Report on phase two of the decision-making variability project

"I'm in two minds about it"
: decision variability in child protection

AUTHORS

Dr. Emily Keddell (Social and Community Work Programme, University of Otago)
Dr. Ian Hyslop (School of Education and Social Work, University of Auckland)

TABLE OF CONTENTS

INTRODUCTION

Decisions in the child protection context take place in a complex environment influenced by individual decision-makers, institutional resources and practices, demographic inequalities, and family responses. While some variation in decision outcomes are inevitable and desirable in order to respond to unique family and whānau contexts, the principles, logics and resources informing such decisions should be consistent. Where they differ too much, families in similar situations receive different responses, contributing to inequities and inconsistencies in decision outcomes. Both children and families should expect intervention in family life to be relatively consistent, so that children's rights to protection, and family and whānau rights to autonomy are transparently and consistently balanced. Wider inequalities are a substantial cause of differences in outcomes, nevertheless, institutional and individual factors also contribute to decision variability. This report describes some of these factors as reported by practitioners in the child protection context in Aotearoa New Zealand, providing an insight into the experiences and perceptions of front-line practitioners. By describing simple and difficult cases, views of the causes of decision variability, and perceptions of what contributes to 'good' decisions, valuable practice-based knowledge can be accessed from practitioners' own practice-rich perspectives. This can be utilized to inform practice development and contribute to equitable outcomes for families and whānau.

EXECUTIVE SUMMARY

This report presents selected findings from phase two of the Decision-Making Variability in Child Welfare research project, which examined the causes of variations in decision outcomes despite similar family situations. The study consisted of two phases: phase one was a mixed methods survey based on a vignette, and phase two consisted of interviews with practitioners (social workers, practice leaders, team leaders, Family Group Conference Coordinators and supervisors) at three site offices of Child Youth and Family (now Oranga Tamariki) in December 2016.

This report describes selected findings from phase two. It describes and discusses decisions that practitioners found 'simple' and 'difficult'; practitioners' own views on the causes of variability; and practitioners' perceptions of what supports good decision-making.

Comparing simple and difficult decisions as perceived by social workers provides insight into the criteria for high and low consensus cases, as well as the construction of legitimate intervention. Simple cases were those that were clearly below a perceived threshold for Oranga Tamariki intervention, and where the main family issues could not be interpreted as abuse. Also deemed simple were those where abuse was very serious, and the causes and evidence of it were clear. Difficult decisions were of several types. Firstly, the decision to remove children, both because the decision had long-term and serious consequences, and because implementing it was emotionally distressing for all parties. Other types of difficult decisions were those made in the context of a lack of placement availability, essentially narrowing options, and those where there was professional disagreement as to what should occur. Cases that contained the most subjectively defined and contested types of abuse, or where the harm to children was not easily responded to with the interventions available were also difficult, such as emotional and psychological abuse, and responding to domestic violence. Other difficult cases were those where parents had intellectual disabilities, as these may not contain any direct abuse, but involved the nebulous and sometimes impossible task of assessing future abilities in the context of children's changing developmental needs, as well as dealing with disability advocacy organisations and other professionals who may hold differing views. More generally, chronic cases where defining the minimum parenting capacity required also provided decision-making challenges, reflecting the lack of broader social consensus on what this consists of.

Practitioners' views of the causes of decision variability were diverse. The most prominent themes were: workload issues, variations in placement availability, social worker relationships with families, personal background and attitudes towards engagement; and site processes and supervisory practices. Less dominant themes were the uneven use of assessment tools and ethical dilemmas about competing rights. Workload issues were perceived to contribute to variability in multiple ways. Where workload was perceived as high, the time needed for cognitive processing was limited, leading to fragmented practice reasoning and reactivity to cases. High workload contributed to a hierarchy of risk, where those cases where risk was perceived as highest or 'attention grabbing' received most attention, leaving other cases for a long period before assessment. This could lead to variations in practice if some families in similar situations waited a long time, while others received a more immediate response. In high workload environments, reporting demands could dominate, affecting information quality due to less time to engage directly with families. High workload consequences were perceived as affecting those sites that were 'struggling' with the combination of high notifications and a large proportion of inexperienced workers, or many unfilled vacancies, while sites without those features did not have these problems. Therefore, workload issues could cause individual, within-site, and between-site differences.

Variations in placement availability were also felt to affect decision consistency. The paucity of placements in general, and a lack of a range of placement types, combined with the increasingly complex mental health and behavioural needs of children requiring care was felt to contribute to differences in outcomes. Some children without high mental health needs and who had a family caregiver available could be more likely to enter care than those with mental health/behavioural problems and / or no family available, leading to variations not based on the degree of harm, but on these other factors. A perception that mental health services were often unwilling to provide services to young people engaged with Oranga Tamariki exacerbated these difficulties, and limited placement availability was always 'in the back of people's minds' when considering care. Some sites simply had no placements available, or only very short term placements.

Factors affecting social workers as individuals could contribute to differences in decision making processes. Attitudes and values relating to family engagement was a strong subtheme identified, as this affected practices

that ultimately affected information quality and ethical tone. For example, some social workers reported they sought information directly from clients, tried to be non-judgmental and respectful and therefore were able to engage with clients, obtain better quality information and identify key supports. But others were less likely to engage with families in this way. Their decisions were more likely to be based on the recorded family history rather than face to face, be more punitive, based on 'power and ego', and more focused on removal of children as a likely option. Ethnicity and class could also cause variable responses at the individual level. Middle class parents were perceived as more defensive and likely to have legal representation, leading to practitioners feeling guarded, anxious and stilted, while people from lower socioeconomic backgrounds were considered to engender a more 'natural' response from social workers. This may mean more middle- class clients exit the child protection system more quickly, as workers may disengage more rapidly. Māori and Pasifika families were perceived as being expected to provide more for children in their wider whānau than Pākeha families, who were more likely to be able to obtain therapeutic supports and other costly resources. This may reflect efforts to practice in a culturally responsive and 'empowering' manner, yet this may inadvertently contribute to inequalities in resources made available to families in similar circumstances. Personal life histories and backgrounds of social workers were also considered to shape decision-making differences, with some respondents perceiving young, childless and inexperienced workers as more judgmental about parenting than others, and practitioner's own issues with parenting colouring practice outcomes. However, many practitioners showed a high level of self-reflection on these types of issues, with some, for example, requesting not to be allocated certain types of cases that they might find difficult due to their own experiences.

Site processes and supervision practices also shaped beliefs about differences in decision outcomes. Firstly, case information from the intake centre was immensely varied, with some reports of concern being full and accurate, while others were sparse and missing basic details. Variable perceptions of risk are most marked where information is vague, so differences in this early information quality will drive differences in decisions (see Keddell & Hyslop, 2016). Sites reported different processes when new cases were received. Some have more supervisory input than others in the initial assessment period. For inexperienced social workers, no supervision at this point could lead to anxiety and variation, as they are unlikely to have the repository of practice experience to guide them about how to respond. Likewise, some sites had more collaborative processes for 'forming a belief' than others. In some sites, the belief (a key legal threshold) was expected for the individual social workers to formulate, then pitch it in a somewhat adversarial style to their supervisor. Others had a group meeting about cases in order to decide if that threshold had been reached. The latter was perceived as more rigorous and consistent by practitioners but was more time consuming, therefore challenging in high workload environments.

The supervisor role was key to maintaining consistency within each team, as well as managing anxiety and work pressures. Some participants felt that differences in decision outcomes really reflected the attitudes and approaches of supervisors more than frontline social workers, and this was perceived as having both positive and negative aspects. There could be marked differences between supervisor's decisions that resulted in differences between teams. Frontline workers who disagreed with their supervisor's decision could feel 'stuck' between clients and their supervisor, with limited discretion despite having the relationship with the family. On the other hand, where frontline social workers respected the decisions of the supervisor, felt supported by them, and the supervisor encouraged reflective practice, in these teams the supervisor was perceived as an important 'check and balance' on practice, assisting with consistency and anxiety-management.

In a less prominent theme, the uneven use of assessment tools was noted, although the tools themselves were not especially related to decisions, but more to the other factors stated above. Some tools were perceived as not helpful to improving consistency because they don't grapple with the bigger issues of lack of definitional clarity, theoretical or ethical tensions, workload or personal differences. Instead, they were sometimes perceived as tools to check whether technical or managerial expectations had been met, rather than provide decision-making guidance. Often, the assessment tool reflected existing decisions, they didn't make them. The exception was the case consult tool, which many practitioners viewed as helpful due to its structured and collaborative nature. This helped with group decision processes clearly focussed on the risks and protective factors present, articulating case logics. This was not consistently used, however, and there were differences between sites around family inclusion in case consults. Finally, the presence of an ethical dilemma in some types of cases was perceived as a cause of variability, for example, balancing a baby's developmental timeframes with a mother's effort and time needed to change could cause difficult tensions practitioners might approach differently.

Frontline perspectives on what personal and institutional factors support good decision-making included (unsurprisingly) inversions of the problems described above. Collaborative practice was perceived to support decision-making, as it provided an opportunity to improve information quality, generate consensus around case interpretations and meanings, and ensure policy guidance was implemented evenly. Providing frontline practitioners with consistent messaging regarding the ultimate or abstract aims of practice such as overarching aims and ethical principles were perceived as important, as well as methods to ensure practitioners followed key guidance. The use of case consults was felt to encourage good decision-making, especially as it encourages practitioners to articulate their case reasoning and reduces anxiety. This process of articulation assists with analytical logic and allows for challenge and constructive criticism by others. Critical reflection was another key aspect of good decision-making as it assisted with separating out the effect of personal experiences, and with avoiding case 'stereotypes', that is, categorising a case too quickly as this or that 'type' of case. This lent depth to case analysis. Supervisory support was key to ensuring that all salient aspects of a case had been appropriately considered, and that the team responses to families were consistent (within the team). Supervisors perceived as good were those whose judgement was respected by the workers reporting to them, were able to be flexible in the amount of discretion they allow to frontline workers and manage worker's inevitable anxieties. Finally, having a range of placement choices was felt to support good decision-making, as it allowed for decisions about removal to be considered based on the child's needs rather than what placement was possible.

BACKGROUND AND CONCEPTUAL FRAMEWORK

In 2015 – 2017, researchers from the University of Otago and Auckland collaborated on a research project examining decision variability, that is, why decisions in response to families differ where the case characteristics are approximately equivalent. Both international and national research has found that frequently decisions made in relation to children in the child welfare system are not consistent (De Bortoli & Dolan, 2014; Doherty, 2016; McConnell, Llewellyn, & Ferronato, 2006; Platt & Turney, 2014; Regehr, Bogo, Shlonsky, & LeBlanc, 2010; Saltiel, 2016; Office of the Chief Social Worker, 2014). While no two families-in-context are exactly alike, wide variations in decisions present a justice problem, as both children and families should reasonably expect their rights for protection and family life to be regulated consistently by state actors (Keddell, 2014a). Aotearoa New Zealand is not alone in this problem and international research points to a range of causes across the ecological spectrum. At the macro level, differences can be due to conflicts in the broad policy orientations of the nation-state, as many nations simultaneously embrace family service and protectionist philosophies -often due to multiple overlapping reforms and interests (Gilbert, Parton, & Skivenes, 2011). There are complex effects of social inequalities, as the intersections of deprivation, ethnicity, supply and demand of services shape differences in chances of system contact and how the child protection system responds (Bywaters, 2015; Bywaters et al., 2015; Gilbert et al., 2011; Keddell, Davie, & Barson, 2019). At the meso level, institutional factors such as organisational cultures, group decision-making practices, assessment tools, and the availability of preventive or care service resources impact on decision outcomes (Bywaters et al., 2015; Fargion, 2014; Platt & Turney, 2014). At the individual level, factors such as practitioners' values, beliefs and experience, knowledge base, role type, ethnic and socio-economic bias, perceptions of risk and safety, and heuristics or rules of thumb learned on the job can all affect judgements (Benbenishty et al., 2016; Boyd, 2014; Bradt, Roets, Roose, Rosseel, & Bouverne-De Bie, 2014; Bywaters, Brady, Sparks, & Bos, 2016; Dettlaff, Christopher Graham, Holzman, Baumann, & Fluke, 2015; Fluke, Corwin, Hollinshead, & Maher, 2016; Graham, Dettlaff, Baumann, & Fluke, 2015; Keddell, 2014a; Keddell & Hyslop, 2019; Platt & Turney, 2014). Finally, relational factors between the social worker and family members can also play a role, for example, how power is managed and the reactions of both parties to the practice relationship (Keddell, 2014b; Maiter, Palmer, & Manji, 2006).

