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Beyond Professional Emergencies: Patterns of Mistakes in Social Work and Their Implications for Remediation

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This paper analyzes the emerging field of government mandated child protection, the work's design, and the public crisis caused by public airing of its mistakes. The cycle of reacting to public revulsion at errors, followed by a return to "business as usual" persists despite official, government inquiries and the social work profession identified with the protection of children. The risk of working in a highly emotional area is discussed through the sociology of "mistakes at work," or professional emergencies. This work balances risks with advantages of evoking emotions. The risk comes from the negative emotions associated with official failures seen by the public as tragic mistakes or worse. In the past four decades social work has become vulnerable to public outcries when a child is killed when supposedly protected. The management of that risk is relatively new to the profession and it has not responded effectively. The sources of child fatalities within the child welfare system are at least partly due to the design of the system, its daily work routines and the central role of the profession in the emerging field of child protection. These routines are described with an analysis of how they contribute to failures. Recommendations for system change are suggested.

Key words: Child protection; child welfare; emotion; mistakes at work; professional emergencies; professionals; social services; social work

"[I]n occupations of high competence such as the professions, we can hypothesize that mistakes and situations of potential error bear a close relationship to the beliefs and organization of work," Donald W. Light, Jr. (1972, p. 821)

The History of a Problem

Light studied the disconfirmation of a professional's core competence through a single error, which he called a "professional emergency" (1972) after Hughes (1951). The disconfirmation that follows a string of such errors becomes a crisis for the profession. This paper addresses the crisis in social work from failures in child protection. I use the sociology of mistakes at work by examining the "beliefs and organization of work" that I find contribute to and even cause these consistent errors (Bosk, 2003; Bosk, Dixon-Woods, Goeschel, & Pronovost, 2009). These causes are hidden from view in work routines that persist, despite changes in policy and procedures.

Child protection is not new, although protective action defined as work by employed professionals certainly is. This paper focuses on the problem that social workers have encountered since they took on the public mandate of protecting children in the late 20th century. This transfer of responsibility for protecting children from the parents and community to a public entity was crystallized by the identification of the battered child syndrome in 1962 (Daro, 2009; Kempe, Silverman, Steele, Droegenmueller, & Silver, 1962). This "discovery of child abuse" led to state laws permitting parents to be reported to government authorities for maltreatment in the 1960s (Nelson, 1984; Pfohl, 1977). By 1974 the federal government was involved in the U.S. by the Child Abuse Prevention and Treatment Act of 1974, and in Britain through the reaction to the tragic death of a child, Maria Caldwell, also in this time frame (Corby, 2003).

Since the provision of federal money in the U.S. for amelioration of child abuse and neglect (CAN), offices of child protection have come to serve the intake function for child welfare systems, making it difficult to obtain funds for family services without a finding of CAN (Cameron, 1988). Besharov and Brown argue that the claims to protect children were just a way to gain political support for family services in the U.S., "No one's interested in child welfare. That's why CPS [Child Protective Services] has become the smokescreen for building the child welfare system" (1987, p. 21).

The same process appears to have occurred in Britain, where Munro and Calder find, "the focus on investigating

child abuse allegations had become so dominant ... making it hard for families with needs that were unrelated to abuse to get help" (2005, p. 439).

There are consequences, both organizational and professional, when social workers serving families become defined as protectors of the family's children. In the emergence of modern child protection, social workers have become culpable for any harm to the child in a family receiving their services. As stated by Munro:

Prior to the 1970s, this uncertainty about which children were in danger and in need of state protection was accepted as a problematic feature of child care work and there was no public outcry holding professionals to account when parents killed a child. (2011a, p. 20)

Today the outcry is unmistakable. Rather than single errors, children are left in harmful hands and are repeatedly battered, and the cumulative effect is great.

The *Sun's* petition demanding justice for Baby P rocketed past a MILLION signatures... A record 1,146,000 share our outrage and back our crusade for those who failed the tortured tot to be fired... The *Sun* today delivers its million-plus petition for Baby P's social workers to be sacked: The PEOPLE have spoken. (Barlow, 2008, P25)

Newspapers also have migrated from outcries about a child's death to gathering statistics on multiple social work errors, as shown in this headline: "Failed by the system: 25 abused children die under the noses of social workers" (Harris, 2011). The result is a crisis for the profession itself, according to this source: "Child protection work facing recruitment crisis... Many social workers quit their jobs following vilification in [the] media and attracting new entrants has become harder" (Butler, 2011).

This paper examines the problematic nature of social work after this long term, secular change in how the work has been organized under media and public scrutiny. The "public outcry" holding social workers to account has become a defining problem for the profession. "Media scrutiny" is a major feature of this problem over the past 40 years (Ayre, 2001) and

itself has been subject to scholarly examination for its effect on an agency (Cooper, 2005), on agencies in general (Chenot, 2011), on legislation (Douglas, 2009, 2012; Stanley, 2004), and on the relationships among politicians, media and the profession (Chenot, 2011; Corby, 2003; Parton, 2004). Some have concluded that social workers face an impossible task in protecting children (Littlechild, 2008), or that, at the least, "mistakes" are inherent in this new work. According to Munro (1996, p. 793), "In child protection work, it is every social worker's nightmare to make a mistake that contributes to the death of a child. But some mistakes are inevitable because of the complexity of the work and our level of knowledge."

