ............................................................................... 1</td>
</tr>
<tr>
<td>Offending history</td>
</tr>
<tr>
<td>Developmental disability</td>
</tr>
<tr>
<td>Mental health/behavioural problem</td>
</tr>
</tbody>
</table>
Author/s:
GILLINGHAM, P.

Title:
The use of assessment tools in child protection: an ethnomethodological study

Date:
2009

Citation:

Persistent Link:
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The use of assessment tools in child protection: an ethnomethodological study

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