The decision -making ecology theoretical framework organises these factors into a conceptual schema that guides this study, proposing that case factors, individual factors, organisational factors and external factors interact to produce decision outcomes. It also includes a theory of individual decision-making based on heuristics, and the concept of a decision-making continuum from notification to substantiation to removal and so on to further understand decision-making in child protection (Baumann, Fluke, Dalgleish, & Kern, 2013; Baumann, Dalgleish, Fluke, & Kern, 2011; Dettlaff et al., 2015).

Because decision-making has multiple causes of variability, addressing decision variability requires a whole of system approach, but simply increasing a technical-rational system via managerial techniques of audit, compliance and 'standardisation' is not effective in improving the content and consistency of decision outcomes (Hodgson et al., 2019). Instead, creating a system that supports professional discretion while maintaining accountability is key. Professional discretion relies on the ability to apply conceptual reasoning, ethics and analytic ability to the case at hand, and is important when responding in the child protection context, where the complex and sometimes unique worlds of families and the uncertainties of future risk require individuals who are able to operate with discretion (Molander, et al., 2012). There must be limits on discretion, however, and the focus of a system that attempts to balance these imperatives must be to support practitioners to draw on shared theoretical and ethical knowledge to construct explanatory 'whole case' formulations; understand common heuristics and biases; critically reflect on emotion and other intuitive elements of decision-making; and encourage ethical practice by focussing the organisation on the qualitative outcomes it espouses (rather than organisational compliance) (Sheppard et al., 2000; Hodgson et al., 2019). In the child protection context, this 'focussing' should be on pursuing participatory practice and positive outcomes for children and families, yet meeting organisational compliance standards can disrupt a focus on these outcomes, implicitly promoting the wrong practices. Including practitioners and families as participants in organisational development assists with the formation of this kind of organisation.

The decision variability project investigates some of these influences in the Aotearoa New Zealand context, where little research exists about decision variability. The research questions are: does decision variability exist in ANZ? If so, what contributes to decision variability? Some basic research from other sources suggest

variability is a concern. For example, there is a wide variation in substantiation and FGC rates as proportions of both notifications and total child populations between different site offices (Keddell & Davie, 2018). Research into inequalities show that while Northland and Gisborne have similar rates of substantiation and holding an FGC, Northland has double the rate of placement of children in care (Keddell et al., 2019). The 2014 Workload review noted how contested the statutory/NGO interface was, and qualitative studies show differences in practitioner constructions of risk, interpretations of parental behaviour and how observations of children are conceptualised (Keddell, 2014c, 2017; Office of the Chief Social Worker, 2014). Different rates of ethnic groups in contact with the child welfare system also suggest bias and inequalities at play (Keddell & Davie, 2018; Keddell & Hyslop, 2019).

Phase two of this exploratory study uses qualitative methods to investigate a range of factors that may influence decision variability at the level of institutional practices and resources, as well as the perceived influences of individual and group reasoning. While this may be a minor contribution to outcome differences compared to wider inequalities, nevertheless it is an important one to explore, as inequalities interact with site and individual differences to shape decision outcomes (Dettlaff et al., 2015).

Methods

This mixed methods study gathered data in two phases. Phase one gathered data via an online vignette-based questionnaire. The vignette (case study) was split into four stages, each stage providing more detail in relation to a family in contact with child welfare systems. The concerns escalated at each stage. Scaled perceptions of risk, safety and harm, and qualitative reasoning were elicited at each stage. Respondents (both statutory and NGO child welfare social workers) were also asked to state what the family problems were, and what they felt was causing them. After this, additional qualitative questions were asked about the aims of practice, and finally, practitioners' own views about the problem of decision variability were elicited. The results of phase one have been reported in a research review, several articles and conference presentations (Keddell, 2015, 2016; Keddell, 2017; Keddell & Hyslop, 2016a, 2016b, 2018; Keddell & Hyslop, 2019).

The second phase (that this report covers) examined individual decision-maker and organisational factors that influence decisions, by visiting three Oranga Tamariki sites and interviewing social workers, team leaders, supervisors and FGC coordinators about their decision-making processes. Focus groups of each team were also held, (2 teams per site, 6 focus groups in total) where discussion was prompted with a case study vignette (interviews, n = 26, focus groups, n = 25). Through these methods, social worker's reasoning was elicited, with a particular focus on decisions they found simple or difficult, organisational decision pathways and processes, reasoning around threshold cusps, and practitioner perceptions of the causes of variability. These areas of focus were used to explore the research question, that is, what contributes to variability in decision outcomes. The interview schedule aimed to understand the ways that social workers make differentiating decisions in order to decide to continue to escalate the case or divert it away from a statutory response (see appendices A and B for interview and focus group schedules).

The three sites were selected by the Office of the Chief Social Worker, in line with maximum demographic variation and excluding sites where there were current known problems. Two sites were in the North Island and one in the South Island. The sites were as follows:

Site 1: Urban, mixed socio-economic area, mostly Pākeha staff, Pākeha plus multicultural clients.

Site 2: Urban, high deprivation area, mostly Māori and Pacific clients and staff

Site 3: Semi-rural site spread across several small socioeconomically diverse towns, mostly Pākeha staff and clients.

Demographics

Table 1: Demographics of phase two participants

	n (interviews)	%		n (focus groups)	%
Total	26			25	
Gender					
Female	21	81	Female	20	80
Male	5	19	Male	5	20
Ethnicity					
Pakeha	18	69	Pakeha	20	80
Maori	4	15	Maori	3	12
Pasifika	1	4	Pasifika		
Asian	2	8	Asian	1	4
Other	1	4	Other	1	4
Experience	1-30 years				

Role			Sites		Group composition (n group 1, n group 2, role)
Social Worker	14	54	Site 1	9	4,5, 3SW, 1SUP; 4SW, 1SUP
Senior SWer	2	8	Site 2	9	5,4, 5SW; 3SW, 1SUP
Supervisor	6	23	Site 3	7	4,3, 2SW, 1SSW, 1SUP; 2SW, 1SUP
FGC Coords	3	12			
Practice Leader	1	4			

Analysis

The interview data were analysed using thematic analysis. The interviews and focus groups were coded by a single researcher and read multiple times for basic codes to be identified, then organised inductively into basic descriptive codes. The themes were then developed to combine codes and consider the interacting nature of themes using some conceptual elements from the decision-making ecology. Due to this, thematization contained both inductive and then deductive processes. While some site comparison was possible, the bulk of analysis was across the entire data set. This was in order to establish basic patterns of practice, however respondents were also asked to report their perceptions of inter-site differences.

Limitations

The limitation of phase two of the study is that only three offices from a total of 58 were visited, compromising the generalisability of the findings. Further research is required to establish how representative these findings are of the whole organisation. Another limitation is that an individual's subjective narrative may not capture the full range of influences on decision outcomes. Interviews about case work rely on recall, but memory about cases in the past might be inaccurate. A final limitation is that of selection bias, where by asking people to describe causes of variability a skewed picture of the size of the issue may be inferred. Nevertheless, the rich qualitative data does give an in-depth understanding of practitioners' perceptions, experiences, reasoning and contexts.

The main themes of the interviews and focus groups outlined in this report are those related to: simple and difficult decisions; practitioners' perceptions of the causes of variability; and practitioners' perceptions of what contributes to 'good' decisions.

Other themes not reported here, but covered in other publications are: how case, organisational and external factors contribute to decisions to hold a family group conference and remove children when the case is borderline, and how institutional decision pathways and feedback contribute to practice variations (Keddell & Hyslop, forthcoming, Keddell and Hyslop, under preparation).

Simple and difficult decisions

Decisions described as being simple or difficult give insight into the types of decisions that practitioners deem straightforward as opposed to complex. Those considered difficult by practitioners illustrate the type of decisions that present the most challenge to consistency, as they are not amenable to easy remedies from policies, guidelines, ethical principles or psychological concepts. In short, they contribute to variability because they are the most difficult to resolve. Simple decisions give insight into those decisions that are likely to be more consistent, and the contrast with those that are considered difficult provides insight into what is needed to improve the *consistency of decision outcomes.*

Table 2: Simple and difficult cases: severity, type, reason and logic

Degree of severity	Perceived as..	Type	Reason	Logic
Low	Simple	Low level concerns such as parenting, budgeting, 'family stress' due to clear incident, DV 'verbal', protective or monitoring factors	Not defined as 'abuse'	Function of the system is focused on abuse and neglect, not family issues
Medium	Difficult	Removal decision	Hard to make the decision, and hard to undertake the actual removal	Long term consequences, negative effect on relationship with parent Emotional distress for all parties
		Lack of placement availability	Means chronic cases can't be 'offered better', and colours decision weighing up of harm	Without a placement, removal is impossible or might create new harms (short term)
		Professional disagreement	Difficult to deal with conflict and find consensus	Many professionals have input to decisions but have different professional and personal perspectives

		Emotional and psychological abuse – especially exposure to DV	Vague definitions, hard to judge severity or objectively determine harm	Little clear consensus about definitions or what to do in practice
		Uncertainty of future outcomes	Extent of harm unknown and harm of foster-care	Risks are not deterministic
		Determining parenting capacity, especially for chronic low-level cases and parents with intellectual disabilities	Minimum standards and judgements into the future are difficult	Lack of social consensus or future knowledge
High	Simple	Severe, objectively verifiable physical abuse	Decision is clear	Role is to intervene to protect – these cases are unambiguous
		chronic situation plus serious incident, extensive history		Provides a clear 'pattern' of factors for intervention

Simple decisions

Practitioners described simple decisions as falling broadly within two categories: those that could be deflected away from the statutory child protection system due to easily recognizable features showing they were not within the organizational mandate, or those that were of a very serious nature so obviously fell within the organisation's remit. These first type of simple decisions - those with lower level concerns - were either rejected at intake or had a simple child and family assessment leading to referral to a community agency. Understanding what the specific criteria are that determine these categories assists with an understanding of cases with a strong consensus in case conceptualization. They also show how workers conceptualise the aims and functions of Oranga Tamariki as an agency.

Defining 'low level' concerns

Examples of the criteria for categorisation of this kind were cases where parental behaviour was explained by family stress caused by an identifiable specific event, there was some evidence of limited 'inappropriate discipline' or similar, there was no history of contact with OT; or it was the result of a domestic violence referral from the police where the nature of the aggression was verbal, there was little or no history, and the police had noted some other protective factors at the callout. These were key signs that the case would likely be closed quickly:

> "Yeah but so if we just stick to family violence 'cause that's a really simple one, I think if we got a family violence callout where there had been little to no history, if it was a verbal altercation and the police seem to have dealt with it and seen some signs of strength on the night, we would NFA that. Yup definitely" Site 2, Social Worker 2.

Not our work: the boundaries are clear

Likewise, if the nature of the problems were most obviously related to other types of family stresses or issues alone, they were also simple as they were defined as not meeting the parameters of OT's purpose:

> *"I guess when it's none of your work, when it's easily identified as an intake, because we receive and intake and quite often we'll look at it straight away and think that's not a care and protection issue it's a budgeting issue, a parenting issue - something that's not actually our work.*
>
> *Int: Yeah so what when you're making that distinction, what would clearly make it definitely your work?*
>
> *Abuse, abuse or neglect yeah. Whereas the rest of it it's more something we'd refer out to a community agency" Site 3a, Social Worker 2*

Protective factors and reasons to 'get out'

Other simple cases were those where there were clear 'protective factors' that ameliorated vague concerns. These were usually defined as someone else who could monitor the family in their everyday life (such as a family member or NGO worker), or where the risk was essentially removed, such as in the case of a domestic violence perpetrator who was no longer at the address. It was noted by several respondents that OT was more likely to try and find reasons to close a case rather than open one, and therefore the focus was always on identifying protective factors as well as responding to identified risks.

