How everyone's business can become no one's business: A systems study of interprofessional referral to child contact centres

Author: Dr. Louise Caffrey, School of Social Work & Social Policy, Trinity College Dublin

Author email: louise.caffrey@tcd.ie

Author profile: http://peoplefinder.tcd.ie/Profile?Username=CAFFRELO

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Abstract

Research suggests that interprofessional working is key to child protection but it is also challenging since misunderstandings and omissions can easily occur. This article explores interprofessional working in referrals to supported child contact services in England. It aimed to understand why procedures and tools introduced to improve interprofessional working in this area failed to have the desired effect. The study adopted a systems approach and involved 58 hours of observations in six case study child contact centres covering both supervised services (which offer a high level of monitoring of contact) and supported services (which provide little oversight). In addition, 47 interviews were conducted with individuals working in centres and solicitor, social worker and judge referrers. The findings demonstrate that cases which could not be safely managed continued to be referred and accepted at supported child contact centres because all actors believed it was someone else's role to analyse the case and make a decision to accept or reject. Only social worker referrers took responsibility for this role but some social workers continued to refer cases that could not be safely facilitated because they assumed the service provided a higher level of vigilance then existed. The study draws attention to the limits of tools and protocols in enabling safe practice and the importance of exploring the potential for, what I term, 'systemic role contradictions'.

Key practitioner messages

- Complexity of child protection systems makes interprofessional working unpredictable.
- Gaps in child protection process can occur due to 'systemic role contradictions'.
- Tools alone cannot address problems in interprofessional working if challenges are cognitive.
- To address systemic contradictions we need to explore actors' 'local rationalities'

Introduction

Interprofessional and inter-organisational working has, since the 1970s, been seen as critical to the work of protecting children from maltreatment (Laming, 2003; Munro, 1999). However, while interprofessional working is seen as a solution to child protection, it is also seen as a problem (Fish, Munro, & Bairstow, 2008) since it is known to be a challenging task where misunderstandings and omissions can easily occur, including misunderstandings regarding professionals' roles and responsibilities in the process of working together (Brown & White, 2006; Fish et al., 2008; Munro, 1999; Peckover & Golding, 2017; Reder & Duncan, 2003). Indeed, inquiries into the deaths of children in care (Department for Health and Social Security, 1982; Department of Health, 1991 ; Laming, 2003; Reder & Duncan, 2013) have repeatedly pointed to evidence of poor interagency knowledge, communication and collaboration. This article uses a systems approach to investigate interprofessional and interorganisational working in referrals to child contact centres in the English family justice system. It explores why reforms introduced into this system did not have the desired effect. It uses the case study of child contact centres to draw out and demonstrate both the challenges of interprofessional working and the limitations to technocratic solutions.

Complex Adaptive Systems

There is increasing interest in complex adaptive systems thinking in the area of child protection work (Hood, 2015; Munro, 2011; Nybell, 2001; Stevens & Cox, 2007). This article argues that viewing child protection as a Complex Adaptive System (CAS) (Byrne, 1998; Callaghan, 2008; Mitleton-Kelly, 2003; Rhodes, Murphy, Muir, & Murray, 2011; Stacey, 2011) and using a systems approach to investigate interprofessional working, can help to identify and explain the challenges of interprofessional working in this context.

On a theoretical level, a CAS approach (Byrne, 1998; Callaghan, 2008; Mitleton-Kelly, 2003; Rhodes et al., 2011; Stacey, 2011) would suggest that interprofessional working is likely to be challenging for a number of reasons. Firstly, child protection is a 'Wicked' problem (Rittel & Webber, 1973); both the problem (child maltreatment) and the solutions (child protection) are inherently contested (Devaney & Spratt, 2009) and so professionals (as well as families) may hold conflicting and contradictory perspectives on both.

Secondly, while systems might (and should) aim to make professional roles and responsibilities clear, CAS can organise themselves in the absence of, or indeed contrary to, external control, pressure or influence (Stacey, 2011; Byrne, 2013). This is because, unlike mechanical systems (e.g. a car), human actors in a system will each interpreted roles and actions from their individual perspectives, influenced by local understandings, histories, motivations and so on. Further, actors in a system are connected and so the actions of each agent can change the context for others (Morin, 1992). Therefore, how actors will, in practice, interpret their own and others' roles and react is inherently unpredictable. Fundamentally, actors may not behave as system designers expect.

Thirdly, child protection is not 'done' by one set of professionals, rather it is an 'open system' (Mitleton-Kelly, 2003) in which professionals in various cross-sector services, the public and families themselves contribute to outcomes. The challenges and associated unpredictability of interprofessional working in this context are compounded by recent trends in public administration, which have seen increasing welfare pluralism in which services intersect the statutory, private and voluntary sectors (Colvin, 2017).