Mistakenly taking a child away from its family is condemned, while leaving a child in the home to be maltreated is also condemned, so that the social worker is "damned if you do, and damned if you don't" (Munro, 2011a, p. 20), or caught "between a rock and a hard place" (Littlechild, 2008, p. 663). As stated by Munro and Calder:

Mistakes are either 'false positives' or 'false negatives.' ...Neither type of error is wholly acceptable but neither type is wholly avoidable. Moreover, if we try to reduce one type of error, given the same level of professional skill, we shall increase the other type. (2005, p. 441)

The Professional Definition of the Problem

From this perspective, the profession is subject to swings from overreacting to CAN by unnecessarily removing children, back to preserving families while risking tragic death, in a "vicious cycle" (Chenot, 2011). After the death of a child, front-line workers respond by removing large numbers of children, called "foster care panic," only to revert to "business as usual" when the furor dies down (Chenot, 2011, p. 169). Professionals respond with "fear and anxiety" for "not assessing, and eliminating, risk, as the government and their employing agencies expect them to do" (Littlechild, 2008, p. 663). Managers respond to media attacks with constraints on workers which interfere with the work, in a "vicious circle" (Cooper, 2005). The implications are enormous, if this negative perspective is accurate. For, regardless of a professional's best efforts, there

are “unavoidable mistakes in child protection work” (Munro, 1996), and “mistakes” can be fatal.

In this view, increasing protection for children at risk cannot be accomplished without pulling families apart in an overreaction or state of panic. Outside political forces are reactive and counterproductive, pushing the profession towards punitive actions towards families (Chenot, 2011; Littlechild, 2008). Worst of all, there is no solution possible when this perspective is adopted, other than a never ending demand for more social workers, more resources for families, more training, more skills and more supervision (Child Welfare League of America, 2005; Daro, 2009; Day, 2011; Lord Laming, 2009; Munro & Calder, 2005; Parton, 2004). Among their other demands, the National Coalition to End Child Abuse Deaths (NCECAD) places a dollar value on the resources needed—three to five billion dollars a year to reduce case loads of child protection workers (NCECAD, 2013).

The Social History of the Social Work Profession’s Identity

The social work profession is self-defined as a “normative profession,” driven by values such as equality and social justice and by claims to be a “helping profession.” While laudable, this stance also has the consequence of creating professional vulnerability to wishful thinking and dependence on face validity for much of its research. Social work textbooks tell stories that serve the mythology of the rise of a helping profession in the protection of abused children, such as the oft-told Mary Ellen case (Watkins, 1990). The conclusion that families must be served instead of protecting children by their removal is not an either-or decision in the value system of the profession, but rather the culmination of a fabled rise of the social worker as a paid professional from nineteenth century reformers and “child savers.” In that rise from the volunteers in protective societies and the laws that permitted child removal on various grounds, the narrative was that family preservation was a hard-earned truth learned from an overreaction of taking thousands of children from their homes (O’Connor, 2001). In checking this narrative, Ross studied the records of the New York Society for the Prevention of Cruelty to Children (NYSPCC),

which was founded as the original protective society out of the Mary Ellen Case (1980). Although the NYSPCC was specifically founded for the sole purpose of preventing cruelty to children (Costin, Karger, & Stoesz, 1996, p. 66), Ross found that of the 932 reported cases of children which were investigated or removed from 1875 to 1884, there were 137 children alleged to have been abused, or less than fifteen percent (1980, p. 74).

Similarly, when Gordon examined the case files of the NYSPCC's rival which advocated family preservation, she found little actual work done to achieve that lofty goal (1988, p. 72). As discussed here, it is necessary to draw conclusions from the process of how the work is actually done, not from laws, policies, procedures and claims about what was supposed to have been done. There is too great a discrepancy between work in the abstract and routine work. This is the sociology of work, or in the case of professional emergencies, mistakes at work.

The social work profession grew from claims to "scientific charity." Historical trends and shifting societal values have alternated between child saving and family preservation. Here I inquire whether this paradigm is adequate and how it squares with the actual front-line work of child protection.

The Sociology of Mistakes at Work

An alternative view of work mistakes is found in the sociology of work (Bosk, 2003; Hughes, 1951; Light, 1972). Here the focus is not on the analysis of mistakes, but careful observation of the work itself, how it is done, how decisions are made, and how work routines are followed. Hughes distinguishes between mistakes that come from the routine carrying out of the work and mistakes from a new, unexpected form of work for which the routines are unprepared. The event of an error creates an emergency. Workplace errors have been found, on observation, to be endemic—a constant, everyday occurrence—so that the occupation responds, not to reduce or eliminate errors, but to accept them as part of the day-to-day routine (Riemer, 1976). When they are brought to the attention of outsiders, the workers cover them up, deny their existence and maintain the public posture that such errors are rare and if they become obvious, will be dealt with internally through "self-policing" (Bosk, 2003; Riemer 1976). Hughes found

medical errors were “buried” in a complex division of labor that made it difficult to establish just where the mistakes had been made. One result of this approach is a “structured silence” among physicians in the face of an emergency (Freidson, 1975).

