‘Do I read it? No’. Knowledge utilisation in child welfare decisions.

Abstract

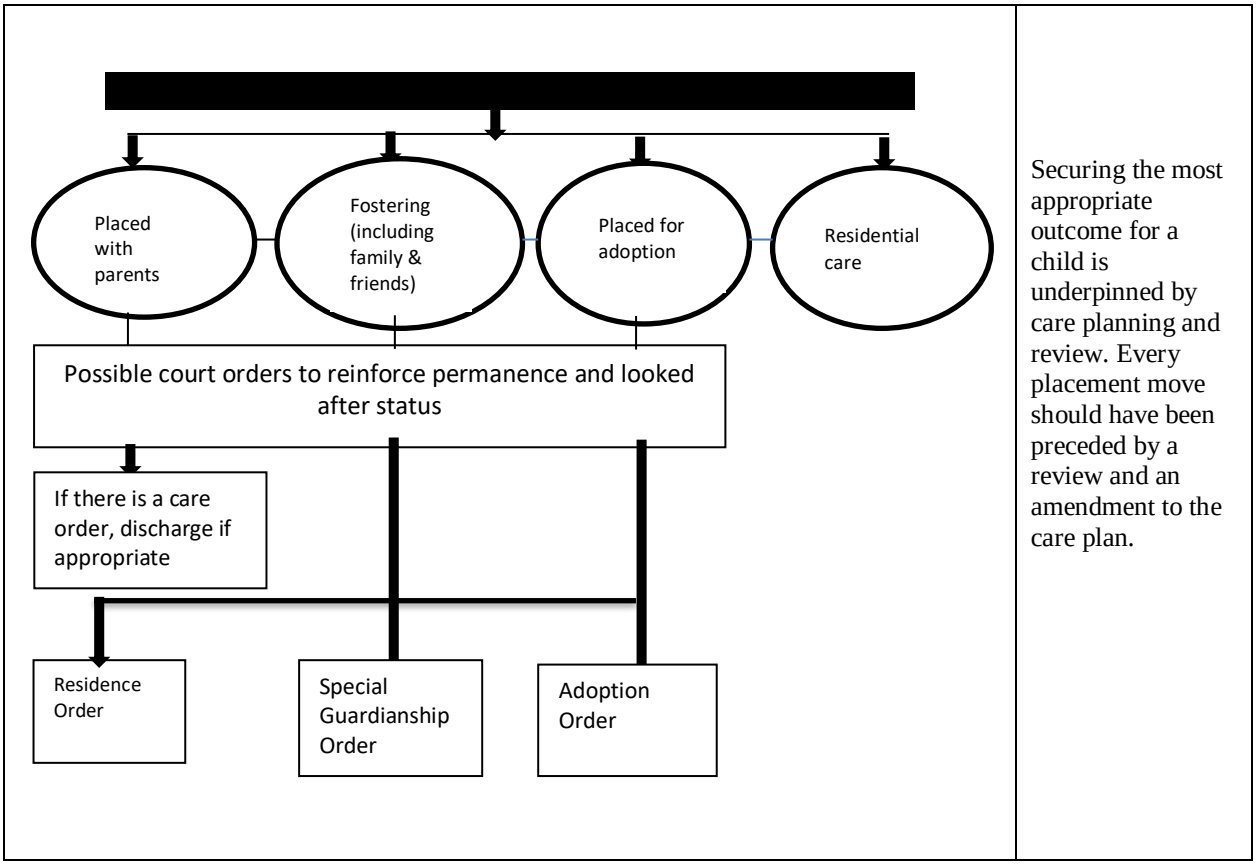
Much as one would like to be able to base permanency decisions on the solid ground of empirical findings and objective knowledge, the nature of child abuse precludes this possibility. In the absence of any unitary knowledge base, it is important to know what knowledge social workers use to inform their permanency decisions. This article presents findings from an exploratory in-depth qualitative research project with the objective of exploring the knowledge that social workers use to make decisions regarding permanency arrangements for Looked after Children. This research formed part of my Doctorate in Childhood Studies at Queen’s University Belfast. Thinking aloud-protocols and semi-structured interviews, in conjunction with a specifically constructed vignette, were used as an innovative methodology to explore the knowledge used to make permanency decisions by experienced practitioners in a local authority in Northern Ireland. A thematic analysis was used to structure the findings. An adapted model of knowledge was used to structure the themes which was based on Drury-Hudson (1997) and Pawson *et al’s.,* (2003) model of knowledge. The findings show that organisational knowledge and practitioner knowledge were privileged almost exclusively over research, theory and service user knowledge. Findings also reveal that using these two sources of knowledge led to overwhelmingly protectionist oriented decisions, significantly affecting the care trajectory of the child in the vignette. Recommendations are made with the aim of improving the extent and depth of practitioner knowledge in this field, thus helping to increase the robustness, consistency and defensibility of decisions taken.