> *"and people are looking for evidence to get out you know like that and that is pretty much how we've trained them you know...like they're looking for reasons to get out, not in" Site 2, Supervisor 1*

It was noted that high quality information, particularly that which includes protective elements is most likely when it is gathered from the people directly involved as opposed to the 'on paper' notification:

> *"so the action tasks around that can be getting more information particularly from the players that are involved, and kind of an appreciative enquiry of drawing out you know the protective factors" Site 2, Supervisor 2.*

Severe abuse also an easy decision, especially with evidence

The other type of commonly identified simple decision was where abuse was very severe, particularly in cases where the evidential component could be confirmed by others, such as where there is physical injury substantiated by the hospital. Where this was combined with an extensive recorded family history of OT contact, if children were clearly afraid and with an obvious perpetrator: these decisions were straighforward. For example:

> *"Severe abuse, like you know when it's staring you blank in the face like ...and if the child's saying "I don't wanna go home, I'm scared" and this and this .. you know you kind of listen to the voice of the child or a kid turns up the hospital with NAI, well it's pretty simple...like you know it's common sensey stuff isn't it you know...there's no question about it and that's our core front of our work is child protection.." Site 2, Supervisor 2.*
>
> *"as weird as it sounds the more severe the situation that easier the decision is. I mean you get a –a child shows up with a black eye and a broken arm and it's quite clear that it hasn't done it itself then it's a really simple decision, because something has happened to that child and you often end up with quite a clear picture as to who*

has done it. And then it's - you connect straight away. Especially if there is also some history to back that up as well" Site 1, Social Worker 4

Chronic involvement plus a crisis event

A subset of these kinds of severe cases, was where there had been extensive previous involvement with a family and many options for intervention had been tried, but then there was a crisis event of some kind that justified intervening:

> *"If you have worked with a family for ages to try and make things better and then some sort of crisis happens, like someone who is arrested for accessory after a murder or whatever and the people who have been moved out of the home arrested for murder…It is really clear, there has been a lot of intensive stuff and there has been at times refusal to engage in some of that… Um, there is a point where…You reach that sort of breaking point. Something major happens, it is actually simple now, we are going to go and do this" Site 3a, Social Worker 1*

These types of cases showed the general ways that evaluations of abuse type and severity, when combined with family history with the agency, an evaluation of risks and protective factors including who was around the family, were used to form judgements relating to whether a case was deemed low level and easily resolved with

Difficult decisions

Removal was the most difficult decision

The most difficult decision was almost unanimously identified as the decision to remove children from their parents. Respondents found this was particularly difficult given that the impact on both children and parents was immense and longterm. Another difficulty was that children usually don't want to be removed, thus to do so sets up conflicts between the injunction to recognise the 'child's voice', longterm outcomes, and to protect them from harm. Respondents also found it difcult as the action of removing children, that is, the process, is emotionally demanding, even if it's the right decision:

> *"...but it's still, even though the, even though the decision is black and white, the action is hard because you still have to go in there, you still have to take that kid out, you know you still have to place that kid somewhere where they don't wanna be, you know most of the time it's with strangers, you know like it's not cool" Site 2, Supervisor 2.*

 Many respondents voiced ambivalence about the decision and the practice, with acknowledgement that there could be overriding concerns that prompted a change of decision from managers, but this would affect the relationship going forward:

> *"Yeah so still against - against my better, well no not against my better judgement, I could see why it had to be done but I still wasn't happy about doing it. When you're working with the family and you've got a plan in place, you hate coming to work the next day to be told bad luck, this has happened and you need to take that child and you need to take that child today….And it's like well hang on, how is that then going to affect not just our working relationship but his relationship, their relationship, you know. Relationship with the child and parents and everything else as well" Site 3a, Supervisor 2.*

Limited placement options

Removing children was also difficult due to a lack of placement availability. Many practitioners mentioned this, as without placement availability this limited both the ability to take children into care, and created uncertainty for social workers attempting to weigh up the harms associated with each course of action:

> *"And I'm in two minds about it, what can we actually offer these girls? And that's the constant – and then I know people who take kids into care have got nowhere to put them..*
>
> *Int: Yeah, what's your placement availability like?*
>
> *It's shit.*
>
> *Int: Right. So you're in that situation really that you couldn't take them into care anyway?*
>
> *Mmm, all we've got to offer really at the moment would be the family homes and then I'm thinking well what are we going to introduce them into there?" Site 1, Team Leader 2.*

Professional disagreement and 'going against the tide'

Another type of difficult decisions were those where there was professional disagreement about the best course of action, both between OT staff, and other professionals. Serious decisions (particularly removal) often involved many consults within the OT site as well as with other professionals such as lawyers and NGO workers. A subset of these difficult interactions with other professionals were when a practitioner wanted to go against the 'usual way of doing things', or overturn earlier decisions, for example, to keep a child with parents whose earlier children had been removed. These types of cases highlighted differences in ways of conceptualising human behaviour and in particular, capacities for change:

> *"...and yeah she's kind of stuck her neck out a bit and advocating that a six month old child who's never been removed from the mother stay with the mother when other sites have taken the older children...people tend to wanna standardise and make things the same across the board and we've gotta have more wriggle room than that, you know people are capable of change and difference and sometimes living through a situation with their child is what grows the maturity in them to be a useful parent" Site 2, Supervisor 1.*

Emotional and psychological abuse – especially exposure to domestic violence

Another type of decision considered 'difficult' were those where the type of abuse was subject to more vague definitions: emotional and psychological abuse. This was deemed difficult to define, difficult to observe, difficult to judge its severity, and difficult to prove. Difficulties in responding to domestic violence particularly was mentioned in relation to this issue. The combination of defining exposure to domestic violence as a type of emotional abuse, but with little guidance as to making finer grained judgements about harm, severity, and best solutions, meant decisions in response to it were challenging:

> *"The hardest ones to make when it's emotional or psychological abuse, because obviously there's gotta be a lot of assessment around whether or not that's actually happening, and whether it is at what level. It's the hardest thing to prove. And also family violence stuff can be difficult in the respect of you know how many notifications do we get before we actually do something". Site 1, social worker 4.*

This was an issue where site differences were most obvious, for example a case with low level concerns about a 'not coping', stressed, sole parent, where the school is concerned led to a child and family assessment at the regional site, but would probably have been closed at both other sites.

Anxiety about uncertainty of future outcomes

Other types of decisions also considered difficult were those where there was a lack of surety about the outcomes of intervention or non-intervention. Dealing with the inevitable uncertainties of estimating future behavior weighed on people's minds:

> *"Well the consequences, outcomes you know. Bad outcomes.*
>
> *Int: Yeah. What are the kinds of consequences that are going through your mind when you are making decisions?*
>
> *Did I get this right, you know have I taken all necessary sort of counsel from my supervisor, from my colleagues. If I can't get around what I should do here" Site 1, Social Worker 6.*

Chronic cases and intervention versus no history and single event

Other difficult cases were where there was a lengthy recorded history of low-level issues, and those where there was none, then a high-risk event. In the first, deciding when or if more action should be taken was difficult, especially when considering the possibilities of imperfect and conflicting information sources:

> *"Chronic, long history - do you wait for something bad or crisis to happen, or get in and remove even if they are doing 'ok'? Also some notifications could be malicious? Juggling the 'awful' looking long paper history with what they are like in person" Site 1, Social Worker 1.*

Simlary, those with no history or chronic issues but who had a sudden high risk event were also difficult to make clear judgements about, especially when there is no clear perpetrator:

> *"Yes, exactly, exactly that. But one case I had a baby who was shaken, and the decision that was the only thing that was of a concern in that case. The absolute only thing. There was no family violence, there was a little – the only other thing that was a little bit of a concern was mum's mental health, but she had always shown the ability to seek help for that and engage well with services, had ongoing support around her, had the most incredible family support you could ever imagine.*
>
> *Int: Yeah, so who had shaken the baby do you know?*
>
> *We still don't know, yeah. Middle to high class family, and which again is unusual for us to see – we do deal with a lot of people in low socioeconomic situations. But very hard to kind of get your head around okay this has happened" Site 2, Social Worker 2.*

Parenting capacity and parents with intellectual disabilities

Another type of difficult decision related to the difficulties of determining minimal parenting standards, and people's capacity to meet those, especially in cases of parents with intellectual difficulties. In these cases, not only was the parenting difficult to make judgements about, but interfaces with other professionals were often fraught. For example, one practitioner explained a local disability organisation wanted OT to intervene more because the parent had screened off the kitchen from the rest of the house, and restrained a toddler when out for a walk in a stroller – the disability agency felt this was abusive, while the OT worker felt this was acceptable given the child's own disabilities and need for safety. Yet in another case, the disability community org was advocating for children to not be removed, while the OT worker felt uncomfortable about the future for a child when there had been multiple previous children removed once they reached a certain age, and the support of the community agency could not be relied upon for the duration of the child's childhood, nor at key times. These two cases give a flavour of the types of cases practitioners are confronted with in the intellectual disabilty arena, where family

realities intersect with divergent professional opinions and mixed community support resources, leading to difficulties in decisions about what is 'best' for children, both in the present and into the future. An associated issue was the level of understanding of some parents with ID, where the disability is not something that can be 'changed' and may lead to challenges in learning new parenting behaviours, and there may not be the right type of support available to embed or monitor new learning over time. This affected perceptions of parent's capacity to change, even in cases where they may be remorseful and accepting that change is necessary or desirable:

> "Yes, to actually make changes or respond or… I mean if a parent has been hitting the child physically and they are remorseful and can understand why they are doing it and they need to change it, is something to work with. But, if they are totally in denial it is like there is nothing there to work with.
>
> Int: Yep. So that makes the decision really difficult, because?
>
> Well, yeah, I mean, when they are remorseful and want to change but maybe haven't got the capacity to change is a difficult one as well. And is it more support that needs to go in rather than you know, more eyes, more people there before and after school or something like that…Intellectual disability is a biggy. I mean we did have a case with a mum with a mild intellectual disability and a son on the autistic spectrum, non-verbal, getting more and more difficult to manage.
>
> Int: It is tough for anyone.
>
> Yeah, it is tough for any parent of a disabled child" Site 3b, Social Worker 1.

In difficult cases, removal was the most difficult decision due to the high stakes nature of the decision, conflicts between children's 'voice' discourse and protection imperatives, and the effects on ongoing client relationships. These were heightened by lack of placement options. Interprofessional conflicts also made decisions difficult, as differences in perceptions of risk and the best solution were common. The lack of clarity of definition of some types of abuse in practice and the difficult conceptual terrain of 'good enough' parenting in chronic cases and cases with parents with intellectual difficulties made were also deemed especially difficult.

Conclusion: simple and difficult cases

Comparing simple and difficult decisions provides a window into the sources of variable decisions, because it outlines the case contexts that attract high practitioner consensus, compared to those where views diverge or are most subject to competing or contested criteria. The simple case theme shows the criteria for which cases are clearly diverted away from OT intervention, and those that are deemed so serious that action is inevitable. Importantly, in both these simple decision types, several factors must align for the decision to be clear. In the first example, a lack of history plus low level type of concerns relating to 'struggling', high quality information, plus the support of a family member, all lined up for a simple deflection. For a clear intervention, the lining up of factors consisted of a serious abuse event, clear and rigourous evidence, a chronic history, child fear plus a clear perpetrator.

The difficult decisions show that challenges relate to conceptual difficulties as well as when the case does not meet the pattern of either low or high risk cases – that is, when factors do not align. This finding concurs with the findings of phase one of this study, where the most variation in perceptions of risk and safety occurred where the concerns were vague and the level of harm was unclear. The most dificult decisions related to removal of children, especially as there were unknown outcomes and competing ethical tensions. Difficult case decisions were those where there were professional, definitional and wider societal conflicts about what consitutes acceptable minimum standards of parenting, and where there were differing views about people's ability to change (White, 2005). This was evident in the subthemes of defining emotional and psycholgical abuse, evaluating different types of intimate partner violence, and making decisions about the parenting behaviours and capacities of parents with disabilities over time or those who had had previous children removed. But hard decisions could also occur where most elements pointed in a particular direction, but there were signficant exceptions to the rule: the parent with remorse but limited ability to change, or the middle class family with many supports, no history of contact, but a shaken baby injury.