In short, errors at work are a normal feature of work, defined by the social construction of the work process. Errors in protecting children require a close examination of the nature of the everyday work of child protection, not rationalizations that workers are “damned if they do, and damned if they don’t.”

This paper seeks to break Chenot’s vicious cycle. The sheer quantity of raw data about individual cases of child deaths and the decisions leading up to each one is striking. As a former insider of the child protection system, I also have knowledge of many such cases that remain confidential. As a Child Protection Investigator (CPI), I had years of experience in making the decisions involved in protecting children. Inside knowledge is necessary to understand mistakes at work that come from “the beliefs and organization of the work” (Light, 1972). I concur with Littlechild; outsiders to the actual work of child protection are poorly placed to understand it, and up to now, they have not been adequately informed:

A vital element...is knowledge and consideration of how social workers perceive their world of work and their professional agency within it. Yet this has not been a feature of any statements or assessment of risk in relation to child protection work in any of the government publications. (Littlechild, 2008, p. 671)

An Overview of Child Protection Frontline Work

No account of the construction of the social problem of child abuse would be complete without comparing the 300 or so cases of child battering found by the physician founders of the CAN movement to almost three million cases reported to authorities each year and investigated by the CPS (Bartholet, 1999; Children’s Bureau, 2012; Waldfogel, 1988). Waldfogel had access to almost 200 confidential case files, so she was able to gain insight into CPI daily work. She noted that attempts to group and classify those cases were fruitless, for they

represented too many sources of variation to be divided into neat categories. The same characteristics of the work are obvious to front-line workers (Johnson, 2013; Parent, 1996). In contrast, the physicians were able to classify child battering into medical categories of bone fractures, burns, internal injuries, poisoning, wounds and the like. Their classification system became the basis for CPI investigations over the following decades and is still used today (Illinois Department of Children and Family Services [IDCFS], 2012). But, as Waldfogel found, the nature of the cases being investigated had dramatically diversified from the physical harms of child battering. So, part of the problem is that the legal basis and allegation system for investigating CAN has not been changed since the first findings of the battered child syndrome in 1962, despite the fact that the medical model has transitioned from the scene, having been replaced by a psychological model of child abuse (Costin et al., 1996). Policy-oriented scholars watch the shifting laws, policies, and objectives of the system without realizing that the frontline work does not always change along with the policies and laws. This results in official and scholarly inquiries failing to provide a realistic assessment of the problems.

An analysis of the data reported by one state (Illinois) gives insight into the general nature of this work. The large majority of child harms reported consist of neglect, not abuse. Physical abuse is only 30 percent of the total (data recalculated in the Tables in IDCFS, 2012). Of that subtotal, most abuse allegations (63 percent) are no longer cases of harm to a child, but "risk of harm." Investigating risk is not looking for what happened to the child, but rather at "risk factors" of what might happen in the future. The CPI looks away from the child to focus on the adults in order to find family dysfunction that could be resolved by social services. This redirection of the investigative work turns child protection on its head, shifting focus away from the detective work of finding the cause of injury to the child to the social work of diagnosing the needs of adults. Investigations of neglect do much the same thing, documenting the child's circumstances and family functioning, not the child's physical state. As for child neglect, the most frequent allegation is "lack of supervision," as the child being left alone or with a caretaker who is not considered responsible. Like "risk of harm," "lack of supervision" does not focus on harm,

but rather on some potential harm that could happen in the future.

The entirety of the medical conditions classified by the discoverers of the battered child syndrome constitute less than five percent of the Illinois physical abuse cases and little more than one percent of the total. The result is that the chances of a CPI investigating an actual battered child case would be about one in a hundred investigations, and for many CPIs, years may pass before confronting such a serious allegation. Child fatalities from physical abuse are exceedingly rare, and are found in only 60 investigations out of 127,414 reports (IDCFS, 2012, Table 11). In short, for almost all of the work conducted by CPIs, routine "normal" family cases are processed, and the variety of the "incoming" cases is enough to strain any investigator. As in the jobs of medical screeners or work in airport security, there is a "low prevalence effect," which is a persistent source of errors when rare cases (such as a gun in the luggage processed by an airport screener) are missed (Wolfe et al., 2007). As Besharov and Brown noted in 1987, "only a small proportion of reported cases involve serious danger to children" (p. 19). All these cases require attention, and when a case of battering is mixed in with the routine family cases, it is likely to be overlooked and/or its seriousness to be misidentified. As a result of this, Besharov and Brown note that:

[We must] have special rules for children who have been seriously injured. We can have rules that say that no child will be returned to any parent who has seriously injured a child until we are very sure that parents can adequately or safely care for the child. (Besharov & Brown, 1987, p. 19)

Besharov and Brown recognize the difference between normal work routines and work that has no normal routine with which to respond, as noted by Hughes. But "special rules" are not the only solution; we need "special everything," from the orientation of the front-line workers to all their routines, including forms, procedures and laws that guide their work. Waldfoegel, one of the few who examined raw case files in her study of CPS, recognized this also:

The statistics show that the system does not always intervene aggressively enough in very high risk cases. The Boston sample [of almost 200 cases] includes several cases of serious abuse or neglect involving families previously known to DSS. ... Clearly, the existing system is unable reliably to prevent repeated abuse or neglect even when cases have been referred to it. (1998, p. 27)

Administrative Causes of Child Protection Errors

In 1999 the Illinois DCFS administration took the Priority One cases (all of the serious medical allegations of battering) away from the front-line CPIs. They were then assigned to a single team. While this action created a division of labor within child protection, it removed almost all front-line workers from the experience of dealing with severe child abuse allegations. This action was based on the belief that serious risk is diagnosed at the front end of the reporting process through the medical categories of battering. The CPS was assumed to have no need to investigate serious child risk when none was referenced in initial reporting. The consequences of this decision magnify the problem of the non-routine risk, or low prevalence effect. This type of managerial thinking fails to take into consideration the nature of the work and hidden threats to children with minor presenting problems, since it fails to include the knowledge of frontline workers.

What is even more troubling is that the investigation of child abuse can be legally constrained to the study of the actual allegation, so that uncovering a worse problem in the course of an investigation does not automatically trigger more thorough work. What the investigation may potentially find is already discounted in this system, due to the assumption that the information available to the original reporter is sufficient to guide an investigation. That is, the administration assumes that the initial sorting of cases for intake is being done by the public reporters of child maltreatment, and the investigative work is merely taking place to confirm the initial suspicions of the public. Thus, when a mother admits she left her child alone, all the information required to assess the allegation of neglect has been officially obtained and the investigation is required to be closed. No work to assess further risk to the child

can officially be done, which is dangerous.

The point here is that the workers dealing with children's harms are not oriented to recognize the dangers the child might be experiencing, thanks to the work itself and how it is organized. Almost all cases workers experience are at a low level of risk, and the same thinking that works well in such cases will have catastrophic consequences when applied to a rarely encountered case of serious child harm and danger. This is especially so for harms not recognized by the reporter or classified as minor when the report is received and an investigation authorized.

Although the politics of child protection work is to claim that children are being protected from serious harms, internally those harms are experienced on the front lines as minimal, as well as discounted in every way in daily work routines. In fact, most cases may involve no harm at all, only a suspicion of risk. As predicted by the literature on mistakes at work, overlooking severe risk and even harm to children is a product of how the work and workers performing it is organized and structured.

The Child Protection Intake for Social Services

In most cases reported for CAN, there is little "credible evidence" that the child is at risk; seventy-eight percent of reports nationally are unsubstantiated (Children's Bureau, 2012, Exhibit S-1). But administratively, child protection work justifies provision of family services, for after an allegation against a family has been substantiated regarding child maltreatment, the family becomes eligible for social services (Besharov & Brown, 1987). Studies have found "that staff deliberately inflated initial scores of cases in order to increase the eligibility of families for services" (Gillingham & Humphreys, 2010, p. 2599). This is the tip of the child protection/family services iceberg. Unrecognized in the statistics of child maltreatment are the cases where an official finding of CAN is applied merely to provide services. These are administrative findings of CAN, where no harm or even risk has been found on investigation. While Besharov (1987) and Besharov and Brown (1987) concluded that minor cases drove families into child welfare services, they didn't realize that many were fictitious.

I personally created such figments while a CPI. In one, a mother herself called the child abuse hotline to report that she was overwhelmed and afraid she would unintentionally hurt her children. The call was duly assigned as "risk of harm." I found the woman needed help, but was no danger to her children. But, in order to obtain help for her, I signed the papers certifying that her children were at risk of child abuse.

More common were cases of homeless mothers with children. They would live in a homeless shelter until their 90 days ran out, then they would be forced to leave. The shelter staff would make a report of neglect, and I would duly fill out forms stating that the children were suffering from inadequate shelter, in advance of the experience of inadequate shelter. The case substantiation would lead to a payment for the security deposit for an apartment, the rent to be paid thereafter from public aid.

Borderline administrative reports have also been common, especially from the schools, the most frequent source of reports (IDCFS, 2012). Teachers are alert to problems with their pupils, such as a child sleeping in class or showing inadequate hygiene. Once the teacher is alerted, any bruise or scratch will become the trigger for a CAN report. I soon learned to distinguish between the presenting problem and the real reason for a report. Medical authorities would do the same, often merely to have the child's home situation checked to help in the diagnosis.

The lack of a direct relation between the statistics and child harm is a secret deeply hidden within state welfare systems. There is little motivation for anyone affiliated with such systems to acknowledge that tangible harms are not always the reason money is being spent, so the secret remains secure. This manner of managing social services through a system of CAN allegations and family investigations is fundamentally flawed. The front-line workers are systematically oriented to experience their work as providing services to families, not providing protection to children at risk. One consequence of this faulty system design is that it has submerged the mandate of child protection within the child welfare system.