Finally, a CAS perspective suggests that interactions within a child protection system can produce 'emergent' properties that arise at the macro level through the interactions of micro-level parts and agents (De Wolf & Holvoet, 2004). This contributes to the challenges of interprofessional working since small, interacting changes in parts of the system can lead to unpredictable and significant systemic effects. Moreover, the underlying causes of emergent effects may be poorly understood since examining each part of a child protection system in isolation is unlikely to help. A systems approach is required because emergent properties are not properties of the individual decisions of people situated within parts of the system, rather the patterns are properties of the system (Byrne, 2013).

Given these properties, from a CAS perspective, we might expect systemic contradiction and misunderstanding as well as innovation and we can see how simple, technocratic solutions alone may not be successful in addressing this complexity (Byrne, 1998; Sidney Dekker, 2005).

Interprofessional working

Wider trends in managing child protection systems have sought to address the challenges of this work through a burgeoning administrative structure focused on technocratic solutions (Houston, 2015). Mirroring this trend, solutions to the problem of communication failures

between processionals contributing to the deaths of children in care have tended to focus on the technical transfer of information, instituting tools to support this purpose (Department for Health and Social Security, 1982; Department of Health, 1991 ; Laming, 2003; Reder & Duncan, 2013). Tools may include, for example, procedure manuals, assessment frameworks and decision making tools (Hall & Slembrouck, 2007; Houston, 2015; Munro, 2011; Reder & Duncan, 2003). Research in child protection systems (Munro, 2011) as well as other high-risk industries (Sidney Dekker, Hollnagel, Woods, & Cook, 2008) has demonstrated that an over-reliance on a technocratic approach may not only be ineffective in securing a safer system, but may also produce unwanted consequences. Indeed, a landmark review of the English child protection system found that an overreliance on procedures and tools had encouraged a focus away from children and families and towards procedural compliance and institutional liability (Munro, 2011).

The technocratic approach has been critiqued fundamentally because, while tools certainly have a place, a singular focus on them ignores the cognitive, emotional, social and interactional elements involved in working together to protection children (Hall & Slembrouck, 2007; Houston, 2015; Munro, 2011; Reder & Duncan, 2003). As various authors have pointed out, the technical transfer of information is only one aspect of interprofessional communication (Fish et al., 2008; Gillingham & Humphreys, 2010; Hall & Slembrouck, 2009; Munro, 2005; Peckover, Hall, & White, 2009; Reder & Duncan, 2003). The more challenging aspects relate to the cognitive skills required to use tools effectively. In order to communicate successfully, professionals require the means to effectively collect information and communicate it to other professionals as well as the means to analyse the information collected and to make decisions based on it (Munro, 2005; Reder & Duncan, 2003). Throughout, the system requires role clarity to ensure that actors understand their role within the wider system of interprofessional working (Caldwell & Atwal, 2003; Munro, 2005; Reder & Duncan, 2003).

Research suggests that tools cannot 'do' child protection work and should not be seen as a substitute for professional practice. Quality information on the question of 'what is or has been happening?' is key since 'the best guide to future behaviour is past behaviour' (Munro, 2008, p. 77). Yet research suggests that identifying child protection concerns is challenging (Robinson & Moloney, 2010; Stanley, Miller, & Richardson Foster, 2012; Trinder et al., 2011), even for highly qualified staff, working with multi-dimensional tools, undertaking a holistic, on-going assessment (Robinson & Moloney, 2010). Theories, research knowledge

and conceptual frameworks are required in the process of collecting information, in the absence of these staff will be vulnerable to merely collecting what families initially tell them (Munro, 1998). Further, unless those undertaking the work are able to attribute meaning to the information collected, "facts on their own [will be] silent" (Munro, 1998, p. 92). Knowledge of relevant theories and research is required to interpret the facts and to formulate assessments of risk (Munro, 1998; Reder & Duncan, 2003). This suggests that the work of collecting and analysing information to come to a decision about it, requires expert skill (Munro, 2008; Robinson & Moloney, 2010; Stanley et al., 2012).

In addition to the cognitive aspects of interprofessional working, communication further encompasses social, emotional and interactions aspects. As discussed above, making use of information requires meaning to be attributed to it. In this process, information is neither neutral nor objective, rather it can be interpreted and understood variously such that it may not mean the same thing for all parties(Hall & Slembrouck, 2007). Indeed, research suggests that professionals also construct their and other professionals' responsibility and that this 'sense making' can be shared between people and across teams (Helm, 2016). Professional narratives may maintain unhelpful ritualized ways of working that reinforce professional boundaries and disrupt collaborative working (White & Featherstone, 2005). Thus, procedural, technocratic solutions to interprofessional working may belie the complexity of the process particularly through their lack of attention to the cognitive and 'relational dynamics of emotionally laden and often volatile situations' (Hood et al., 2017, p. 706).

