The child protection jigsaw

Article

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The Child Protection Jigsaw

David Lane[1]*, Eileen Munro and Elke Husemann*

THE NEED TO REVIEW

Child protection is difficult. The broad aspiration is to make children safe, to try to ensure their welfare and development. Children's Social Care departments are central to this but, for example, police, schools, general practitioners, health visitors, family courts and a range of charities all have roles to play in child protection. Having all those different agencies makes things complicated. The work itself is demanding. For example, scrutinizing possible cases of child maltreatment is an important aspect of child protection work. To do this, child and family social workers must confront two key questions - both difficult to answer.

First: is the child actually being maltreated? Children get bruises all the time – she wasn't pushed, she fell. But parents or carers who harm their children sometimes tell lies. Children also lie sometimes; to protect their parents they may conceal the harm that they are experiencing. Consequently, understanding what is going on and why is hard; abuse can be missed.

[1] Correspondence to: Prof David C Lane, Henley Business School, Whiteknights, Reading, RG6 6UD, England. E-mail: d.c.lane@henley.ac.uk

Even if you are sure there is abuse you confront the second question: what is the best thing to do? Removing a child is the obvious step. However, outcomes in care are not always good and disrupting a childhood and breaking up a family is a very significant step. The alternative is to work with the family to make it safe for a child to remain. And what if you fail?

In 2010 morale amongst child and family social workers was poor and public esteem for the profession was at a low point. The Government believed that even though previous reviews had been well-intentioned, they had not worked. It therefore launched a review of the child protection system in England.

The 'Munro Review of Child Protection' was based in the Department for Education - which oversees child protection in England. It had a 'Reference Group' of people from relevant professions (health, social work, judiciary, etc.). A core element of the resulting work was the wish to understand past and potential future policies in an holistic way. This was approached using Systems Thinking. The following sections give a sense of the central role played in the review by a combination of Systems Thinking ideas.

IS THIS HOW WE GOT HERE?

Things started with a broad view of the sector, with the aim of understanding how the existing situation came about. Comment elicited from the Reference Group, published papers, and interviews with experts were all used, as well as the range of evidence collected specifically for the review. The story that emerged was visualised using a causal loop diagram derived from System Dynamics modelling and a range of other Systems Thinking ideas. The resulting diagnosis is shown in the box.

Systems Thinking-based account of
how an addiction to compliance emerged in child protection

A strong belief that a prescriptive approach for child protection would be effective led to the creation of procedures. In System Dynamics terms this was a powerful balancing loop getting compliance up to the desired level. In organizational learning terms, ensuring compliance with procedures is 'single loop learning', or 'Doing it right'.

However, more procedures meant less scope for using professional judgement and that resulted in 'unintended consequences'. Reduced staff satisfaction and increased staff turnover were among these 'ripple effects'. The cybernetic concept of 'requisite variety' proved useful: staff with less scope for tailoring their interventions produced lower quality help for children. That response could have produced a correction effect via a second balancing loop. What might have resulted was a questioning of the effectiveness of a prescriptive approach, or 'double loop learning' as the sector wondered whether it was 'Doing the right thing'. However, that did not happen. The very existence of procedures allowed the 'we followed the rules' response. This 'defensive routine' reduced the ability

to acknowledge less effective work - so the learning loop was not working. Worse still, the temptation was to introduce more procedures and so a 'vicious circle' emerged, a reinforcing loop (see Fig. 1). The sector experienced an upwards spiralling use of prescription combined with a downwards spiralling ability to see the deficiencies of that approach. This was 'organisational addiction'.

What Systems Thinking helped bring to light was that applying a prescriptive approach to child protection had led to the emergence of a 'tick-box culture' of compliance. A detailed version of this diagnosis was made public in the review's first report. There was a good response to this from staff working in the sector. Many commented that the account chimed with their lived experience.