This is a generally unaddressed change in how child protection front-line work has been done over the last four decades. It has become harder for the social work profession to claim it

works though client voluntary acceptance of social services. The CWS' services now rest on the CPS threat of removing the child.

One question posed by child protection failures is how well the profession has adapted to this public recognition of its authority and control over clients, in contrast to the professional ideology of providing voluntary, beneficial services. While gaining greater control over clients, the profession has accepted a costly risk that horrifying failures to protect children will be laid at the profession's doorstep. Yet, the risk has been accepted in every state in the USA and in other countries as well. For despite its dissimilarity to the public image of the profession, taking on such power and control over clients has helped increase the size and resources available to the profession. One way this seizing of power is done is through the official investigations of social work failures. The answer to a tragic case of child injury or fatality from the profession is more social work: more training for the front-line workers (in social work); more degrees (in social work); and even accreditation of the policies and procedures of the CPS and CWS (by the social work profession). In Illinois, the child protective system was accredited by the National Association of Social Workers after a years-long infusion of social work principles, including sending all supervisors, at state expense, to obtain their MSW degrees at local colleges and universities. Social work professors and consultants conducted weeks-long training for all front-line employees. I myself was "retrained" at the master's level at state expense.

The claim that social work is a beneficial, "helping profession" is increasingly discredited the more the profession is held responsible when there is a catastrophic failure. These failures and the emotional charge associated with them are something new to a helping profession. The professional image of voluntary assistance and advice must be accommodated to reflect new, legal liability as the *de jure* parent. While outside forces create pressures to unite families more quickly or disassemble them more rapidly, the profession does not fundamentally change. While core values must be preserved, it is not clear that they are being protected by rigidity. The profession's resistance to change contributes to the findings that new laws and social policy changes have little effect on the work or its

outcomes. This failure to adapt is risky for a profession subject to intense emotional reactions by the public when work goes wrong, and a mystery to governments that introduce various reforms without any effect. (This sentence is really confusing. What are you trying to say here?)

The Two-Edged Sword of Public Revulsion

What is yet to be noted in the social work literature is the parallelism between the emotions invoked by the claims makers advocating for child abuse laws from their cases of children battered and killed, and the emotions evoked by social work failures when children under supervision are battered and killed (Johnson, 2013). The profession that has benefited most from the stirring up of emotions about child maltreatment is now exposed to those same emotions, turned against it, for its apparent failings. The profession has apparently made a devil's bargain of accepting a frightening risk of exposure in order to gain control over clients and more work for its professionals. The highly publicized child abuse horrors that were mobilized by the claims makers were useful for the profession initially, but they became a threat. The social work response has been to keep all records and files confidential (New York State Temporary Commission of Investigation, 1996). But errors, particularly fatalities, may be impossible to hide.

In Illinois, as in other states, the records have been stored under a law that requires unsubstantiated cases against a family to be expunged within 90 days if nothing was done for child protection. If later a child is injured or killed and the case is brought up in the media, the spokesperson of the system will duly report that "There is no record of the Department being involved with this family." Of course there is no record, because it was expunged as soon as possible.

What Child Protection Errors Reveal

I do not have to refer to a litany of horrific cases of child fatalities, for my experience as a street-level bureaucrat gives me direct experience of errors, usually not leading to a child's death. In one case assigned to me, I began by reading the history in the files of the social service provider, files normally

not available to me. I read that the mother and her partner got into a knife fight in front of the children, and the man's eye was put out. The fight was duly reported in the file of the caseworker servicing the family, as one of a series of violent episodes in front of the children. Each child was severely injured at one time or another, and the police took custody in each case, only to have the children returned home by the caseworker defending the family to the police and child protection investigators. Because CPS investigations are treated as merely the admissions system for CWS social services, front-line investigators defer their judgment to the social workers on the case, one of the main (unstated) reasons that children whose families are repeatedly investigated for abuse continue to stay in their battering homes.

The case was repeatedly investigated because outsiders saw the harm to the children, while the social worker never made a report of risk. Yet, there were repeated notes documenting violent incidents she made in her case file. She took no independent action on any of these violent incidents, even though she was obviously aware of them. No supervisor responded to this situation, although the case was supposed to have been monitored continuously. Since no child died, there was no media report nor awareness until a judge reviewed the case of the eldest child, who was so disturbed that he had seriously injured his little sister. The judge wondered what services had gone on in this case and asked my division of child protection to look into it.

I was charged with investigating my coworker. She had left the case and I spoke with her replacement, who immediately took action. His first question to the woman was, "Do you want these children?" She responded, "No." The children were then removed and finally referred for adoption. It is hard to imagine anyone in this family being served by the social services being offered, other than the caseworker herself, who kept busy to justify her job.

The systematic avoidance of addressing harm to a child in a family receiving social services has become a routine cause of news headlines and government inquiries. The social work profession prefers to treat these horrifying events as if they were isolated, rather than systematic events. Just as in my experience, the publicized cases show service providers

ignoring the child being injured before their eyes (Curry, 2007; Lord Laming, 2009). This has led to pressure to reduce the statistics on reinjury. In one study, 40 percent of families where CAN was substantiated consisted of cases previously substantiated in earlier investigations (Gillingham, 2006, p. 86). Similarly, 30 to 50 percent of child fatalities are estimated to happen in families which have been reported before (Besharov, 1987).

