Meeting the challenge

***Rob Laking** discusses elements in reducing and managing risk in social work practice*

Introduction

In a number of high-profile cases involving the death of a child, it has been revealed that social workers handling the case made decisions that appeared to violate the organisation's established procedures or commonly-held ideas of good practice. When an accident is attributed to failure to follow the rules, the common reaction is "how can they have been so stupid, neglectful or disobedient?"[1] The usual response from the authorities is to conduct an investigation, apologise for the error, possibly discipline the offending social workers and introduce more rules.

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The problem of apparently inexplicable disastrous operator decisions is not confined to social work. Experienced surgeons remove the wrong limb from a patient. Pilots deliberately fly well below safe altitudes and into mountains in clear, still air. At Chernobyl, engineers disabled safety interlocks, leading to a catastrophic explosion in the reactor. In the last two decades, accident investigations into these high-risk activities have begun to take a systemic approach. Questions to ask include:

- What was it about not only the decision-makers but about the situation they were in that might have contributed to the error?
- Why did the usual safeguards against error fail in this case?

Analysis of the systemic origins of human error in air accidents was pioneered by James Reason (1990). A path-breaking inquiry based on a systemic analysis was the Royal Commission of Inquiry into the Erebus crash, where Justice Mahon concluded that Air New Zealand as a company contributed to the accident as well as errors made by the pilots.

It is not only air accident investigations that take a systemic approach – the Reason analysis has also been applied to the Cave Creek disaster (Capper, Crook and Wilson, 1996) and similar modes of analysis are applied in cases of medical misadventure. The Health and Disability Commissioner's 1996 investigation of the "Patients are Dying" cases at Christchurch Hospital is a textbook case history of how organisational stress can affect communication and decision-making in a hospital (Stent, 1998). Others make cases for rethinking how to achieve a safety culture in New Zealand hospitals,

1. This article draws on work done in Child, Youth and Family as part of the baseline review and also on subsequent discussions with staff of the Department. The Department did not, however, contribute to the preparation of the paper and is not responsible for any of the ideas or opinions expressed.

analytically founded on the Reason model (Roberts, 2003).

Viewed through the lens of the Reason human error model, something seems to be missing from the published investigations of child deaths. There is usually a careful analysis of the events that preceded the death and the role of public employees in these events. There is often no convincing explanation of why the responsible staff made the decisions they did and it is not easy in these situations to find out why people make mistakes or break the rules. The risk to the workers of being found out in error – whether deliberate or not – can be considerable. In both child protection and health services, the analysis is taking place in the context of investigation of causes of serious injury or death, where the personal stakes are high for the staff involved and defensive responses can inhibit open discussion. Incident reporting systems in hospitals may understate practice error because of workers' fear of the consequences. In her investigation of the medical errors in Christchurch Hospital, the Health and Disability Commissioner reported that for a whole year under investigation, virtually no incidents were reported by clinical staff – the commonest reason given was fear of punishment (Stent, 1998). Where fear of blame is present, these reactions are perhaps predictable. Nevertheless, understanding why people do what they do is surely critical in understanding how to reduce the risk that in similar future circumstances they will make similar mistakes.

The relationship between social worker performance and client outcomes

Analysis of child homicide statistics reveals that only a minority of the children who are killed by a parent or caregiver in New Zealand are known to Child, Youth and Family workers at the time of their death (Doolan, 2004). But when it appears that the child or their family members were "on the Department's books" at the time of the child's death, the tendency is to look for failures in performance that might have contributed to the tragedy. What then follows in reports and recommendations is usually primarily focused on recommending changes to rules and systems designed to reduce the risk of further similar occurrences. When the report is published, the focus in the media is almost exclusively on errors in case management in order to attribute responsibility and blame for the failure.

Hindsight is a particularly deceptive basis for policy change in a profession as complex as social work. New Zealand children suffer injury or death for a wide variety of reasons that have little to do with social worker error and a lot more to do with their family circumstances. The case manager faces multiple paths to an outcome – paths that interconnect and events that influence each other – and many factors that are outside the control of social workers. Indeed the appropriate scope of analysis of the "social work system" is not the boundary of the organisation but a much broader perimeter encompassing the child or young person, their family and other significant peers, and adults and the wider community, including other organisations with which they have contact.

It follows that even best practice in social work may on its own have limited impact on client wellbeing. There is a wider issue of what strategies can be employed that will help reduce risk in the larger social system. To say that social worker control over outcomes is uncertain is not to say that there is no accepted best practice in a specific case management situation, only

that decision-making in social work is a matter of weighing up probabilities and risks. Putting it this way raises significant issues – similar to those in medicine – about the relationship between best practice and clinical judgement.