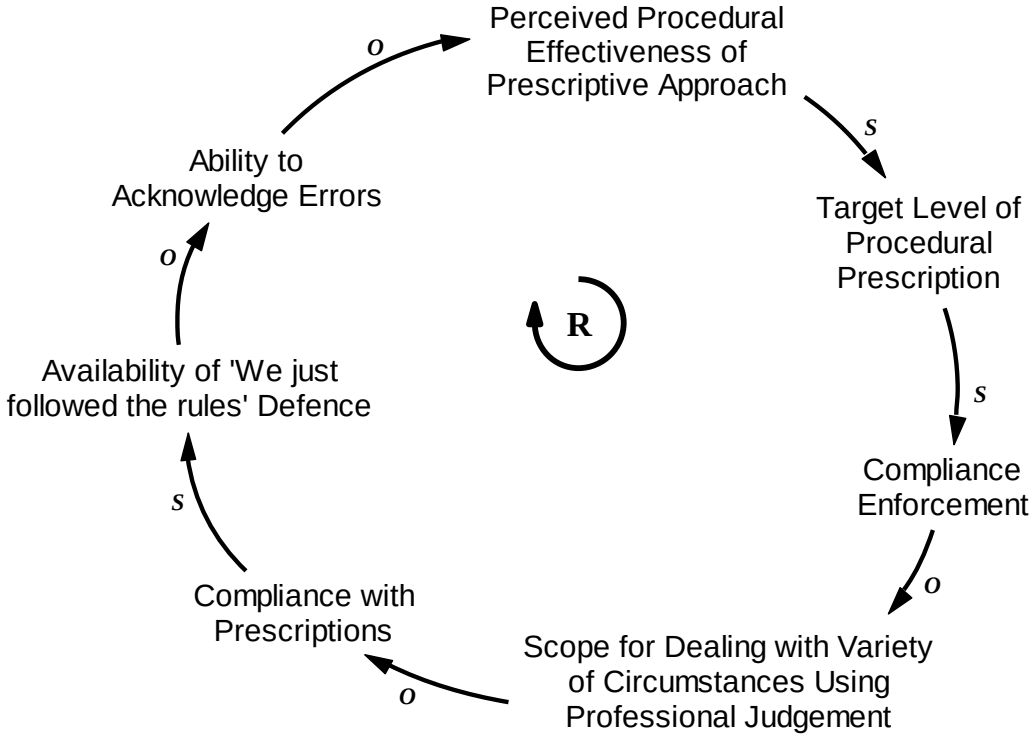

Fig. 1. Causal loop diagram illustrating the 'compliance addiction' phenomenon. Links marked 's' produce changes in the same direction whilst 'o' links produce changes in the opposite direction. The result is a positive feedback loop, or reinforcing effect.

UNDERSTANDING THE EXISTING JIGSAW

Moving from this broad view, we created a detailed map of the jigsaw pieces that had made up the policies and operations of the sector in recent decades. This involved a 'group model building' approach. In a sequence of meetings we worked with a group of professionals and specialist in child protection. Participants sat in a room discussing the sector. An evolving systems model was projected onto a large screen. The aim was to express the contributions that participants made. The job was to ask questions and to represent in the model what was said. The participants talked with each other and referred to the projected map, discussing where it was right, where it was wrong, asking for changes and clarifications. This approach continued over a number of sessions and resulted in a map of almost 60 variables.

Whilst the knowledge elicitation and mapping process involved a lot of iterations and re-visiting of issues, there was a general sequence of analysis throughout. That was structured around a series of questions applied to different aspects of child protection, as follows.

1. What problems had the sector experienced in the past?
2. What policies were implemented to address those problems?
3. What were the anticipated effects of those policies?
4. What were the ripple effects, or unanticipated consequences of those policies?
5. What were the feedback loops produced by those policies?
6. Is there qualitative/quantitative data to support or challenge the previous answers?
7. Which feedback loops dominate? Which are dormant?
8. What can be deduced about the key drivers of the sector?

We applied this sequence across the range of current operations, looking at time spent with families, quality of outcomes for children, staff skills levels, recruitment, workloads, sickness rates and a plethora of other factors. The map helped the group manage and think about the connections within and between the different areas, to see both the pieces of the jigsaw and how they fitted together. The 'big picture' that emerged was not encouraging. What the map told us about the state of the sector can be expressed in terms of feedback loops.