In Illinois the administration adopted a goal of reducing their statistic of reinjuries. The pressure to reduce reinjury reports fell mainly on the caseworkers providing services, and the only practical way to do this was to stop making any reports of harm themselves, as all of their service cases were families where risk had already been substantiated. At each step of the process, from hotline call personnel to investigators, there was pressure to drop repeat cases without investigations. This is another managerial failure to understand the consequences of a policy implementation or changes in the work process. These managerial design flaws result in front-line workers who are systematically oriented away from perceiving child protection as a priority in their work.

The Inherent Conflicts of Interest in Child Protection Work

When the professional giving the help is also the person evaluating it, a conflict of interest emerges in full force. Who is being helped, the client or the professional? The problem is greater than the ill-founded crusade of a well intentioned outsider. The social work profession has become an insider to central social institutions, providing social services to families through CWS offices and being mandated to protect the children of those families being served. Inherent in these two contrary mandates is a conflict of interest. The policy decision to unite the office mandated to protect children with the office mandated to provide social services to their parents is responsible for many failures in protecting children.

The primary conflict of interest in our social service systems is self-evaluation. The professional who provides the services then testifies to their success. In the courts where decisions are made on how safe it is to return a child to a troubled

family, the decisions rest on the testimony of service providers such as trainers, counselors, therapists, and caseworkers. If the family members have cooperated with the court-mandated services, then they have completed the court requirements to have their children returned. There is no mechanism, other than the professionals' admission of failure, to evaluate the impact of services and the fitness of the parents. Here the motive is self-validation of one's own professional competence. Helping professionals become completely convinced that they have aided an unfit parent, for their intentions were all to the good. They look upon uncertain results and perceive certainty therein.

Another conflict of interest is in the decision to supply social services to a troubled family. Needless to say, the more troubled the family (a "multi-problem family"), the more services are found to be needed. If, on the other hand, a child's mistreatment is judged sufficient to remove that child from the home permanently and provide for her adoption, no social services will be needed, and the profession of social work loses work.

Finally, if the profession that is responsible for the protection of the child is also the one that is serving the family, then the adults' needs will become primary. In fact, services are rarely given to the child, but rather to the adults in the maltreating family. Social service professionals are oriented to see the adults as the clients, not the children. This point of view was made clear early on, as the new field of CPS became tightly linked with CWS, as described in the interesting book *Helping the Battered Child and his Family* (Kempe & Helfer, 1972):

Simply the desire to help or the feeling of compassion for battered *children* is not enough... The focus is on the *parents* and not the children. Our premise is that if the parents are all right, the children will be protected. (p. 45, italics in original)

Other authors reported similar styles of thinking on the situation. "The interviewer must, at all costs, resist the desire to find out who actually hurt the child. This approach is much too threatening and unrewarding." (Schneider, Pollock, & Helfer, 1972, p. 55).

The second "belief" in the IDCFS training follows this same line of thinking:

Families engaged around the issue of their child's safety and with recognition of their strengths are more likely to cooperate with following interventions than families confronted with accusations of the perpetuation of maltreatment against their children. (Child Welfare Institute, 1997, p. 2)

These statements are clear indicators of goal displacement and the denial of child harm. The goal of protecting children in the CPS has been set aside for a different goal of serving the adults in the CWS. The belief that if battering adults are in process of being reformed, their children are protected is patently false, as case after tragic case of catastrophic failure attest. Furthermore, the very basis of child protection is to determine "who actually hurt the child." Avoiding that responsibility because it will interfere with the battering parents' acceptance of social services is a disservice to the injured child and to the public. The child has the obvious needs in these situations, but the social work tool kit of services is filled with services for adults. So their needs become paramount, while the child's are displaced, as is shown in the following statement: "From the onset the response must be to the parents' needs. Although the family comes to our attention usually because of the child, it is the parents on whom we must focus our attention" (Alexander, 1972, p. 23).

Indeed, the literature that arose with the discovery of the battered child syndrome revealed quite clearly the dilemma facing the CPS within the CWS:

When stories of child abuse are published, the reflex response of the general public is to demand punishment for the parent and removal of the child. Descriptions of injuries inflicted on a child evoke a sense of horror, fury and the feeling that no punishment can be too great... [T]here is little interest in, or support for, helping the parent become a better parent. (Polier & McDonald, 1972, p. 210)

So, from the first, the social worker has been oriented to ignore and avoid the negative emotions evoked by cases of child mistreatment as a “reflex response” and instead focus on the needs of adults for support. By seeing the family in a favorable light, not only is the family more likely to accept social services, the providers are more likely to view the family as salvageable and ignore the risk to the child in the process. When the child is being harmed in front of the social worker, the textbook advice to “‘manage’ any bitter, shocked or incredulous feelings about parents who hurt their children” can have horrendous consequences (Curry, 2007, p. 74). In the DeShaney case, in which an incident of tragic harm to a child was carried to the U.S. Supreme Court, one justice commented that the social worker’s notes had “an eerie, emotionally detached quality given the horrendous nature of the events she was relating in them” (Curry, 2007, p. 74). Meanwhile, the social work literature promotes the view that social services are the routine answer to children being harmed.