PRACTITIONER PERCEPTIONS OF THE CAUSES OF VARIABILITY

Practitioners own perceptions of the causes of variability are important, as front-line workers often have valuable insider knowledge. Their 'practice-near' perspectives reflect the messy realities of the practice context (White et al., 2009). In the phase one survey findings, respondents perceived the problem of decision variability to be a significant one, with 55% of respondents stating the problem was 'quite severe' or 'fairly severe' and 44% stating it was 'moderate'. The main reasons given for variability from the phase one survey content analysis were:

1. Social worker values and beliefs, culture and theoretical perspective (20)
2. Skill level and experience of staff (9)
3. Differences in perceptions of risk, harm and abuse (8)
4. Workload (7)

Less common reasons given for decision variability were:

Current policy trends (2), quality and content of supervision (4), impact of other professionals (3), variability in family situation (3), quality of information (2) , resources (3), risk averse management/senior staff (3), site culture (2), quality of relationship with the family (2) (Keddell & Hyslop, 2016a).

The phase two data builds on these themes, explaining them in more depth and adding additional nuance to the decision-making variability picture. In the phase two interviews and focus groups, the most dominant themes were:

1. Workload
2. Lack of placement availability
3. Social worker factors such as relationships with clients, values and experience
4. Site processes and supervision.

More minor themes also reported here are: the variable use of assessment tools, and ethical dilemmas in chronic cases.

. . . .

Workload issues

Respondents commented that where workload was too high, there was not the time or mental capacity to make consistent and clearly thought through decisions. In these contexts, decision-making became more random and variable. Decisions were 'less discussed' with others, there was less high quality information underpinning them, and it was less likely that practitioners had an opportunity to engage properly with the whānau, further affecting information quality. One noted that in order to be responsive to all her cases, she needed about ten cases, but currently had 30. High caseloads led to a fragmented approach to case assessments:

> *"because right now, I have to jump from one case to the next within minutes...and I might not have thought fully about a decision I've made before I have to respond to it" Site 2, Social worker 3.*

Another effect on decision-making was that high workloads could lead to feeling stuck or paralysed by the workload, leading to extending the time until a decision was made, meaning some cases were responded to quickly while others were not.

Hierarchies of risk

High workload also affected decision variability in other ways. Those cases that were evaluated initially as 'high risk' or were for some other reason were 'attention grabbing' or in constant crisis could lead to other cases being ignored in a context of finite capacity to respond. Some of these latter cases might not be followed up for months and then not get the same level of assessment:

" I think what happens is that what grabs your attention on that particular day will impact in a way that the other stuff falls off. So these ones sitting over here may be low levelish and are not on the radar, they get affected because they're not seen as high priority.

Int: Mmm, and what's the consequence of that?

Well because you get to the point where we talk about it and like well I haven't done anything for months, it's been months you know so what are we doing and if you haven't seen someone for months and months and you can't be that concerned about them" Site 1, team leader

Ironically, it was also noted that sometimes cases had resolved 'on their own' after several months of no response. From a variability perspective, differences in the timing of response could lead to marked differences in decision outcomes, if some families get an immediate assessment that could lead to intervention, while others might be closed if the presenting issues appear to improve after time has passed.

Reporting demands dominating

Another reason high workload could lead to variability was where reporting demands could lead to losing track of case details, and in these situations the administrative reporting jobs and need to meet 'KPIs' dominated the available time. This was also felt to reduce the ability to gain quality information that can only be gained through time spent with families, also affecting decision outcomes.

A further effect on decision variability caused by workload differences was in relation to the resources gained for children in care. With few clear guidelines, those social workers who were motivated to pursue more resources for children on their caseload could get more, while others wouldn't.

Variability caused by workload only a problem at some sites

The problem of variability caused by high caseload was felt to affect those sites that were 'struggling', that is, those with many notifications and mostly inexperienced staff:

"Int: So How serious do you think is the problem of decision variability? Do you think it's a very large problem for the organisation, or do you think it's relatively minor? It is there, you know it happens sometimes but it's not a big serious issue. Where would you put it on that sort of continuum?

Oh okay, I think for sites that are struggling it's a major issue.

Int: Right, do you mean struggling with too many cases not enough staff, those kinds of things?

Yeah, organisational - and folk that are you know that didn't - sites where… you know getting a lot of young ones that haven't got good, that you know haven't got a balance with more experience" Site 1, Social Worker 7.

Those sites that did not have this combination were felt to have better consistency, and not all practitioners had high and unreasonable workloads, for example with some noting that at earlier times (or at other sites) their caseloads had been much higher than in the present.

Responses to high caseloads

Despite these issues, respondents also had methods of managing these problems, and as stated, not everyone had high caseloads. Strategies reported that were successful in managing high workload were developing good routines, the use of lists and plans, and the important role of the supervisor to help manage deadlines and mitigate pressure on social workers.

Views on specialized teams to improve workload management and decision variability were mixed. Some thought more specialized expertise might help routinise decisions made often, improving consistency, while others thought it might lead to displacement of responsibility. For example, the care team might end up overwhelmed if too many children end up in care when a child who is removed can be rapidly 'passed on' to the care team. The decision-maker has little ongoing responsibility.

Variations in placement availability

Many respondents noted that the lack of availability of placements was a significant and longstanding issue that impacted on decisions in multiple ways, including leading to variability in decisions made. Obviously if there is no care available in one location, but there is in another, this can lead to differences in decision outcomes despite similar family circumstances. But other factors were also at play. It was perceived that not only are placements scarce, but there is a 'perfect storm' combination of more children with complex needs needing care combined with fewer placements available to put them in. Now, children and young people with complex behavioural and mental health problems, suicidal children, and those who pose serious threats of violence to caregivers, as well as large sibling groups all made finding caregivers a challenge:

> "...it's never gonna change, it's always gonna be what it is, I think what, the issue for us now is that the complexity, like I know, I'm pretty sure like you know, we didn't have all these, I'm pretty sure they had complex kids back then but you know, you've got multiple complex issues on a kid … and where do you put them?" Site 2, supervisor 2.

Some sites had some short-term caregivers available, others had none at all, while others struggled to get respite for the few they had. This affected decisions not so much for immediate safety cases, but in those less immediate situations, it clearly affected decision reasoning:

> "We just picked up two a couple of weeks ago and we're like where the hell are we gonna put these kids but we're like – we'll find somewhere… But yeah that's always at the back of people's minds you know pre-care meetings where they're going how can we do this we've got nowhere to – 'cause you can't can you, you can't go and pick up your children and oh we're just going to sit around the office here" Site 1, social worker 3.

Lack of placements affect chronic cases the most

Others noted that lack of placement availability affected the 'weighing up of harms' when cases involved chronic neglect or other more nebulous kinds of cases where there were ongoing family issues rather than extreme abuse events. In these kinds of chronic cases, the lack of placements increased the threshold at which children would be removed, as the lack of quality placements led to a higher harm threshold needing to be met. For example, if the placement type was less than ideal, or removal may lead quickly to multiple moves with no permanent options:

> "I know that we – that I have said things to people in the past like I'm not bringing these [children] into care because the placement that I can offer them isn't a family home, and that's not going to be any better than where they are right now. Or we just don't have placements, we just don't have any. We literally have no placements really.
>
> Int: Yeah. So if you had two kids that had to come into care today, would you be able to place them?
>
> We'd be able to place them in a transitional placement but that would mean multiple moves" Site 1, Social worker 2.

It did make people work harder than they otherwise might have to seek whānau caregivers and informal care solutions, but these were sometimes not ideal. One participant reported social workers sleeping in the office with children they couldn't place. Others stated they had some emergency options, while other sites didn't even have those.

Mental health needs and lack of access to mental health services

The problem of the increasing mental health needs of children intersected with the lack of mental health services for young people, and a perceived lack of willingness of health services to get involved with young people connected with Oranga Tamairki who have mental health problems:

> *"they've got a strategy of what they want but we don't have the support system to do that so they want us to deal with the work that's ours but we have an inadequate mental health system that isn't able to deal with it and won't work with us..." Site 2, Supervisor 2.*

Social Worker relationships with clients, personal background, values and attitude

Factors directly related to social workers themselves were also reported as affecting differences in decision outcomes.

Participatory practice and attitudes to engagement

The ability to form positive, engaged relationships with clients was strongly felt to affect decisions made. This ability was related in many accounts to an ethical focus on empowerment, respect for persons and being non-judgmental. A number of participants commented that this ethical stance or attitude was a precursor to engaging with clients, which flowed onto a number of other quality decision-making elements: better quality information; more trust; more knowledge of parent's support and care networks; more ability to identify key people in their lives who could offer care; a better understanding of both parent's and children's perspectives about their lives; and a more 'empowered' outcome. Crucially respondents noted that there were some who practiced in this way while others did not. This led to variable levels of engagement, and in participants' views, variable decisions. Some practitioners - as reported by others - tended to ascribe to 'on paper versions' of clients rather than the information they gained through direct interaction, be more judgmental, were more likely to emphasise their powerful position and more likely to threaten or implement removal orders. This was especially the case for decisions about 'vulnerable women':

> *"I've been out with most people on the staff floor and seen how they've interacted in their practise, and sometimes I've just shook my head and gone oh wow. You know it's not what I want to do, it's not how I'd do my work. I'm very focused on engagement and the Durie model, you know engagement, enlightenment, empowerment. It's a simple sort of stepping stone process. You can't get to any of those other places unless you've engaged first.*
>
> *Int: True, you can't do anything without that. What do you think holds other people back from being engaged?*
>
> *Prejudice, ego, judgement.*
>
> *Int: And as – when we think about decisions that then need to be made, how does that – someone's who's really engaged with a family versus someone who's not. How do you think that affects the decisions that get made?*

I think that they are often driven by – so I hear quite regularly, have heard quite regularly this idea that you know ' I'm going to take those kids away'. And I just shake my head, you know I can't understand that mentality that somebody's so absorbed in their power that they've forgotten about the human element that's playing out here. Because that would be one of the hardest decisions I think I'd have to make." Site 1, Interview 6.

Several participants noted that the most judgmental social workers tended to be childless, inexperienced, or have entered the job for the wrong reasons. This could improve with experience for some:

"if you haven't got a relationship, you're not giving the right information and they're not gonna be honest and open with you, you know you need to build those relationships so then you're getting the right information or who can be the right support people or who can look after little Johnny or you know, if you don't build those engagement stuff, yeah you're not gonna get far

Int: And some of your workers are better at that than others?

Yeah shit yeah, yeah.

Int: Yeah, where does that come from?

I think it comes from their own, again I think it's stages, stages of social work where you're at...and it definitely comes from your personality, who you are as a person... and just yeah, 'cause you can come, you know it depends what purpose you're in the job for too I think like you know, a lot of people come with their own bullshit..." Site 2, supervisor 2.

Class and socioeconomic status of clients

Another social worker factor affecting decision outcomes was the class position and ethnicity of clients themselves. While a more minor theme, some respondents noted that practice differed with middle class clients, who tended to be more defensive, critical of the social worker and likely to have legal representation. This led to more defensive, careful and 'stilted' responses from social workers, while those from more working-class backgrounds elicited a more 'natural' response. Others noted that different responses were offered to Māori and Pasifika families compared to Pākeha from management. The interpretation of empowering and working with wider Māori and Pasifika whanau could have the unintended consequence of less resources offered to families who were 'brown', while Pākeha families got more support from the organization:

The other upsetting thing too is that um...is that sometimes we're told, depending on, and this is a reality here...and a lot of us see that here, is that our white families… get everything that's asked...we go in and we're trying to advocate for our poverty stricken families and being told no and then we go in with this other, other [Pakeha] families and asked, yes, you know it's...absolutely double standards.. although they are family but the family could be, it's just as bad off poverty wise and is looking for that financial support to feed that extra mouth and yet told no, and that's where the frustration becomes really … then in the end it breaks down because they really can't afford to feed another mouth even though they're family...our brown families are told go back to the family, try the family, get them to be more supportive, get them to do this and do that...and yet they're the very ones that need the help more than these ones that have got finances …" Site 2, Social Worker 5.

A related issue was how differences in cultural and socioeconomic background of the social worker could affect perceptions of risk. For example, one respondent noted that another worker had included the fact that a family slept on a mattress on the floor as an indicator of risk, whereas others from working-class backgrounds might not view this as a risk factor. Similarly, values relating to family were also at play, for example with some valuing child safety most, while others emphasised family maintenance. So, while directly racist or classist comments were not made, other less expected differences in interactions with people from diverse ethnic and socio-economic backgrounds were reported that affected the tone of interaction, the resources and responses to families, perceptions of risk and how competing values were prioritized.