Child contact centres

In England, child contact centres are predominantly voluntary sector services, with some private provision. They facilitate contact between children and parents where there is concern about the parent and child meeting alone. While statutory services provide contact facilities for children in care, there is no statutory provision for private law cases, in which parents have separated and the child lives with one of his/her parents and has contact with the other. Contact centres were set up in the 1980s by individuals in the voluntary sector to address this gap in service provision (Aris et al., 2002). Although situated outside of the statutory child protection system, the courts, solicitors, Child and Family Court Advisory and Support Service (Cafcass) officers (specialised social workers) and statutory social workers make referrals to child contact centres. Safe referral and acceptance of cases in child contact centres therefore requires effective interprofessional working between multiple professional types working across the statutory, voluntary and private sectors.

Child contact centres provide two types of services: 'supervised' and 'supported'. In supervised services, paid staff closely monitor contact with one worker allocated per family to listen in to conversation, observe behaviour, and report back to the referrer. These are suitable for cases with a risk of child maltreatment. 'Supported' contact services, by contrast, are run by volunteers. Here multiple families have contact together in a large room(s); behaviour and conversation are not closely monitored and there are no routine reports to referrers. These are designed for cases where there is no known maltreatment risk and may be used, for example, in cases where parents are experiencing entrenched conflict and do not wish to meet or where a separated parent simply requires a cost-free, child-friendly place to have contact with their child. Indeed, centres were first established with these latter, low-risk cases in mind but have since evolved in recognition of the needs of cases with a maltreatment concern (Kroll, 2000).

Previous research indicated problems in interprofessional working in referrals to child contact centres. While, in theory, cases involving a risk to the child should only be facilitated at 'supervised' contact services, in practice, supported services have been found to receive and accept what have been termed, 'inappropriate referrals'; cases which involve a level of child maltreatment risk above that which the centre is able to manage (Aris, Harrison, & Humphreys, 2002; Furniss, 2000; Thiara & Gill, 2012). Indeed, supported centres were found to be facilitating cases involving significant evidence of domestic violence, including cases where non-resident parents had convictions for violence, attempted murder, non-molestation and occupation orders as well as cases where the child had a child protection plan due to abuse (Aris, et al., 2002).

Previous research found that inappropriate referrals to supported centres were the result of a lack of supervised services (Aris et al., 2002) as well as confusion surrounding the terms 'supervised' and 'supported' contact (Aris et al., 2002; Furniss, 2000). There was confusion surrounding the amount of information referrers should share with centres and some referrers were willing to refer any cases to a child contact centre (Furniss, 2000). Furniss' (2000) research reported that solicitors may not have had the training to screen cases, while Aris and colleagues' (2002) report found that while referrers reported that they screened cases (referrers were almost all Court Welfare Officers in this study) centres did not themselves always have screening or assessment procedures (Aris et al., 2002). In addition it was suggested that in a minority of cases solicitors may have been concealing information in the hope that the centre would accept the case (Aris et al., 2002).

Since this research was published reforms were introduced aiming to improve interprofessional working. Since 2004, in order to receive state funding and be accredited, centres must use the National Association of Child Contact Centres' (NACCC) Standard Referral Form to manage referrals. Further, a 'Protocol for Referral of Families to Supported Child Contact Centres by Judges and Magistrates' and a section in the 'Family Law Protocol' for referral to contact centres by solicitors were introduced. 'Definitions of Levels of Contact' aimed to clarify the services provided. These tools aim to address problems by clarifying services and working relationships. The Definitions of Level of Contact stipulate that supervised contact *'should be used when it has been determined that a child has suffered or is at risk of suffering harm during contact'* and set out the differences between supported and supervised services. Meanwhile, the Standard Referral Form outlines the information that referrers must provide to centres on referral. This includes the family's demographic and health details, custody and contact arrangements as well as questions regarding court or social work involvement, abuse allegations, convictions, risk of abduction or allegations, injunctions or convictions for violence. The Protocols for Referral seek to set out the roles and responsibilities of referrers and staff in centres in the process of referral.

Nonetheless, research by Thiara and Gill (2012) suggested that referrers continued to issue inappropriate referrals. The research suggested this was due to a lack of supervised services and that referrals were accepted by supported contact services because of a lack of awareness around domestic violence and a lack of resources which led some services to 'struggle to adopt risk assessment and screening procedures' (Thiara & Gill, 2012, p. 129). The current research sought to understand why problems in inter-professional working have persisted despite these reforms.

Methods

This study adopted a systems approach to examine why 'inappropriate' cases, that could not be safely facilitated, continued to be referred to and accepted by supported child contact centres, despite the introduction of reforms. The data were collected between December 2011 and December 2012 .The wider study included quantitative analysis of the NACCC annual survey of child contact centres from 2000-2010; 58 hours of observations of practice in six case study child contact centres; qualitative interviews with 27 individuals working in these centres and with 20 referrers to child contact centres (9 solicitors, 8 social workers and 3

judges). The case study centres were selected using data from the NACCC 2009/10 survey to represent a range in terms of the service they provided, their source of funding, the level of cost per family, their profit status and the mix of staff to volunteers in the centre. The qualitative data in this article refer to the four centres providing supported contact: 20 interviews with staff, 38.6 hours of observations as well as the 20 interviews with referrers, outlined above. Interviews ranged between 42 and 103 minutes long, were semi-structured and analysed thematically, using Nvivo software. Written informed consent was received from all participants who took part in interviews and the research was approved by the London School of Economics (LSE) Research Ethics Committee.