To the outside observer, it is not clear that social workers agree on what constitutes best practice. But senior Child, Youth and Family management argue that the definition of best practice is not an intractable problem. There is a swing back to the idea of evidence-based practice in social work and there is firm evidence that some practices significantly reduce the risk to clients. Best practices in social work can or should be recognised and error, a departure from best practice, can be defined.

Causes and consequences of error in social work

So why don't social workers follow the rules? Here the appropriate empirical questions are: what personal or workplace factors might contribute to social worker error and what can be done to reduce this source of risk to children?

James Reason's human error model asserts in brief that mistakes and intentional rule breaches that lead to accidents can be analysed in terms of both the personal situation of the workers involved and the workplace in which they operate. An implication of Reason's analysis is that the most effective response to organisational risk is often not to impose more operating rules at the "sharp end" but to consider strategic responses at the level of organisational systems and culture.

There are a number of general points relating to the specific characteristics of social work that probably need to be considered:

1. The effects of the wider environment are likely to be more significant in the case of social work organisations than in the case of airlines. Indeed, as discussed earlier, it seems useful to regard the social worker's "workplace" as encompassing both the organisation and the client community in which they operate.

2. Much of the argument in the baseline review of Child, Youth and Family in 2003 implicitly treated social workers as bureaucrats, in the sense that they were primarily working within clear organisational rules. It may be misleading to think of social workers in this way. Much of what social workers do takes place in an environment where tightly defined performance measures are not effective and outcomes are uncertain and complex. There is no doubt that rules do constrain social worker behaviour – child protection and youth justice work are law-driven processes – but there are certainly tensions between rules and discretion in social work that are analogous to those between management authority and clinical governance in hospitals.

3. Social workers in the wider workplace are attempting to manage, in the sense of influence, a much wider range of resources than is available to them from their budgets and legal powers. Conversely, significant constraints on, and incentives for, social worker behaviour may originate from this wider workplace. These environmental factors need to be folded into the analysis. With these provisos in mind, the Reason analysis might be a useful starting point for a similar analysis in Child, Youth and Family.

Where to from here?

How can Child, Youth and Family move towards a more strategic approach to managing risk? First, managers and staff could develop a common understanding of best practice and how it might be at risk from systemic factors in the organisation and the worksite. One approach might be for groups of task managers and experienced social workers to see if a classification of possible system factors helps them analyse sources of risk. Caseworkers could be asked to consider situations in which they believed that a mistake or violation occurred that could have led to an accident but didn't, and to identify factors that they thought were important in contributing to the accident risk. Staff could be surveyed on their assessment of risk-making factors in the organisational and community workplaces. Task managers and caseworkers could workshop the development of system models.

Secondly, information needs to be collected in a way that identifies the systemic factors in performance risk. Within existing quality assurance practices, audits could be enlarged to systematically consider environmental factors that might be present, and risk-inducing factors could be included in reporting on performance and conditions at worksites. A further and more ambitious step is to develop an incident reporting system based on near misses rather than disasters. A first step towards such a reporting system is to reach a consensus among experienced task managers and caseworkers on "sentinel events" – deviations from approved practice that may increase risk for the organisation – as a basis for error reporting.

Possibly the most important element is to consider all information collection and analysis from the viewpoint of how it will enhance collective understanding of the risk to children and how to manage it. To do this, reporting and analysis of risk factors has to be separated from blame. Of course social workers must carry responsibility for their personal actions in the workplace, but the quality of the information on risk will be itself at risk if open reporting and analysis can threaten personal reputations and careers. The challenge facing Child, Youth and Family management is to assure the public that it is accountable for the safety of children and that it is competent at an organisational level to understand and manage that risk. A more collective and strategic approach to understanding risk may help.

REFERENCES

Capper, C, Crook, C and Wilson K. (1996) 'Systems Safety Issues in the Wake of the Cave Creek Disaster'. Conference paper, Australasian Evaluation Society. Wellington.

Doolan, M. (2004) 'Child death by homicide: An examination of incidence in New Zealand 1991-2000'. In *Te Awatea Review 2(1)*. Pp 7–10.

Reason, J. (1990) *Human Error*. Cambridge University Press. Cambridge.

Roberts, P. (2003) *Snakes and Ladders: The Pursuit of a Safety Culture in New Zealand Public Hospitals*. Institute of Policy Studies and Health Services Research Centre, Victoria University of Wellington. Wellington.

Stent, R. (1998) *Canterbury Health Ltd: A Report by the Health and Disability Commissioner*. Health and Disability Commissioner. Wellington.

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