The role of personal experience

The practitioner's personal life and experiences were perceived to contribute to variability. For example, whether a previous intervention or type of case had gone well or not could affect perceptions of future similar cases. People's life experiences in relation to their own children were also perceived to influence decisions, although many workers showed awareness of these types of issues. One, for example, felt that having her own children made her less judgmental towards other parents, and another undergoing fertility treatment asked her supervisor to not assign her to any work with pregnant women or newborns in the immediate future. Others recognized that a client who reminded them of someone in their own personal networks could shape decisions, but again many were able to reflect on these issues. The factor of whether having children affects practice perceptions is an area needing further research.

Site processes and supervision

Sites have different ways of processing cases once they receive a report of concern from the intake centre. Within each site, there are teams that have a hierarchy of roles, all over-seen by the site manager. There are a range of group and individual processes and assessment tools that are used to assist with decision-making at different stages. The interaction between these factors leads to decisions, and of course, differences between them can create differences in decision outcomes between and within sites.

The site process – intake and initial assessment

This study examined three sites only, but some participants had worked at other sites. Examining differences in how cases progress through each site helps examine how varaiations might result in different outcomes for families notified to different sites. Many respondents reported variation in the information quality that sites receive from the centralised intake centre, and there were also initial assessment differences in the ways cases were processed once received.

Quality information needed from intake and families

In order to make clear decisions once intake notifications are received, quality information is required. This was not always the case with information received from the national intake office. Some notifications were full and clear, but others were vague, short and with basic information about the family incorrect or missing. This was a persistent theme. In short:

> "It's variable and it's inconsistent, and it needs an overhaul." Site 1, Social worker 7.

Initial assessment process

Differences in initial assessment processes affected case progression. Some sites have a process that an allocated case is summarized, drawing on the recorded history plus current notification information initially by the social worker alone. Then they present their summation and initial thoughts to their supervisor. At other sites,

the supervisor works with the social worker to do the initial information gathering and evaluation. This small difference in process was perceived as having possible different outcomes, particularly if the social worker was inexperienced. Given that more experienced workers tend to make more consistent decisions, the co-working of supervisors and new social workers in the initial assessment phase seems to be key to maintaining consistency at that stage of the decision-making continuum.

Similarly, at some sites as noted in Keddell & Hyslop (forthcoming, 2019), supervisors expect social workers to 'form a belief' alone, and then convince their supervisor, while others have pre-FGC meetings where the decision is made collaboratively with the team. The 'alone' process can mean that more is left to the discretion of the social worker and this may create more variation, because some social workers might be more or less interventionist, and the mediating effect of supervisors and colleagues is left until later in the process.

Allocation practices themselves can also differ. At some sites, a social worker on intake takes all the cases that come in, while at others they are distributed by a supervisor to ensure fairness. In the first model, workers can be rapidly overwhelmed, exacerbating the workload effects described above. It also provides a disincentive to accepting cases at all.

The supervisor role

As alluded to above, the supervisor role was considered crucial to maintaining many of the positive elements of good decision making, including consistency. Supervisors were noted for being able to have an overview of multiple cases, more experience that assisted with consistent case responses, could assist with reflection for social workers when they knew they were relying overly on their 'intuition', and were key to ensuring that social workers felt supported and less anxious in their jobs. But this could also go the other way. In less supportive teams, there was a clear split between supervisors/managers and frontline staff, particularly when frontline workers felt that management 'excluded' them from decisions, even though they were the ones with the face to face relationships. Similarly, some social workers felt that supervisors were suspicious of clients and risk averse, overriding their frontline judgements. Others felt that their supervisor emphasized different ethical imperatives, for example bicultural practice over a worker's view of maternal rights, or risk aversion versus whānau choice. For example, this respondent felt their supervisor was too focused on risk:

> " Yep. Do you get enough supervision do you think?
>
> I think I get enough supervision on the technicalities of Child Youth and Family risk management. What I feel is a deficit is – I don't get enough supervision from a personal level of how I'm coping with my workload, the challenges of various cases and then sort of –
>
> Int: Mmm so the deeper stuff around your own emotional wellbeing, the way you interpret things, it's not so –
>
> Yeah also taking too much ownership and then feeling deflated, let down and manipulated. I don't feel like we get enough supervision. And in fact, this isn't probably the right environment to get that supervision from. You know -
>
> Int: In what sense? Do you mean it would be better if it was an external person doing it?
>
> Well because the driver all too often is the ministry's risk aversion" Site 1, Social Worker 6

Because of this dynamic, a number of respondents considered that differences between decisions really reflect differences between supervisors and their views of the cases those in their team are working on, rather than differences between frontline social workers. This view, however, was not uniform, as some workers had more discretion in their job compared to others as mentioned above.

Due to this crucial role, participants noted the important function of supervisors in maintaining consistency as well as contributing to worker morale. Those that were perceived as respectful, supportive and trustworthy, gained worker's trust and workers felt they could ask them anything. Others felt their supervisor was more driven by 'KPIs' or budgets and were judgmental of clients:

> *"Okay from sites it (variability) comes down to the management team and how they operate, I've worked with a number of managers obviously, and because within each office there's sometimes a number of managers. Some managers are amazing at managing people, so they are really good at making - they understand that if their team is feeling supported more work is going to get done and probably of a better quality. I mean we all know it's a given, you treat someone with respect and you treat them well, they're gonna work hard for you. Then there are other managers that are more KPI driven, budget driven, it's more difficult making decisions because it's just like ugh I'm going to go and have to ask for money, that sort of thing. And it does have an impact, and also it impacts the morale. You know obviously because of the work we do, and because it can be quite dangerous in some of the houses that we go out to, we need to be able to trust our teammates... So yeah at our site level it does come down to the management team" Site 1, Social Worker 4*

An important aspect of decision-making in the child protection environment is responding to anxiety, particularly about making the wrong decision. Social workers don't want to be criticised for 'not managing the risk', and some pointed out that decisions can vary due to a worker feeling supported or unsupported in their decision by their supervisor.

While supervisors do have a lot of power over decisions, and can mitigate decision variability, they also carry therefore a lot of responsibility and pressure on them to manage workloads and decisions. They felt they were the 'meat in the sandwich':

> *"Yeah, yeah and so I think the trick around that or trying to avoid that happening [being paralysed by too much work] is just you know being aware of what's happening for each person. The time on their caseload, and that's how you allocate as well, you just go no. She cannot have anything because she just - we'll tip her. And that's why people leave. Because they just yeah can't see the trees or woods. Sad to watch, because you're getting pressure from here to do something about that here, and you're aware of what's going on there.*

> *" Yeah I think that can't be good for decision making, it puts a lot of emphasis on supervisors to mitigate poor decision making, you know I think supervisors carry a lot of responsibility in a site environment. An awful lot of – you know much more so than any single social worker carries".*

Assessment tools

A more minor theme contributing to variability was the uneven use of assessment tools, with most perceived as technical requirements. The exception was the case consult tool. There are various tools used including the safety assessment or intake decision-making tool, the child and family assessment, case consult tool, case evaluation tool and Tuituia assessment framework. These figured surprisingly little in worker's accounts of decision making. They were not always used and tended to be perceived as a task to be completed, rather than of assistance with decision making.

> *"Int: Right, is that called the decision making tool or something like that?*
>
> *Yeah, but no one uses it at the site office level.*
>
> *Int: Why is that?*

Too long, too I don't know. Oh you see if you went through that tool with every case you'd be sitting here all day.

Int: I haven't seen it so – is it too arduous as a first decision?

Yep I think so. The only thing that would solve the problem is more staff so you're not constantly overloaded." Site 1, Supervisor 1

The case evaluation tool was perceived as an audit for technical details rather than a way to assist with reflective practice that examined conceptual or ethical principles, or as a check for consistency. Also, as it was usually undertaken at the end, this was perceived as not helping with decisions as they get made:

" No I mean then what the practise leaders are meant to do is sit down with the social worker and go through it with them and explain why – how they came to their …their decision. And so that – the idea behind that is it'll then improve their practise about what – how to do it better next time, the tuituia.

Int: Yeah so – but you don't think that's especially useful? Or you do or – how do you feel about that tool?

How do I feel about it – it's just one more thing they expect us to use in supervision and – or when we're reading the tuituia …We sit there reading the tuituia and go through with pages and pages of – Did they use the child's name in every sentence type thing. That kind of thing…Is there evidence of that the child was spoken to. Is there – that kind of that's what it's like" Site 2, Supervisor 2.

The exception was the case consult tool, which many workers spoke of as key to assisting with big decisions, and useful to engage the views of other workers in a structured and purposeful way. It was felt to assist with clarity around risk and safety through risk statements, and to be able to separate out some aspects of the family life that were not able to be changed. In short, it helped to gain a range of views and analyse the case information in an in-depth and balanced way. Studies of group decision making note that where group decision-making has clear structure, purpose and control, group decision-making assists with decision quality and consistency, and avoids the downsides of 'group think' (Janis, 1982). Only one respondent mentioned family could be included in this consultation process though, despite the original progenitors of the tool aiming for family inclusion(Turnell & Edwards, 1999).

Some participants commented that there is a lack of nationwide consistency in the ways assessment tools are used, leading to decision differences:

"Yeah I think so. And again I think there's been constant inconsistency throughout the country, and it's because there is no – no protocol around it I suppose or how to deal with it. Yeah I mean that's like [child] again, when we're thinking they should come into care but you get another site say no, so that's contradictory – isn't it?" Site 1, Supervisor 2.

Ethical dilemmas about rights and needs over time in chronic cases

Another relatively minor theme that resonated with the kinds of cases that practitioners found difficult, was the subtheme of ethical dilemmas, particularly in chronic cases where it was difficult to define the outcomes of particular parenting styles over time. In cases where there was a need to balance the needs of a baby's development with mother's need for time to change for example, was mentioned as the type of case that was likely to be a cause of variation, because of the competing needs of the baby's safety weighed up against their need for family belonging, and the mother's needs over time.

Conclusion: practitioner perceptions of the causes of decision variability

Practitioner's perceptions of the causes of variability were diverse. They include both individual decision maker factors and organizational context factors. Both are perceived to contribute to decision outcomes due to the contingent and socially negotiated nature of decisions. Where workload was high, this was felt to impact decision quality consistency. While not apparent across all sites, high workload could lead to inconsistent decisions due to a variety of causal mechanisms including fragmented thinking, losing track of case details, cases in crisis taking priority and making others wait, and administrative tasks taking precedence over relational ones, affecting information quality.

The lack of placement availability shapes decision outcomes and leads to variations in the removal decision, as it is a constant factor affecting practitioner's weighing up the harms and benefits of removal. It is exacerbated by the increasingly complex nature of young people needing care, particularly their mental health and behavioural needs. This could mean that variability occurs as children who have available whānau carers might be more likely to enter care, along with children who do not present with complex behavioural or mental health needs, or in chronic as opposed to high risk situations. Clearly this could result in differences in decisions for children who may have experienced similar levels of harm, but have differing levels of available family caregivers or caregivers able to cope with their mental health and behavioural problems. This appears to be exacerbated by lack of support from specialist mental health services.

Site processes and supervision also affect decisions. Variations in the information quality at intake, as well as differences in the points at which collaboration between social workers and supervisors occur, are key to understanding how decision variations might happen. The balance between social worker discretion and supervisor power is a fine one, but certainly for inexperienced practitioners, the support of supervisors and their oversight helps maintain consistency as well as reduce anxiety.

Practitioner factors such as differing levels of commitment to participatory practice was also considered key to gathering quality information and the type of decision outcome likely. Those more committed to partnership with clients tended to engage in more relational practice and be less judgmental and interventionist. Differences in responses to people from different ethnic groups and class positions could also occur, not due to direct class or ethnic biases, but due to differences in the expectations of Maori and Pasifikia families to 'care for their own', and because the heightened response from middle class clients made practitioners more on guard in their interactions with them. Differences in personal experiences also affected practitioners, though many showed reflective capacities on this last issue.

Finally, smaller reported effects were related to the inconsistent use of assessment tools, their tendency to focus on technical compliance, and the difficulties of ethical dilemmas in chronic cases. Case consults were felt to be a robust and useful way to make group decisions.

WHAT SUPPORTS GOOD DECISION-MAKING?

As well as identifying what contributes to decision-making variations, practitioners also identified individual and organisational elements that contribute to decision-making which is perceived as positive. These mirror some of the themes described above. Key elements were: collaborating to ensure high quality information; focussing on the child; collaborating with others; being consistent in messaging and accountability expectations; the use of case consults; an ability to reflect on one's own parenting experiences; avoiding easy categorisations; being flexible and contingent as new information comes to light; and having placement choice.