Table 1 here: Characteristics of case study centres providing supported contact services

The systems approach is outlined elsewhere in detail (author's own, 2017) as are the study's wider findings (author's own, 2013, 2014, 2015). In brief, the approach sought to understand 'local rationalities' (Woods, Johannesen, Cook, & Sarter, 1994); how actors' behaviour made sense to them given the local context they acted in. The 'local rationality' principle asserts that 'people's behaviour is rational, though possibly erroneous, when viewed from the locality of their knowledge, attentional focus and strategic trade-offs' (Woods et al., 1994, p. 93).Therefore in the systems approach, the focus is on understanding why people do what they do, rather than on judging them for what we think they should have done (Fish et al., 2009; Dekker, 2002; Woods, 1994). In other words, rather than searching for human failures, the systems approach searches for human sense-making (Sidney Dekker, 2002).

The systems approach further asserted the importance of the high degree of 'coupling' (Perrow, 1984), or interconnectedness, in the system, noting that in such systems actors may be unaware of the potential effects of their actions on other parts of the system and responsibilities may become unclear (Woods et al., 1994). In this vein, it explored through interviews whether centre coordinators viewed risk assessment as their role, and in turn how referrers constructed their own responsibility within the system. Observations in centres were used to triangulate this data, where possible, by directly observing the in-take process (achieved in two out of four centres) and how this was discussed amongst staff in the centres.

Finally, unlike previous research, the systems approach did not assume that the effect of tools introduced into the system would be positive so long as actors used them (Sidney Dekker, 2008; Hollnagel, 2003). Therefore, in this research the Standard Referral Form is positioned as a tool and is a specific focus of investigation. The analysis sought to understand how well the Referral Form and actors interacted, given their capacity and working environment. This was achieved through interviews in which actors were asked about how they used the form, their understandings of the purpose of it and their perceptions and experiences regarding other actors' use of the form. Observations in centres, again, provided triangulation by observing how coordinators made use of the form.

Findings

Analysis of the NACCC survey of child contact centres in England suggested that in 2009/10 the vast majority of referrals to supported centres were by solicitors (83%). Unfortunately, it is not possible to distinguish from these data cases referred by court order and those negotiated exclusively through solicitors. However, the data do indicate that Cafcass and Children's Social Care make direct referrals to supported-only services. In 2009/10 56% of supported-only services reported that they received at least one referral from Cafcass and 38% reported receiving at least one referral from Children's Social Care. In a further 3% of cases, families self-referred and 1% were referred by family mediation services.

All of the case study child contact centres were observed to use the NACCC Standard Referral form and all of the referrers interviewed reported use of the form. However, as discussed above, the technical transfer of information is only one aspect of interprofessional communication (Fish et al., 2008; Gillingham & Humphreys, 2010; Hall & Slembrouck, 2009; Munro, 2005; Peckover et al., 2009; Reder & Duncan, 2003). Successful communication requires the means to also effectively collect information, communicate it to other professionals and analyse the information to make decisions based on it (Munro, 2005; Reder & Duncan, 2003). Further, actors must have clarity on their role within the wider system of interprofessional working. (Caldwell & Atwal, 2003; Munro, 2005; Reder & Duncan, 2003). The findings below demonstrate how short-comings in these domains led to unsafe referrals at supported CCCs.

Collecting Information

NACCC does not stipulate any particularly qualifications for the role of coordinator and none of the case study supported services' coordinators were registered social workers. Two had previously worked as teachers, one had worked in a Children's Centre and one in administration. All coordinators should have attended annual two day training through NACCC but only three of the four coordinators reported that they had been able to attend. Three out of four were volunteers. Analysis of the 2010 NACCC survey data suggested that, nationally, only 3.5% of workers in supported-only services were paid staff.

The supported services all positioned referrers as responsible for providing information through the referral form, before the case could be accepted. Where coordinators did collect information, the findings suggest that they improvised the process rather than relying on evidence-informed practice. Interviews suggested that some coordinators were unclear about what information they should collect. For example:

> *'R: Some of the things you don't really want to know, do you?*
> *I: Like what?*
> *R: (Pause) like, I mean is it your business to know what actually caused the break up?*
> *We're only concerned with the children really.'*
>
> **[Coordinator, Centre 1, supported-only service]**

This disassociation of the causes of parental separation on the one hand, and safety and child protection concerns on the other, would seem to imply a lack of knowledge surrounding the links between partner abuse and child abuse (Holt, 2015, 2016). The study's wider findings (author's own, 2015) suggest that this lack of engagement with key safeguarding information may have been underpinned, not just by an absence of professional social work expertise, but by emergent organisational goal conflict. While workers were aware of their safeguarding responsibilities, a perceived focus on the need to ensure centres were "welcoming" "neutral" and "non-judgemental", could conflict with instituting practice designed to protect children. Therefore, both an absence of adequate professional training and perceptions regarding the role of supported contact, could influence how coordinators interpreted the information they collected and received from referrers.