The more that direct services intervene into children’s distress and provide direct assistance to parents, ... the more the children’s welfare will be promoted and the ultimate goal of child safety and healing for parents as well as children can be achieved. (Ferguson, 2004, p. 205)

In social work with children and youth, and particularly in the field of child protection, ... it has been shown repeatedly that the best means of reducing the incidence of child maltreatment is to provide generous and appropriate support for families. (Jackson & Coram, Research Unit, 2004-2005)

Once again, the needs of children are conflated with the needs of adults, to the point that the latter supplant the former. These statements also conflate the needs of troubled adults for social services with the needs of the service providers for clients. “Generous” social services for harmful parents also means plentiful work for social work professionals. The provision of social services to the adults is based on a new definition of such people as needy themselves and holds that they are presenting their needs to the providers through the harming of

their children. So, harm to a child is reinterpreted as a demand for adult services.

Child Protection by Proxy

Thus, if a child is injured, protection can be achieved by placating the parents through services. But that may be found to be awkward. Suppose the battering parent is not available or cooperative. Then the services can be supplied to another family member! Faith in the success of services is boundless.

It is a fascinating question ... why ... the focus of treatment, and indeed of diagnosis, has been upon the mother, ... but it is not surprising. ... The mother was more readily available to a social worker ... while the father was at work ... Moreover, the philosophy of protective services for the past fifty years has been geared to the ... mother ... even though the father might be the primary abuser. (Kempe, 1976, p. xi)

While Kempe looked forward to an improved philosophy of protective services, such philosophies are difficult to change, especially when ingrained into work habits and routines.

Hypotheses about Social Work Failures

I have a working hypothesis about the root cause for child protection failures, along with various details of the front-line work and managerial decisions that direct it away from protecting children. While the casual observer sees that a child is being systematically harmed in a home and reacts with horror, the professional social worker is trained to see that more services are needed in that troubled family, and avoids facing the maltreatment while serving the needy adults. It becomes "professional" to deny emotions in order to deal with difficult clients. When the social worker is mandated to both provide social services to the family and to protect the child, a conflict of interest is created. Systematic errors of leaving a child in a harmful environment will result, for the service provider is trained to see the service needs not the need of child removal.

The training of which I speak is not restricted to the schools of social work or the retraining received by staff; it is designed

into the very system of child protection. The checklists and evaluation forms of the child protection investigator's daily workload focus the worker's attention on a series of family needs, described under a rubric of "risk assessments" for the child (see Gelles, 1996, pp. 70-72). There is a direct translation of such "risks" at the intake end of the process (child protection) into "services" to address each risk at the processing end (child welfare). So, any lack of cooperation with the system staff and/or unwillingness to accept services become risk factors that supposedly endanger the child, when they really endanger the caseworker's work. This disconnect is one step in a programmed distraction of the worker from facing the needs of the child to focusing on system needs through evaluating the family's adults. Each step of the process of investigation of child maltreatment is designed to lead to direct services to adults.

Forms, case notes and other paperwork also distract the worker from the child's needs by focusing on evaluating the adults, assessing their needs, and planning for their services. The shift of attention from the child to the needs of adults is designed into the CPS work routines as part of a consistent, pervasive organizational culture. This is the professional culture of social work, which emphasizes services to families, not child protection. In fact, in the *Encyclopedia of Social Work*, the article on "Child Protection" only mentions services to families in order to protect children, without a word on the removal of threatened children to safety (Edwards & Hopps, 1995). This organizational and professional culture is so strong that all evidence will be interpreted to support the conclusion that the professional response to child harm is to provide services. If the child is harmed in a family which is receiving services, then more problems have been exposed and more services are needed.

Evidence that this hypothesis is correct is available in the cases of child fatalities available in the media and government inquiries. We find that the deaths of children in families receiving services are preceded by public knowledge that the child is being severely injured, but that knowledge is rejected by the service providers. Far from the profession's defense that the deaths are unforeseeable and onetime occurrences, they are sometimes the culmination of a months- or years-long series

of harms apparent to everyone but the service workers. In the case of Eli Creekmore, the grandmother repeatedly called the authorities about severe injuries, as did the child's teacher and doctor, but they were ignored. The waitress in the restaurant where the boy was taken for his birthday party broke down in tears when interviewed for the PBS documentary on the case, when she recalled the little boy who could not eat his ice cream because his mouth was filled with blood (KCTS-TV, 1988). Matthew, a child whose troubled mother was receiving social services even before he was born, was investigated 60 times for maltreatment during his almost six years of life. He was under investigation from birth until death and serviced by 21 different social workers and their supervisors. This posed a mystery to those conducting the inquiry of the case, who found that "Many social workers were confused about their role and did not treat the safety and well-being of the child as paramount, giving priority to family unity instead" (Gove Inquiry, 1995, Conclusions).