Collaborative practice

Quality information was considered key to good decisions. This was not only information about the family, but also matters of process and policy. Practitioners noted that asking when unsure, collaborating with colleagues, and understanding key policies while interacting with families and being focussed on the child all tended to be key elements to decisions perceived as 'good':

> "...and then you need to consult with the experts you know, and then the senior management about your decision, collaborative thinking, consultation, what else, review of the policies...and then working with the families and of course, you've got the child at the centre…if it's a child focussed decision, yeah" Site 2, Social Worker 1.

Clarity of ultimate or 'higher order' aims

Another key element of good decisions that were more consistent was clarity about ultimate intentions or aims. Having a clear and shared consensus on improving the actual family conditions over time, in order to improve resilience, for example, was perceived to assist with decision quality:

> " I think clarity and having a full sort of grasp of what your intention is, understanding what your intention is here for when you make a decision and not necessarily the dichotomy of good or bad, but actually is it going to improve you know coping, resilience, the decision whether to apply for a service unit so that you can get a whole extra level of NGO support into a family. Rather than just you know a parachute sort of support" Site 1, Social Worker 6.

Ensuring frontline workers have consistent education about what those key aims are, as well as being held accountable for the outcomes of their assessments were another element of perceived good decisions, reflecting the discretion/accountability concepts introduced earlier:

> "Yeah I think – yeah. Mmm, I think it's the consistency of the messages that they're getting. And following like you say processes, being held accountable for their you know – being able to demonstrate their assessment outcomes really clearly." Site 1, Supervisor 2.

Use of case consults

The use of case consults as mentioned above was a strong theme mentioned at all sites. These assisted workers to engage in robust collaborative decision-making, encouraged workers to articulate their reasoning and be accountable for it:

> "Good risk statements, having consults and whatnot. Yeah pretty much going through the process from the get go through to your supervision through to consults and knowing you're not making decisions – they're not making decisions by themselves helps. A lot of the time you go out and you've already decided on the way home – (laughs) – back to the office where you're going. But you still have to go through the process of talking about it and nutting it out. And you know, it's pretty clear cut... yeah I do believe it encourages – we try to encourage good decisions for children and being - making sure the social worker can articulate why we're thinking, what's behind the thinking" Site 1, Supervisor 1

> " Several different people having an input, a case consult definitely. I kind of don't feel like I've made a decision properly until I've had a consult about it. Site 1, Social Worker 2.

Critical reflection on own experiences

Being able to separate out one's personal experiences of parenting or being parented from their decision-making processes was considered important. Again, there was some ambiguity around this, with some people saying it affects some people's decisions, while others were clear that it had little effect:

> "Decision making? Yeah you hear a lot of well – yeah it really bugs me but you know oh when I was a child blah blah blah, or when I had my kids, blah blah blah and I'm thinking it's got nothing to do with that. And this is from senior people. Yeah I think they bring their own experiences with them. Again it's that ability to be able to pick that up from us and tease it out with them.
>
> Int: Right, 'cause everyone does. Everyone has a background that influences them but it's to what extent that's –
>
> Yeah I do think that most people have the ability to put that aside though and make the right decision for that child" Site 1, Supervisor 1.

Supervision support

The support of supervisors was considered crucial to good decision making, and implicit in this was that this ensured that all relevant aspects had been considered:

> "When – another thing is when you've had your supervisor's support or something. They're saying yep I agree with you, I think you've done what you need to do, you've thought about all the different aspects of things." Site 1, Social Worker 2.

Avoiding stereotypes or simple categorisation

Ensuring that all relevant information had been gathered, and that it was not being used to rapidly categorise a type of case was also considered important in good case decision-making:

> "So talking, discussing, good assessment. Lots of ground work, making sure you've talked to all the necessary people. Not looking at cases as you know fitting into a box. Sort of not assuming I guess, as soon as it comes in it's going to be one way or the other" Site 1, Social Worker 1

Positive decisions were also perceived as contingent on new information – not fixed in concrete. For this reason, slowing decisions down was considered important. Being able to adapt to new information was necessary to reflect the fast-changing nature of family and other circumstances as a case progressed, especially for new cases as they came in:

> " Decisions – what decisions, yeah I think probably what I've said just – it kind of grows like yeah. So decisions aren't – well for me aren't made like as soon as a case comes in you know like I said to meet with the supervisor, you make a plan and then you come back and that plan's like gone through the window (laughs). Or you know something's gone off or something else has happened so it grows and I think that going with that's probably yeah. So not being too quick, not being too like 'close this' " Site 1, Social Worker 2.

Placement choice

Finally, echoing the major theme above about the lack of placements, if there was a solid range of placement choices available, this was also felt to improve decision outcomes. Where quality placements existed, decisions would not be so constrained because of that lack.

> " So I'm nearly there, I'm nearly finished. This is great, rich discussion. What supports good decision making then? If obviously you're constrained by all these different factors, if you had an ideal world that supported good decision making, what would you have?
>
> You would have a choice of placements … a choice of placements so you weren't in that dilemma of should we or shouldn't we. If you really wanted to that's what you needed to do, you know and you'd be sure of that, that's what you needed to do". Site 3a, Focus Group.

Questioning the consistency ideal

Participants also questioned the consistency ideal, leading to a number of reflective comments about the whole premise of the study, which is to focus on variability. A number of participants pointed out that differences between sites were inevitable and may reflect positive individualised decision-making, and differing priorities and landscapes in local communities:

> "Yeah I think it's really hard to say because on the one hand, having similar outcomes for families in a similar situation, that sounds like a good idea...but then you also have to think well how similar can two families really be, that is, that sort of...
>
> Int: Yes yes, is consistency always a good thing?
>
> (or) just an arbitrary ideal for having the same consistent decisions...
>
> Int: Yes yes, it's an important question.
>
> Yeah so it's, I don't know if there's anything that can be done about different sites making different decisions...and I recall having a meeting with, in the morning when we're talking about well sometimes that's what we want to have these different decisions coming from different sites because each area is different" Site 2, Social Worker 3.

Conclusion: what supports good decision-making?

Frontline perspectives on what personal and institutional factors support good decision-making included, unsurprisingly, inversions of the perceived contributors to variability. Collaborative practice was felt to support decision-making, as it provided an opportunity to improve information quality, generate consensus around case interpretations and meanings, and ensure policy guidance was understood and followed. Consistent messaging regarding the ultimate or abstract aims of practice were perceived as important, as well as methods to ensure practitioners followed key guidance. Case consults were felt to encourage good decision making because they require practitioners to articulate their case reasoning. This process of articulation assists with logic and allows for challenge by others. Critical reflection was another key aspect of good decision making as it assisted with separating out the effect of personal experiences, and with avoiding 'case -stereotypes', that is, categorising a case too rapidly as fitting a certain 'type'. Supervisory support was felt to ensure that all salient aspects had been appropriately considered. Finally, placement choice was felt to support good decision making as it allowed for decisions about removal to be considered based on a child's needs rather than what placement was possible.

DISCUSSION

Decision-making in child protection is a process where individual decision-maker factors such as experience and values combine with the quality and interpretation of information, the meanings attributed to parent and child behavior, the nature of relationships with families, and institutional resources, policies, tools and culture to produce decision outcomes. Inequalities in system contact and differences in resources also contribute. In this complex setting, variability is inevitable, and in some cases, desirable. Professional discretion is an important aspect of judgements that are responsive to family needs and priorities. However, ensuring that similar principles, processes and resources are available is important, in order to ensure that the explanatory theoretical logic of decisions and the resources available to implement them are fair, resulting in consistent use of important ethical and conceptual principles rather than decisions that for want of these things, are arbitrary. This short discussion covers some of the key issues these findings raise, before turning to the implications for policy and practice.

Decisions made by practitioners in this study relied on some 'in common' concepts and practices which are important from a decision variability perspective to ensure decisions are generally relying on a shared knowledge base. These included an understanding of child abuse and neglect as encompassing physical abuse, emotional/psychological abuse, sexual abuse and neglect, as well as knowledge of well-known additional risk factors, such as substance abuse and lack of support. Protective factors were also actively looked for, especially in the early stages of practice. These were generally conceptualized as people able to offer support and monitoring of the family, as well as protective actions by adults. In addition to these knowledge bases, most practitioners understood the broad legal and ethical principles at play, such as the need to support the family while also protecting the child.

While these basic understandings were clearly reflected in the practitioners' narratives, there was less consensus about how to apply these when there was conflict within these concepts and ethical precepts, or knowledge of them was superficial, or knowledge about the family itself was limited. These tensions were most evident in relation to the decisions deemed difficult, where for example, knowing that exposure to domestic violence can be a form of emotional abuse, did not translate into a clear practice response in relation to what to do about it, that is, what action to take and at what level of severity. This reflects a common lack of consensus about how to respond to domestic violence in the child protection system, and conflicts in theoretical explanations (Hester, 2011). Likewise, where parenting was generally a struggle, such as for parents with an intellectual disability, but there was little direct abuse, this also presented conceptual and ethical difficulties for practitioners, as were chronic cases where the child protection system structure of notify-investigate is not a good match for the ongoing chronic needs that some families have. In those cases, assessing the minimum acceptable level of parenting capacity is challenging, as what is deemed acceptable is subject to diverse values, cultural expectations and societal expectations (White, 2005).

There is no systematic relationship between parenting competence, intellectual disability and child outcomes: research relating to the effects on children is mixed. Differences in the nature of the disability, parental support levels and social context make each case unique (Aunos et al., 2008). It is difficult to know if children's developmental needs may or may not be well met, and their right to be raised in their family of origin and the parent's rights to parent their own children, as well as cultural identity issues are all important to consider, leaving few clear decision pathways. Assessing parenting capacity relies on a culturally specific set of cultural norms that may not apply to Māori or Pacific children in the Aotearoa New Zealand context (Choate & Lindstrom, 2017). Parenting capacity assessments can create an over-reliance on a specific set of markers or indicators of risk (such as ambivalence about the baby) that are widespread among pregnant women, and where clear guidance is not provided, the concept of parenting capacity in practice can be subject to wide differences in interpretation by individuals and in different communities. As Choate & Engstrom, (2014) note "Such ambiguity leaves families with the probability that the standard against which they will be judged will vary from worker to worker and from community to community …this leaves case management open to inconsistencies that can include systemic biases which can work against rather than for the best interests of the child" (p. 368). As mentioned above, these more nebulous issues were those where variation in outcomes were most likely.

A study of care proceedings by Trowler et al, (2018) notes that in the context of increases of children in care, the statutory reponse to children should maintain 'clear blue water' between children subject to legal intervention and those who should not be; that "thin, red line decisions, where the decision to remove a child from his or

her parents could go either way, should be diverted away from Court. There should be clear blue water between children brought into care proceedings and other children considered to be at risk of significant harm." (2018, p.2). In the rapidly moving context of expanding definitions of abuse and harm (such as the inclusion of concepts relating to well-being, future outcomes, and exposure to domestic violence in the Oranga Tamariki Act amendments that came into force July 1 2019), it is clear that greater education of practitioners around the key evidence, debates and thresholds for intervening in cases of domestic violence, emotional abuse, parenting capacity and intellectual disability is needed in order to ensure that this 'clear blue water' exists (Munro, 2007). The threshold for statutory interventions such as removal should be a high one that rests on ensuring immediate safety, with other legal requirements of promoting wellbeing and early intervention being met via family, whānau and hapu supports, as is set out in the Oranga Tamariki Act 1989.

Ensuring that the causes of harm in these types of cases are informed by a social or public health approach is the first step in ensuring that families receive a response that can address the causes of potential harm in an effective and consistent manner (Featherstone, Gupta, Morris, & White, 2018; Featherstone, White, & Morris, 2014; Scott, Lonne, & Higgins, 2016). Many of these types of cases (emotional abuse, neglect, parenting capacity) are sensitive to poverty and other social conditions, so addressing both the causes of poverty and its effects on family life are important first steps that recognise the rights issues at stake – that poverty should not become a reason for removal either directly or indirectly (Gupta, 2015). For some families, poverty -aware practice will include better financial support, housing advocacy, therapeutic work, and those that provide family support and education (Krumer-Nevo, 2016). Having a clearer understanding of this can assist with ensuring that families are not drawn into statutory intervention when a different type of response would be more effective. The ongoing lack of resourcing in the NGO service sector, plus the rapid increase of notifications, and renotifications, over the last 15 years sector means that families may be engaged in the statutory system that should have a different response from a different service in order to ensure the 'clear blue water' exists (Martin, 2019).