Given centres' limited role in information collection and limited training to collect such information effectively, the findings suggest that in practice, the system relies heavily on referrers to effectively collect information and to communicate this information to centres on

referral. Cases referred via the courts all receive Safeguarding checks with police and Children's Services and should include a screening phone call to parents by a Cafcass social worker. This provides an important component in the screening process, which is not available through any other referral route. However, a full assessment and engagement with children is only undertaken in cases subject to a Cafcass Welfare Report (Children Act 1989, Section 7). Solicitors in the current study reported that, due to funding shortages, Cafcass was not always appointed where a solicitor felt their expertise was required. In addition, all three judges interviewed reported that when they ordered Cafcass Welfare reports, they were experiencing delays in receiving them of between six weeks and five months. They reported that, as a result, they had not necessarily received the Report by the time that contact was ordered at a contact centre:

> *'Some of those cases, we would then go on to get a [Welfare Report] but the contact centre involvement had, would already have taken place by then because that would be at in our current waiting list another four months down the line, at least by Cafcass timescale. So if we didn't order any form of contact, there would be a delay of probably at least six months.'*

> [Judge B]

Therefore, although referral through the courts provided an opportunity for a more comprehensive collection of information, it by no means guaranteed it and cases were being facilitated before a full assessment had taken place.

Solicitors articulated that where they were acting in a case that had come via the courts, they were responsible for providing centres with the court order and any other relevant information from the court case, requested on the referral form. Therefore in cases coming through the courts, solicitors' role was to communicate information already collected, while playing a minor role in its collection. However, where the case was negotiated through solicitors, without the involvement of the courts, solicitors articulated that they were required to speak with parents in order to complete the Standard Referral Form. The findings suggest a number of limitations in terms of the capacity of solicitors to effectively collect and communicate information to centres.

Firstly, in keeping with previous research (Furniss, 2000), the findings suggest that private law solicitors do not usually meet children or speak with them about the case. Therefore

children's wishes and feelings were not accounted for. Further, misconceptions were evident amongst some solicitors. For example:

> *'There might be some issues about potential risk of harm from the absent parent, particularly violent cases. But I think those cases are fairly few and far between. The cases where there is true risk of violence will usually be dealt with differently, not by using supported contact centres, but by using, you know, supervised contact centres or really with the involvement of social services [Children's Social Care].'*
>
> **[Solicitor E]**

Contrary to this solicitor's assertion, research suggests that child protection concerns are by no means unusual in private family law cases. Indeed there is evidence that more than 50% of cases present with child protection concerns (Cassidy & Davey, 2011b; Hunt & MacLeod, 2008). Despite this, the current research suggests that it is very unusual for statutory children's services to provide supervised contact in private law cases.

By contrast, other solicitors were aware of the challenges of disclosure. They suggested that solicitors may not be effective in collecting information about families, particularly since solicitors cannot carry out safeguarding checks with the police or social care. As discussed above, this process is only undertaken if a case goes to court:

> *'I think you're very dependent on what someone will reveal and it's not completely unusual for, for you not to get told the whole truth, or for someone to minimise certain behaviour on their part, or for that matter on the other parent's part so that if you do then subsequently end up at court and Cafcass have done their checks and social services and the police, you can then see information come out which, which you kind of think to yourself, well I wish they'd told me that in the first place.'*
>
> **[Solicitor I]**

The findings above should perhaps be unsurprising. Solicitors are not trained to engage with vulnerable children for the purpose of collecting child protection information. Neither are they trained in risk assessment nor in the specific task of collecting information for that purpose (Furniss, 2000). Knowledge on child welfare is not an element of their training. Indeed, in previous research solicitors reported that they had learnt about domestic violence

(DV) 'on the job', or from their own research and/or from involvement with local DV services (Hunter & Barnett, 2013).