First, child protection was strongly influenced by a set of 'vicious circles' - 'reinforcing loops' which were detrimental to the sector. For example, poor staff morale increased turnover, which reduced the average experience level in the sector, leading to poorer quality outcomes for children which (because staff are very aware of such effects) reduced morale further. Similarly, interventions which did not get to the root of the problem produced re-referrals which added to the workload, making it more likely that staff would lack the time to understand and address the core problem.

Second, the sector's learning loops were thought to be weak. For example, Serious Case Reviews, by which child deaths or severe injuries are investigated, tended to concentrate on allocating blame to individuals, rather than also considering possible systemic factors. Learning was therefore limited.

ASSEMBLING A NEW JIGSAW

The large map and its Systems Thinking-based diagnosis were then used to develop and test alternative policies. In abstract systems terms, the idea was to break or reverse damaging reinforcing loops (turning 'vicious circles' into 'virtuous circles') and to strengthen desirable learning effects. Specific recommendations addressed the key drivers in practical, implementable ways. Those recommendations were formulated and tested by trying to think through their systemic consequences. In other words, those recommendations were supposed to be 'systemically consistent', holding together in a coherent and integrated way. The map was therefore the organising framework both for the detailed diagnosis and for the recommendations made in the final review report.

The final report discussed the drivers, the root causes of the sector's problems. These included: a lack of understanding amongst both politicians and the general public of the inherent uncertainty of child protection work; and the limitations of the Serious Case Review process.

Fifteen recommendations for change were made in the final report. This integrated set had a number of core ideas. They involved actions that rolled back prescription: instead of measuring an activity, or recording compliance with a set process, there should be measurements of actual improvements in the lives of children. The recommendations also aimed at increasing the role of social work professionalism and expertise. The idea was to improve ways for further developing expertise amongst staff by promoting learning; in other words, changing the culture of the child protection system into that of a learning organisation. To help do that the general use of systems approaches was recommended and, picking up on the second driver mentioned above, the increased use of systems ideas in Serious Case Reviews was championed as a way to improve learning about professional practice.

CHANGING THE FACTS ON THE GROUND

Responding for the Government, the Parliamentary Under-Secretary of State for Children and Families accepted the recommendations, saying:

> *"Moving away from a culture of compliance by reducing central prescription and placing a greater emphasis on the appropriate exercise of professional judgment represents a fundamental system-wide change."*

Consequently, the recommendations have been implemented via changes in the law, changes in the inspection regime and changes in the culture of the child protection sector. For example:-

- The status of the profession needed improving and public understanding of its work addressed. To help here we recommended that the post 'Chief Social Worker for Children' be created. This was done and the post has been filled.
- Child protection is inspected by the Office for Standards in Education, Children's Services and Skills. Ofsted published a new inspection approach, '*Framework for the inspection of local*

authority arrangements for the protection of children'. This significantly reduces the auditing of processes, instead judging whether children are receiving practical help.

- The Department for Education has now published new statutory guidance '*Working Together to Safeguard Children'*. There is less prescription. Instead, much more weight is given to the role of professional judgement.

Social workers are now encouraged to spend more time with children and families, building relationships, applying their continuously developing expertise and using their judgements - for example, to answer the two key questions at the start of this article. With the addition of such new pieces of the jigsaw, a different picture is beginning to emerge - and this was only possible using Systems Thinking.

David Lane is Professor of Business Informatics at Henley Business School. Eileen Munro is Professor of Social Policy at the London School of Economics. Elke Husemann specialises in analysis and education based on systems approaches.

Additional Information

A more detailed account of the work may be found at:
Lane, D. C., Munro, E. & Husemann, E. (2016). Blending systems thinking approaches for organisational analysis: reviewing child protection in England. *European Journal of Operational Research*, **251**(2), 613–623.

The official Government reports relating to this work may be found at: www.gov.uk/government/collections/munro-review