Clarifying when a family should move on to a child protection response, and what that should be, requires a clear conceptually and ethically informed response. Lack of clarity exists where there are multiple competing theoretical explanations and ethical tensions in the child protection context, for example, multiple theories of domestic violence and differing responses in different sectors, or lack of clarity around the minimum parenting provision (Hester, 2011). While some theories and ethical concepts will always have some degree of tension, a complex, theoretically informed consensus can and should be developed to ensure practitioners are able to respond in consistent and effective ways. In order to ensure this, practitioners need clear education on undertanding the literature on each type of case issue, and for it to be applied to practice through problem-based education of workers using nationally shared case studies. As noted by Hodgson et al (2019), greater compliance or control is not what is needed, but rather an organisational context that supports depth of case reasoning based on agreed theories of explanation and ethical concepts promoted by the organisation through continuing education and problem-based learning.

Difficult decisions were not only those with difficulty around outcomes and definitions. They were also identified as those where most elements pointed in a particular direction, but there was some particular exception to the recognised criteria for case types. In these cases, the case did not fit the pattern, so the best responses were less clear. Recognition primed decision-making suggests that people develop complex heuristics through experience, learning to identify which factors are salient and how they should combine. When faced with new cases, they attempt to match it to these patterns, then select the most practical response that fits with that case from the prescribed templates available to them. In these difficult cases, the case could not match the pattern as most factors, but not all, were present, so responses were more confused (Klein & Hoffman, 2008). Also, less experienced practitioners may not have learned which factors are most salient. This leads to a more nuanced picture of variability – as occurring not just because definitions are unclear, but when the total picture does not align with a pre-conceived overall pattern of risk/protective factors. Ensuring practitioners can move beyond simpler case 'types' and thin heuristics to understand the underlying principles and theories can assist with responding to cases in these circumstances.

Practitioners' perceptions of the causes of variability provide valuable insights into frontline practice and its concerns. It is important to remember that asking about causes of variability elicits just that: a focus on

variability and associated problems, making estimating the impact of each factor difficult. Nevertheless, the stated effect of workload differences on decision variability provides valuable insights into the possible causes of site -based differences in decision outcomes. It may be that variations in intervention rates reflect sites where the workload is unreasonably high, leading to more variation. The lack of placement availability and its intersections with the complex nature of the problems faced by young people needing care requires careful examination. These two issues of workload and lack of placements both appear to be a classic effect of the interaction between demand and supply of services, where the quantity and quality of service provision interacts with the circumstances of the client to produce decision outcomes (Bywaters et al., 2015; Harwin, Alrouh, Bedson, & Broadhurst, 2018; McLaughlin & Jonson-Reid, 2017). McGlaughlin and Johnson-Reid (2017) for example, found that decreasing funding to child protection services led to an increase in cases 'screened out' and a reduction in substantiations. Having less staff capacity can result in less intervention in general. In this study, the three sites ranged from some limited short-term care availability to none at all and this meant that the bar for entry to care was high if were no whānau caregivers available. Clearly this may affect children's chances of intervention unrelated to their level of need. Differences in site processes that affect both information quality and the mediating effects of supervisory input can also affect consistency. Ensuring that supervisors have supportive relationships that assist new practitioners at key points such as with new cases is valuable to ensure consistency. Ensuring that supervisors are motivated by outcomes for families and not the need to meet KPIs means they are more likely to promote key ethical and theoretical concepts (such as complex case explanations and being non-judgemental and participatory), and gain the respect of those in their teams. As Hodgson et al note: "Systems that valorise technical-rational and highly structured approaches to practice signal to workers what is valuable. Consequently, compliance and rule-following becomes the norm that is rewarded …Instead, what should be built into organisational cultures are conditions that foster better thinking.…Organisational leaders can promote a values-based climate towards ethics, which includes example setting, feedback and communication, and recognition and reward of other-regarding behaviour" (Hodgson et al., 2019, p. 119).

Social worker differences in relationship orientation, response to class and ethnic differences and personal experience also shape variations in practice. Differences in commitment to participatory practice is common in child protection practitioners, where different motivations and orientations affect value positions and practice (Fluke et al., 2016). While practitioner attitudes towards family preservation are well known to interact with decisions, the effect of this on information quality and nature is less researched. This study points to the increase in information quality when practitioners pursue direct engagement, family participation and respect (Benbenishty, Osmo, & Gold, 2003; Benbenishty et al., 2016).

Differences in resources for whānau based on ethnicity may be a perverse unintended consequence of a whānau empowerment commitment in a resource poor environment. Likewise, the differing relational quality when working with middle class as opposed to families from low socioeconomic backgrounds may inadvertently contributes to class and ethnic disparities. If middle class parents cause less comfortable and more fraught interactions, these may be avoided by practitioners, especially if they are anxiety provoking. This might be a 'supply-side' factor contributing to the marked socio-economic differences in intervention rates (Keddell et al., 2019).

What was perceived as supporting good decision-making included consistency in the promotion of the overall aims of practice to front-line workers, the retention of case consults, critical reflection on one's own personal life experiences, having placement options for children, and accessing supervision support. Not leaping to decisions quickly was also a key to good decisions, echoing much decision-making research that points out that poor decisions and confirmation biases are most likely where decisions are made rapidly and with poor quality information (Kahneman, 2011). The crucial role of supervisor as a mediator of consistency as well as of the anxiety and stress of the role was emphasized. This is a key role that needs support in order to maximise these important functions, and is more crucial than the use of common assessment tools to ensure consistency. Ensuring that there is consistency between teams (who have different supervisors) and between sites is a key focus for future development.

Implications for practice

Not all the causes of variable outcomes are within the control of Oranga Tamariki (such as wider inequities), and each case requires to some extent, an individualized response. However, there are some broad principles to consider that this research highlights. Generally, important promoters of consistency between individuals are achieved when decision-making processes are based on decision-making theory that includes:

Depth of information gathering directly from key people,	Sparse information leads to variation as people 'fill in the blanks' unconsciously Information directly from conversation has more nuance and depth than written information
Time to critically reflect on it,	Lack of time leads to reactive short-cuts to thinking and over-reliance on biases (confirmation, anchor hypotheses, base rate fallacy etc) and simplistic heuristics (rules about how things should be done)
Utilize theories of causation and ethical principles,	Decisions should reflect an understanding of theoretical explanations of the problem causes, role understanding and ethical principles
Enable feedback on decision quality	It's by feedback relating to the outcomes (for children and families, not system feedback) that people learn how to make good decisions and build up 'deep heuristics' – nuanced explanations
Learning of deep heuristics based on direct case-based learning and supervision support – especially for 'newbies'	Using case-based learning across the whole organisation shows how to apply concepts and principles in practice. By utilising shared cases, these applied understandings are shared
Provide opportunities to unpack biases or assumptions through supervision and case consults.	Having time to reflect on our own experiences and logics helps reduce biases and poor logic

Implications for practice should be developed in consultation with front-line practitioners. However, some suggestions for discussion with practitioners based on these findings are as follows:

Organisational recommendations:

1. Ensure workloads are consistent between sites to enable support for the many elements of decision-making affected by workload pressures, in order to gain more consistency between sites.

2. Promote understanding of common decision-making concepts such as heuristics and biases, recognition-primed decision-making, and the effects of feedback, time and groupthink.

3. Produce practice guidance for the specific types of cases that have vague definitions: emotional/ psychological abuse , including exposure to domestic violence, assessing minimum parenting capacity in chronic cases, and parents with intellectual disabilities. Guidance on these case types should take a social model, rights-based and theoretically informed approach, emphasizing principles of early intervention outside of the statutory system. Guidance for OT social workers' direct practice should be based on shared conceptual understandings of theoretical causal mechanisms and ethical principles. Specifically, clear guidance in relation to when a statutory response might be needed is important, in order to ensure that there is 'clear blue water' between cases that do and do not meet a threshold for statutory intervention.

4. In addition to practice guidance, use problem-based learning employing the same case studies at the nation-wide level to ensure that practitioners across the organization learn to apply key conceptual and ethical concepts consistently. Case studies should cover the case types above.

5. Follow implementation principles of practice observation, critical reflection and a 'no-blame' environment to ensure organisation-wide shared understandings of these types of cases develops.

6. Provide direct education on how to make sense of cases where there are some exceptional factors that mean it does not align with a recognisable pattern or case type, especially for newly qualified social workers. These cases also need more critical supervision support and knowledge of heuristics, biases and recognition-priming.

7. Improve the consistency and quality of intake information by ensuring depth of information is supplied to the site office, based on direct interaction with key people. Recognise the limits of recorded history as the sole source of information, and don't make decisions based on limited information.

8. Examine site differences in collaborative practices around initial assessments between supervisors and social workers when assessing new cases, and when 'forming a belief'. More robust collaborative processes at these two points may help ensure consistency at key points, especially for new social workers.

9. Ensure supervisors and practice leaders have a national forum at which they can compare case examples to ensure 'between team' consistency and develop collegial support mechanisms.

10. Engage in a national recruitment campaign for foster caregivers both stranger and kinship and consider payment for those caregivers taking children with particularly challenging problems.

Site level recommendations:

11. Explore differences in the expectations placed on families to meet their own needs based on ethnicity, ensuring that families are enabled to access resources equitably. Ensure that practitioners are engaged in critically reflective conversations and have the support to engage equitably with parents from different class positions.

12. Continue to encourage practitioners to engage in critical reflection with supervisors of the impact of their own personal life experiences, particularly their experiences of being parented, or of being parents.

13. Continue the use of the 'case consult' tool and ensure practitioners gain education in its use so as it is implemented rigorously, in line with its family inclusion ideals.

14. Engage practitioners in ongoing education around working with families in ways that prioritise direct engagement, respect and collaboration, recognizing that these values and practices contribute to all whānau getting a consistent, ethically informed response as well as information quality.

Individual Interview schedule

Consent form signed

1. Explain to me the decision pathway of cases as they progress through your organization (if not covered in focus group)
   - How do they come in?
   - Who makes the initial decision?
   - Can you draw a rough picture of the pathway of decisions through your agency?
   - Who makes the final decisions?

2. Can you describe to me a common case where the decision is simple.

3. Can you describe to me an unusual or exceptional case where the decision was difficult.

4. Explain implicit and explicit, perverse feedback etc. What feedback is available to decision-makers after they make a decision – from the ICT system, from supervisors, from the family and child?

5. When a case is 'on the cusp' between going to an FGC or not, what factors, to you, would mean it should or shouldn't go? Give examples. IF NGO service, what would mean a case was/wasn't referred to CYF?

6. What are the significant aspects of a case that would mean children would definitely be removed? Give examples.

7. When compared to other offices, how does your threshold for different decision points compare? Why do you think this is?

8. Are there any unwritten rules around decisions at your site? If so, what are they?

9. Do you think any of these things have an impact on decisions? In what way?
   - social workers' relationships with client families
   - fear of difficult clients/client cooperation
   - placement availability
   - contradictory discourses, concepts, policies, principles
   - fear of getting it wrong
   - social worker's emotional health and wellbeing
   - social workers' values, culture and beliefs
   - time/caseload

10. Regarding consistency, what factors do you think contribute most to any differences between practitioners, teams or sites?

11. In your experience, what factors or principles support good decision making?

12. What decisions are most difficult in your work? (competing considerations)

Interview participant demographics:

Gender												
Ethnic group (s)												
Length of experience												
Agency type: NGO or CYF												
Site												
Position (senior, manager etc)												
Team (ABC etc)												

Team focus groups

Present with vignette as a conversation starter.

Then ask:

1.   What do you think are the most important issues facing this family?
2.   Do you think this situation is harmful to the children in this family? Why?
3.   What else would you need to know?
4.   What would you do? (Reasons?)
5.   In cases like this…what are the key things that 'tip it' for you?
6.   Do you think different teams might view this case differently?
7.   What supports good decision making?
8.   What decisions do you find most difficult?