Communicating information

Research in the statutory child protection sector has demonstrated that information which has been collected is not always passed on (Reder and Duncan, 2003; Munro, 1999). In keeping with research on child contact centres from more than a decade previous (Aris et al., 2002; Furniss, 2000), all of the case study supported services reported that solicitors often did not communicate important information to them at the point of referral. Coordinators reported that they sometimes had to follow up referrals by contacting solicitors, Cafcass or Children's Social Care. For example:

> *'I think [solicitors] might gloss over information* or *you know supposing this person has been up for abuse or something they might just say, you know if he's been in court or something or there's an injunction but they don't tell us what…why there's an injunction or there's…they just give you the barest of outlines, you know you've got to do it yourself…you've got to find out that information.'*
> **[Coordinator, Centre 1, supported-only service]**

> *'We should have had a new family but [pause] I think the solicitor was a bit sparing with the truth on his form. He has been [pause as she reads the referral form] "ABH" [Assault Occasioning Actual Bodily Harm] he does say, but he was supposed to start today and he phoned up and said well he couldn't start today [laughs a little] because he's excluded from the [place name] area.'*
> **[Coordinator, Centre 5, supported-only service]**

All of the coordinators reported that they made efforts to follow up referrals where information was missing or where the referral seemed particularly inappropriate. However, this took additional time. Particularly where coordinators were donating their time on a voluntary basis, chasing up referrers was, at times, a significant additional burden. Coordinators also reported that solicitors, Cafcass Officers and social workers were often difficult to contact, presenting challenges to their ability to gain additional information where they had concerns

Analysing Information & making a decision

Analysis of the National Standards suggest that they are unclear on the issue of who is responsible for analysing the information collected on the referral from and making decisions about it. The Protocol for judges seems initially to imply that the responsibility lies with centres. The Protocol requests that before making a referral judges should ensure that the contact centre coordinator has:

> *'been contacted and has confirmed that...b) the referral appears to be suitable for that particular Centre, subject to a satisfactory pre-visit or equivalent...a...centre can refuse to accept families if the circumstances appear to them to be inappropriate for the Centre'. [p.3]*

However, it also seems to imply some role for judges in referring appropriate cases when it suggests that they should consider visiting a local contact centre as such visits, *'will help you to understand the facilities available locally and thus the type of case that is most suited to contact at the Supported Child Contact Centre' [p.4]*.

The Protocol for solicitors also seems to suggest that Centres are responsible for analysing the information and deciding whether the case is appropriate:
'Contact Centres are not equipped to deal with abusers who pose a serious threat to their families and it is vital that the Centre Co-ordinator is given the full background (orally, if necessary) in order to decide whether the Centre can accommodate the family' [p.1]

Interviews with centre coordinators suggested that the information they received and collected was principally used to weed out two types of cases: cases where supervised contact had been recommended by another professional and cases where an individual having contact had been convicted of the sexual abuse of a child. Outside of this, centres did not, and indeed could not, provide an assessment of the case to decide whether or not it could be safely facilitated. Rather, across supported services, information was commonly used to understand and sympathise with family members' reactions to contact rather than to make decisions about whether or not the case should be accepted. For example:

> **I:** *And how does that information help you?*

R: Well it just helps you to maintain that impartiality and make sure that you are not viewing somebody as being a nasty something but just to see that that parent could have great anxiousness and anxiety in coming through the door and bringing the children through the door…but that you don't let it influence your judgement about what is happening between the parent and the child and that they are coming in to have this time together.'

[Coordinator, Centre 2]

As this extract suggests, across supported services, the information was used to inform the centre about the family. However, the information collected was not used to analyse whether or not the case can be safely managed at the centre, the assumption is that *'the parent and the child…are coming in to have this time together.'*

Centres' lack of capacity to analyse the information they received was particularly evident in relation to their concerns about 'self-referrals'. In the extract below a centre coordinator expresses concern that in 'self-referred' cases, centres are expected to collect and analyse the information and make a decision about the appropriateness of the case:

'R: One thing I would like is for Cafcass, and it's short of money and they've got far too much to do, if referrals were to go to Cafcass, all referrals to Cafcass for supported or for supervised and somebody there could look through them and decide, that family could go to [Centre 3], they would be fine there, they'd be dealt with perfectly. That would be really helpful.

I: Yeah how do you feel about making those decisions about whether families are appropriate to come to your centre when Cafcass doesn't do it?

R: Now that is getting harder, or it will do. Because they don't have so much Legal Aid now, families don't, we are going to get far more self-referrals, which means both parents have to fill in forms and we don't have a solicitor to fall back on, which actually means it, it's up to us to work out, if there has been domestic violence then how bad is it and do more interviewing and work out the risks in a way that, when referrals come from solicitors we feel we've got a fall back on the solicitor.'

[Coordinator, Centre 3]

The suggestion that where cases are referred by other professionals, centres can 'fall back' on solicitors would seem to imply an assumption, common across centres, that solicitors are undertaking this analysis. Moreover, it highlights the general incapacity of centres to collect information, analyse it and come to evidence and theory-informed conclusions about it in order to accept or reject cases referred through referrers or families themselves.