In contrast to the conclusion of the Inquiry that more social work training was needed, I conclude that the social workers were following their training all too well, and the training was the cause of the problem. The alternative conclusion, that 21 successive social workers all were severely undertrained, strains credibility.

How to Manage Services to Children and Families

The resolution to the apparent dilemma between services to protect children and services to aid families is, simply, triage. We accomplish it by evaluating families based on their known risk to the child, and classify the case into one of three categories. First, we have the cases that are too risky to let stand, and too costly to try to correct. These are the cases for child removal and assignment to adoption services. Second, we have the cases where serious risk is found, and the families require assistance to remain whole. These are the cases for social services. Third, we have the families with problems which are not serious enough to warrant services, nor likely to cause serious child harm, so they can be left alone, or referred to volunteer social agencies or other resources, such as their extended family.

Triage works to adjust the classification decisions to the resources available. If resources are plentiful, then more cases can be included in the second category to receive services. When resources diminish, then more families will have to be placed in the first classification and their children removed permanently. This is not a call for foster homes, but for adoption. The funding authorities will have to face the decisions about how far the system goes to break up families, and how much to try to preserve them, taking much of the pressure off the social workers for this decision, once it is rationalized. I maintain that the persistent complaint among the apologists for social work errors, that workers are "damned when they do and damned when they don't" remove a child is not representative of the real problems of decisions and choice that the system faces. That argument becomes a form of special pleading for more jobs and more resources, rather than adapting to and managing the available resources to maximize both services to families and child protection.

Now I turn to the management of the child protection and family services systems. While triage seems to be a rational response to the child protection problem, instead we have constant demands for more resources. The families that are most harmful to their children are often those supplied with the most services, draining the system of resources needed for less troubled but salvageable families. There are several reasons for this contrary state of affairs. It begins with the decision to not supply families with social services until some finding of abuse or neglect has been made. This orients workers to link services with risk to children, and respond to risk within a serviced family with more services instead of permanent child removal. Administratively, it is easier to manage several workers serving the same family than workers spread among many. The same logic applies to long term services for a family compared with assessing and providing short term services. Workers work together and establish long term relationships among their colleagues and with family and community members such as the schools, medical staff and the police that require more work when many families located apart are being served.

Short term services to stabilize a family may be an efficient use of resources, but these cause management problems and are less attractive to workers. The families become dependent on

services, and so they must continue or the family will relapse. In parallel, the workers, supervisors and managers become dependent on business as usual, reinforcing work routines and decision making that make the workload manageable.

As one example from my former work, child protection staff were given a standard number of cases to investigate in a month, regardless of their seriousness. If the investigator decided that a full investigation was not necessary, she was decreasing her own work load. The contrary decision meant that the investigator was working harder than usual. If the case appeared to call for removal and an appearance in court, even aside from the full investigation required, the paperwork was extreme, including 28 different forms, some of them, like the interview form, filled out multiple times. In one month I was scheduled for 20 court appearances, appearing to testify almost every work day. This required full investigations and screenings for each case, as well as the usual assignment of investigations. There was no reduction of my or any other investigator's workload to account for the different demands of the work. Thus, when I became an acting supervisor (without authority), members of my work team simply refused to take any case that appeared to require additional work. Clearly, only the most conscientious and dedicated worker, a nonconformist like myself, or one faced with an unavoidable "heater case" (our term for a family case drawing negative publicity) would make the effort to do the necessary work. As Hagedorn (1995) found, in another state, only the naïve new hire could be trusted with a serious case. New workers would soon "burn out," while the veterans would sit in the cafeteria, drinking coffee and fill out forms without having done complete investigations, or any investigations at all. While the work situation in my workplace had not deteriorated to this extent, I could discern the tendencies in all of us.

Conclusions and Recommendations

Many child protection failures result from a conflict of interest designed into the work. Rather than adopting a system of triage, the child welfare system defines the problem as requiring family services, delivered in proportion to the harm. Systematic distortions of the work result. Child protection workers investigate service needs and service providers are

distracted from harm to the child by serving adults.

By being self defined as a helping profession, social work operates within a professional and organizational culture of self-validation, generating evidence of professional success. Negative emotions and negative outcomes are ruled out as non-professional. By looking the other way when a family receiving social services harms a child, case workers risk a tragedy. They also risk creating the same negative emotions that supported the entry of the profession into the field of child protection originally. The profession is partially protected from its errors by forbidding access to case records as "confidential" and by systematically destroying them. But when a child is killed, the exposure of systematic errors brings about a public outcry. The inquiries which follow seem to be patterned to tamp down the outcry by being dispassionate and looking for reforms in the communication and management of official rules, procedures and laws. The language of rational management is invoked to smooth over the details, to suggest that polishing up the rules and laws will solve the problem.

A systematic redesign of the CPS and CWS, as well as their linkage, will be required to resolve the problem. The day-to-day front-line work needs to be redesigned, so child protection is not treated as a distraction from the central objective of diagnosing family needs for social services. Perhaps the only way to accomplish this major organizational change in values and behavior is to remove the social work professionals entirely from the management of both child protection and child welfare. Then the inherent conflicts of interest would be mitigated.

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