Focus group 1 Demographics:

Gender												
Ethnic group (s)												
Length of experience												
Agency type: NGO or CYF												
Site												
Position (senior, manager etc)												
Team (ABC etc)												

Focus group 2 Demographics:

Gender												
Ethnic group (s)												
Length of experience												
Agency type: NGO or CYF												
Site												
Position (senior, manager etc)												
Team (ABC etc)												

BIBLIOGRAPHY

Aunos, M., et al. (2008). Mothering with intellectual disabilities: Relationship between social support, health and well-being, parenting and child behaviour outcomes, *Journal of Applied Research in Intellectual Disabilities* **21**(4), 320-330.

Baumann, D., Fluke, J., Dalgleish, L., & Kern, H. (2013). The decision-making ecology. In A. Shlonsky & R. Benbenishty (Eds.), *From evidence to outcomes in child welfare: An international reader* (pp. 24 - 38). NewYork: Oxford.

Baumann, D. J., Dalgleish, L., Fluke, J., & Kern, H. (2011). *The decision-making ecology*. Washington, DC: American Humane Association.

Benbenishty, R., Davidson-Arad, B., López, M., Devaney, J., Spratt, T., Koopmans, C., . . . Hayes, D. (2016). Decision making in child protection: An international comparative study on maltreatment substantiation, risk assessment and interventions recommendations, and the role of professionals' child welfare attitudes. *Child Abuse & Neglect, 49*, 63 - 75. doi: http://dx.doi.org/10.1016/j.chiabu.2015.03.015

Benbenishty, R., Osmo, R., & Gold, N. (2003). Rationales provided for risk assessments and for recommended interventions in child protection: A comparison between canadian and israeli professionals. *British Journal of Social Work, 33*, 137 - 155.

Boyd, R. (2014). African american disproportionality and disparity in child welfare: Toward a comprehensive conceptual framework. *Children and Youth Services Review, 37*(0), 15-27. doi: http://dx.doi.org/10.1016/j.childyouth.2013.11.013

Bradt, L., Roets, G., Roose, R., Rosseel, Y., & Bouverne-De Bie, M. (2014). Poverty and decision making in child welfare and protection: Deepening the bias–need debate. *British Journal of Social Work*. doi: 10.1093/bjsw/bcu086

Bywaters, P. (2015). Inequalities in child welfare: Towards a new policy, research and action agenda. *British Journal of Social Work, 45*(1), 6-23 doi: 10.1093/bjsw/bct079

Bywaters, P., Brady, G., Sparks, T., & Bos, E. (2016). Child welfare inequalities: New evidence, further questions. *Child & Family Social Work, 21*(3), 369 - 380. doi: 10.1111/cfs.12154

Bywaters, P., Brady, G., Sparks, T., Bos, E., Bunting, L., Daniel, B., . . . Scourfield, J. (2015). Exploring inequities in child welfare and child protection services: Explaining the 'inverse intervention law'. *Children and Youth Services Review, 57*, 98-105. doi: http://dx.doi.org/10.1016/j.childyouth.2015.07.017

Choate, P. W. and S. Engstrom (2014). The "Good Enough" Parent: Implications for Child Protection. *Child Care in Practice* **20**(4), 368-382.

De Bortoli, L., & Dolan, M. (2014). Decision making in social work with families and children: Developing decision-aids compatible with cognition. *British Journal of Social Work, 45*(7), 2142 - 2160. doi: 10.1093/bjsw/bcu087

Dettlaff, A. J., Christopher Graham, J., Holzman, J., Baumann, D. J., & Fluke, J. D. (2015). Development of an instrument to understand the child protective services decision-making process, with a focus on placement decisions. *Child Abuse & Neglect, 49*, 24 - 34. doi: http://dx.doi.org/10.1016/j.chiabu.2015.04.007

Doherty, P. (2016). Child protection threshold talk and ambivalent case formulations in 'borderline' care proceedings cases. *Qualitative Social Work*, 1 - 19 doi: DOI: 10.1177/1473325016640062

Expert Panel. (2015). Modernising child youth and family expert panel final report. Wellington: Ministry of Social Development.

Fargion, S. (2014). Synergies and tensions in child protection and parent support: Policy lines and practitioners' cultures. *Child and Family Social Work, 19*(1), 24 - 33.

Featherstone, B., Gupta, A., Morris, K., & White, S. (2018). *Protecting children: A social model.* Bristol: Policy Press.

Featherstone, B., White, S., & Morris, K. (2014). *Re-imagining child protection: Towards humane social work with families* (Vol. null).

Fluke, J. D., Corwin, T. W., Hollinshead, D. M., & Maher, E. J. (2016). Family preservation or child safety? Associations between child welfare workers' experience, position, and perspectives. *Children and Youth Services Review, 69*, 210-218. doi: http://dx.doi.org/10.1016/j.childyouth.2016.08.012

Gilbert, N., Parton, N., & Skivenes, M. (2011). *Child protection systems: International trends and orientations.* Oxford: Oxford University Press.

Graham, J. C., Dettlaff, A. J., Baumann, D. J., & Fluke, J. (2015). The decision making ecology of placing a child into foster care: A structural equation model. *Child Abuse & Neglect, 49*, 12 - 23.

Gupta, A. (2015). Poverty and child neglect: the elephant in the room? *Families, Relationships and Society.*

Harwin, J., Alrouh, B., Bedson, S., & Broadhurst, K. (2018). Care demand and regional variability in england: 2010/11 to 2016/17. Lancaster: Centre for Child and Family Justice Research, Lancaster University.

Hester, M. (2011). The three planet model: Towards an understanding of contradictions in approaches to women and children's safety in contexts of domestic violence. *British Journal of Social Work, 41*(5), 837-853. doi: 10.1093/bjsw/bcr095

Hodgson, D., Watts, L. & Chung, D. (2019) Understanding and improving discretionary judgment and decision-making in child protection practice: Towards a whole-of-system policy evaluation, *Social Work and Social Sciences Review*, (20) 1, 109 – 127.

Kahneman, D. (2011). *Thinking: Fast and slow.* US: Farrar, Strauss and Giroux.

Janis, I. L. (1982). *Groupthink: Psychological Studies of Policy Decisions and Fiascoes.* Boston: Houghton Mifflin.

Keddell, E. (2014a). Current debates on variability in child welfare decision-making: A selected literature review. *Social Sciences, 3*(4), 916 - 940. doi: doi:10.3390/socsci3040916

Keddell, E. (2014b). Theorising the signs of safety approach to child protection social work: Positioning, codes and power. *Children and Youth Services Review, 47* (1), 70 - 77. doi: http://dx.doi.org/10.1016/j.childyouth.2014.03.011

Keddell, E. (2014c). Weighing it up: Family maintenance and children's best interests discourses in child protection decision-making. *Child & Family Social Work, 21*(4), 512 - 520. doi: doi:10.1111/cfs.12168

Keddell, E. (2015). *Researching the role of ethnicity in child protection decision-making.* Paper presented at the 14th Australasian Conference on Child Abuse and Neglect, Auckland.

Keddell, E. (2016). Is decision consistency in child welfare achievable without reversion to technical –rational approaches? *Visiting Academic, Child Welfare Inequalities Project, Coventry University, July 14th.*

Keddell, E. (2017). Comparing risk-averse and risk-friendly practitioners in child welfare decision-making: A mixed methods study. *Journal of Social Work Practice, 31*(4), 411-429. doi: 10.1080/02650533.2017.1394822

Keddell, E. (2017). Interpreting children's best interests: Needs, attachment and decision-making. *Journal of Social Work, 17*(3), 324 - 342. doi: 10.1177/1468017316644694

Keddell, E. and G. Davie (2018). Inequalities and child protection system contact in Aotearoa New Zealand: Developing a conceptual framework and research agenda, *Social Sciences, 7*, 89 - 100.

Keddell, E., Davie, G., & Barson, D. (2019). Child protection inequalities in aotearoa new zealand: Social gradient and the 'inverse intervention law'. *Children and Youth Services Review*. doi: https://doi.org/10.1016/j.childyouth.2019.06.018

Keddell, E., & Hyslop, I. (2016a). First findings from phase one of the child welfare decision-making variability project: Research briefing paper. Dunedin: University of Otago.

Keddell, E., & Hyslop, I. (2016b). *Improving decision-making consistency in child welfare contexts: Accounting for ethical, institutional and knowledge dimensions*. Paper presented at the Joint World Conference on Social Work, Education and Social Development, Seoul, Korea, June 30th. .

Keddell, E., & Hyslop, I. (2018). Role type, risk perceptions and judgements in child welfare: A mixed methods vignette study. *Children and Youth Services Review, 87*, 130-139. doi: https://doi.org/10.1016/j.childyouth.2018.02.017

Keddell, E., & Hyslop, I. (2019). Ethnic inequalities in child welfare: The role of practitioner risk perceptions. *Child & Family Social Work, 0*(0), 1-12. doi: doi:10.1111/cfs.12620

Klein, G., & Hoffman, R. R. (2008). Macrocognition, mental models and cognitive task analysis. In J. M. Schraagen, L. Millitello, T. Ormerod & R. Lipschitz (Eds.), *Naturalistic decision making and macrocognition* (pp. 57 - 80). Hampshire: Ashgate.

Krumer-Nevo, M. (2016). Poverty-aware Social Work: A paradigm for social work practice with people in poverty, *The British Journal of Social Work* **46**(1), 1793–1808.

Maiter, S., Palmer, S., & Manji, S. (2006). Strengthening worker-client relationships in child protective services. *Qualitative Social Work, 5*(2), 167 - 186. doi: 10.1177/747222500606-4255

McConnell, D., Llewellyn, G., & Ferronato, L. (2006). Context-contingent decision-making in child protection practice. *International Journal of Social Welfare, 15*(3), 230-239. doi: 10.1111/j.1468-2397.2006.00409.x

McLaughlin, M., & Jonson-Reid, M. (2017). The relationship between child welfare financing, screening, and substantiation. *Children and Youth Services Review, 82*, 407-412. doi: https://doi.org/10.1016/j.childyouth.2017.10.013

Minstry of Social Development. (2018). Key statistics and information for media Retrieved August 14, 2017, from http://www.cyf.govt.nz/about-us/key-statistics/

Molander, A., Grimen, H. and Eriksen, E. O. (2012) Professional discretion and accountability in the welfare state. Journal of Applied Philosophy, 29, 3, 214-230. doi: 10.1111/j.1468-5930.2012.00564.x

Munro, E. (2007). What is child abuse and neglect? *Child protection* (pp. 61 - 121). London: Sage.

Office of the Chief Social Worker. (2014). Workload and casework review: Qualitative review of soial worker caseload, casework and workload management. Wellington, New Zealand: Child, Youth and Family.

Platt, D., & Turney, D. (2014). Making threshold decisions in child protection: A conceptual analysis. *British Journal of Social Work, 44*(6), 1472-1490. doi: 10.1093/bjsw/bct007

Regehr, C., Bogo, M., Shlonsky, A., & LeBlanc, V. (2010). Confidence and professional judgment in assessing children's risk of abuse. *Research on Social Work Practice, 20*(6), 621-628. doi: 10.1177/1049731510368050

Saar-Heiman, Y. and A. Gupta (2019). The poverty-aware paradigm for child protection: A critical framework for policy and practice. *The British Journal of Social Work.* https://doi.org/10.1093/bjsw/bcz093.

Saltiel, D. (2016). Observing front line decision making in child protection. *British Journal of Social Work, Online first, Dec 15*(46), 7. doi: 10.1093/bjsw/bcv112

Scott, D., Lonne, B., & Higgins, D. (2016). Public health models for preventing child maltreatment: Applications from the field of injury prevention. *Trauma, Violence, & Abuse, 17*(4), 408-419. doi: 10.1177/1524838016658877

Trowler, I. Webb, C., White, S., & Leigh, J., (2018) CARE PROCEEDINGS IN ENGLAND: THE CASE FOR CLEAR BLUE WATER, University of Sheffield. Retrieved from: https://www.sheffield.ac.uk/polopoly_fs/1.812158!/file/Sheffield_Solutions_Clear_Blue_Water_Full_Report.pdf

Turnell, A., & Edwards, S. (1999). *Signs of safety: A solution and safety oriented approach to child protection casework*. London: W.W. Norton and Company.

White, A. (2005). Assessment of parenting capacity. Australia: Centre for Parenting and Research, NSW Department of Community Services. .

White, S., Broadhurst, K., Wastell, D., Peckover, S., Hall, C., & Pithouse, A. (2009). Whither practice-near research in the modernization programme? Policy blunders in children's services. *Journal of Social Work Practice, 23*(4), 401-411. doi: 10.1080/02650530903374945