Yet the findings suggest that some referrers did not see this as their role and assumed that contact centres did analyse the information on the Referral Form to decide whether or not to accept the case. On account of this misperception, some referrers believed that they could refer all cases to supported services and that those that were inappropriate would be rejected. For example Judge A commented:

> '[Centres should be given sufficient information] *to enable them to make a decision as to whether they can properly offer the facility. So if they are told that father for instance has a long history of drug taking, alcohol abuse and serious unpredictable aggression and violence, then they need to know that in order to enable them to ensure that they can properly provide the facility and indeed make sure their own staff are properly looked after…and if they say "we can't cope with that", that's fine….common sense would dictate to me that they will assess their own facilities, they will assess the prospects of a child being injured in some way, and address those issues. They would also obviously carry out an assessment, for instance if there is going to be a disruptive parent or child coming, not only what service they can offer to that disruptive individual but what the impact of having that individual there would be on the other families and indeed their own staff.'*
>
> **[Judge A, referred to Centre 2, supported-only service]**

Indeed this judge also reported that the orders he made for contact did not stipulate whether the case should go to supported or supervised contact.

Similarly, Judge B believed that the centre would 'screen and decide' which cases were appropriate, although this judge stipulated that judges should try to refer appropriate cases in order to avoid delays:

> *'It's obviously, it's up to the centre it's the centre's own admission policy. <u>They screen and decide</u> which cases they're prepared to take…we can't force them to take any cases. Obviously in order to try to avoid delay, we would try to make sure that we are only referring cases that are appropriate for whichever place it is that we are sending them to…these supported centres are not appropriate for dealing with cases that involve serious risk or serious violence.'*
>
> [**Judge B, ordered contact at Centre 3, supported-only service**]

Similarly, some solicitors believed that centres undertook risk assessments which would allow the centre to make a decision about whether or not the case was appropriate to the centre. For example:

> *'I: Do the families that you refer to [Centre 3] ever need to be screened for risk before they go to the centre?*
>
> *R: Well the centre always undertakes that em, that role... You know it's not just about making a referral and being accepted; the referral is made, the coordinator will <u>undertake a risk assessment</u> and then on that basis get back to you as to whether or not the family can be accepted'.*

> *[Solicitor D]*

The findings suggest that solicitors were in part influenced in referring inappropriate cases to supported services by the absence of sufficient access to supervised services. As described in detail elsewhere (Author's own, 2014, p. 142-156), gaps in provision of services meant that, in some areas of England, families would have to travel long distances to access a supervised service. In addition, referrers and centres reported that public funding was only available for supervised contact of private law cases in exceptional circumstances and so families routinely had to foot the bill. Since supported services are more prevalent and significantly cheaper or cost-free, these services were, in some cases, reported to be the only viable option for families outside of no contact. Some solicitors therefore referred high-risk cases to supported services with the expectation that centres would reject the case if it were unsuitable.

By contrast all of the social workers interviewed took responsibility for collecting information about families and, on this basis, undertook a risk assessment. No social worker

interviewed relied on contact centres to collect information, analyse it or to make a decision about the level of vigilance required for the case. The role of social workers therefore seemed clear compared to the other referrers.

Nonetheless, the findings suggest that some social workers assumed that there was a higher level of vigilance in supported services than was available. One social worker interviewed reported that he had referred a case to a contact centre because the Local Authority service did not operate on the weekend. He subsequently realised that, contrary to his expectations, the case was not being monitored as he expected because such a service was not available. One centre coordinator suggested that in her experience, social workers *"don't have a clue what child contact centres are about"* she also reported that the cases referred by social workers were *"particularly difficult".* Therefore, a thorough assessment by a social worker could nonetheless lead to an inappropriate referral. Misperceptions about the level of vigilance available in supported services also persisted amongst some solicitors. One of the three judges interviewed did not believe it was the judiciary's role to know the details of the service provided. Rather, he felt, that this was irrelevant since, as he understood it, the contact centre was responsible for deciding which cases were appropriate to their service. There were therefore gaps in his knowledge about key elements of the service provided.

Discussion

The findings suggest that inappropriate cases were often being unsafely managed at supported services because no one in the system (neither centres nor referrers) was undertaking an assessment that would enable a decision about acceptance or rejection to be confidently made. The study illustrates how in a system requiring interprofessional working, the work of protecting children, which is rhetorically, 'everyone's business' (HM Government, 2018) can, in practice, become 'no one's business'.

The study contributes to the body of research illustrating the challenges of interprofessional working (Fish et al., 2008; Munro, 1999; Reder & Duncan, 2003). The findings suggest that reforms did not address the problem of 'inappropriate referrals' to supported services because they did not in themselves address the difficulties, which actors in this context face. In line with findings in other contexts (Hall & Slembrouck, 2009; Munro, 2005; Peckover & Golding, 2017; Reder & Duncan, 2003; White, Hall, & Peckover, 2009), the research

suggests that the technical transfer of information is only one aspect of effective interprofessional working. In order to manage the safe referral of cases, actors also need to be able to a) effectively collect relevant information about families b) communicate that information to other actors and c) analyse that information to make decisions about referral of the case (Munro, 2005b; Reder & Duncan, 2003).

To achieve this requires expert skill (Munro, 2008; Robinson & Moloney, 2010)(Trinder et al., 2011). Yet key actors in the system of child contact centres - centre coordinators, solicitors and judges - are not qualified to undertake this work. Social workers are the only referrers equipped to do this work but are not involved in most cases. In this context, the research illustrates how professionals working together in a complex adaptive system can experience what I term "systemic role contradiction", whereby each assumes that the other is responsible for key aspects of a process (in this case referral) because the task is inappropriate to their own expertise. This can mean that responsibly for important aspects of a child protection process are, in practice, not seen as anyone's responsibility.

The findings of this study further illustrate that the transfer of information is not simply a technical process, but a psychological, social and interactional one (Hall & Slembrouck, 2009; Munro, 2005b; Reder & Duncan, 2003). While the research findings suggest deep systemic ambiguity about who is responsible for collecting information, analysing it and coming to a decision about it, actors in the system of child contact centres confidently constructed the boundaries of their responsibility (Reder & Duncan, 2003). Many of these actors did so in ways which assumed that the difficult task of coming to conclusions about cases was not theirs.

Finally, the study illustrates how misperceptions of services can impact referral. This problem affected all referrers. In the case of social workers it demonstrates how, although social workers were qualified and capable of undertaking all aspects of this work, they could nonetheless contribute to the facilitation of unsafe cases because they assumed the service had the same level of vigilance available in the statutory sector.

Conclusion

Child contact centres provide a vital service to facilitate contact between children and parents in difficult circumstances. Like most children and youth services, they do not operate in isolation but within a system, and this requires interprofessional and interorganisational

working. While problems in interprofessional working may be characterised as "errors", this study suggests caution in how this term might be understood. The findings clearly demonstrate that the facilitation of inappropriate cases at supported services did not represent a random mistake nor a 'slip' in centres' or referrers' practice. Rather this practice was the outcome of problematic but 'normal' (Perrow, 1984) interprofessional working in this system, influenced by the absence of appropriately located expertise to undertake the work and referrer misperceptions regarding the service provided. This study suggests that actors will confidently assert the boundaries of their responsibilities based on their 'local rationalities'. These rationalities should be routinely and systemically investigated in order to identify and address the potential for, what I have termed, "systemic role contradictions".

Given the known vulnerability of children in the cohort of families referred to child contact centres, the absence of appropriately positioned expertise within the system to carry out risk assessments in cases, is particularly alarming. In this context, the introduction of forms may merely have served as a 'security-blanket' in a 'form-led' process (Horwath, 2002:204), masking the underlying problem of an absence of resourcing for professional risk assessment and inadequate provision of supervised services. Solutions, in this sense, lie 'outside the "technocratic box' (Houston, 2015).

Since this research was undertaken, the system of child contact centres has been impacted by changes in legal aid (Legal Aid, Sentencing & Punishment of Offenders Act, 2012), which have resulted in a dramatic increase in parents self-referring (without the assistance of a referrer) to child contact centres. Self-referrals to supported centres increased from 3% of referrals in 2010 to 49% of referrals in 2018 (NACCC, 2019) and this represents a concern since, as discussed above, supported centres are not equipped to undertake a professional risk assessment. In response a "Safe Referral" online platform has been set up through NACCC. The platform is staffed by qualified social workers who undertake an assessment, can carry out safeguarding checks with police and Children's Services and can contact parents and other professionals involved in the case for further information. However, currently only 2% of referrals are routed through the Safe Referral system (NACCC, 2019). NACCC (2019) suggests this may increase if more contact centres join the system.

While this is an important change, given that the Safe Referral system is only being used for a small proportion of contact centre cases (2%), and only for cases that are self-referred by parents, it cannot address the absence of appropriate expertise required to assess and make

decisions on cases referred through the courts and solicitors and the majority of self-referred, which are not being assessed via this system. Nor does it address social workers' misperceptions regarding supported services or insufficient provision of supervised services in private law cases. Further research could usefully evaluate the new system using a systems approach and consider why more centres have not joined the Safe Referral system and whether that system could effectively be used for to assess for all self-referred cases as well as cases referred through the courts and solicitors. At a policy level, access to supervised services, where this is a suitable option, should be addressed.

The systemic concerns highlighted by the current study regarding supported contact service referrals therefore remain, despite recent changes. More broadly, the study serves as an illustration of problems that can occur in interprofessional working. In keeping with CAS thinking, it illustrates the unpredictability of interprofessional working, the tendency of actors in a system to each construct their own and others' responsibilities and the need, therefore, to study the 'local rationalities' that underpin behaviour in order to identify and understand problematic outcomes, like 'inappropriate referrals'. The study further contributes to the broader literature on interprofessional working, by substantiating the limits of tools and protocols in enabling safe practice and by highlighting the importance of identifying 'systematic role contradictions', which can contribute to problematic practice.

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