Key words: decision-making; permanency; child welfare; knowledge.

Introduction

Based on the recognition that long term security and stability should drive permanency decisions for a child (Fiermonte and Renne, 2002; Tearse, 2014), the following options (summed up in figure 1) that social workers traditionally have to choose from to secure a child's permanence are, (i) reunification with parents, (ii) residential care, (iii) permanent placement with relatives/legal guardian (kinship care or foster care), and (iv) adoption (Freundlich *et al.*, 2006; Health and Social Care Board, (H&SCB, 2010; H&SCB, 2015).

Figure 1. (Permanency options for LAC – taken from Harnott and Humphreys, (2004).



A core government policy, permanency aims to give children 'a sense of security, continuity, commitment and identity through childhood and beyond' (Department for Education (DfE), 2012, p. 12). In this context, it is hoped that permanence will help a child develop supportive, involved, compassionate and enduring relationships with a caring adult/s and that these relationships will last into adulthood (Department for Education, 2015). At its core, permanency is about 'securing

the right placement for the right child at the right time' (Boddy, 2013, p. 1). In this sense, Sinclair (2005), Sinclair *et al.,* (2007), Biehal *et al.,* (2012), Schofield and Simmonds (2011) and Salazar *et al., (*2018) emphasise the importance of permanency providing a child with stability, emotional constancy and solidity. For a child to feel a sense of permanency therefore, their living arrangements need to be characterised by balanced emotional attachments to adults and siblings and a feeling that they are part of a family (Salazar, 2012; 2013). In a permanent living arrangement both the children and adults can expect or usually assume that they will be living together in both the short and the long term (Moran *et al.,* 2016).

Making permanency decisions is far from an exact science however and they are exceptionally complex (Fleming *et al.,* 2015). When making permanency decisions, child welfare professionals are entrusted both ethically and legally with acting in children's best interests and deciding where and how those best interests are met (Bartoli and Dolan, 2014). These best interest decisions are recognised as being among the most testing decisions a child welfare worker is likely to make due to their complexity and contested nature (Helm, 2011). They are complex too because they incorporate 'multi-layered negotiation, applications of professional judgement and interpretation of knowledge and evidence' (O'Connor and Leonard, 2014: p. 2).

Government guidance (DoHNI, 2017) acknowledges this, recognising that assessing significant harm and deciding whether the child meets the threshold criteria for removal from parental care is complicated, requiring extensive knowledge to make an informed decision. However, much as one would like to be able to base such important decisions on the solid ground of empirical findings, the nature of child abuse precludes this possibility (Bartoli and Dolan, 2014) due to its moral indeterminacy (Houston, 2002), messy complexity (Ferguson, 2005; Hood, 2014) and the fact that social workers have no unitary knowledge base to draw on to inform their decisions (Enosh and Bayer-Topilsky, 2015). As a consequence, mistakes have been made (Dettlaff *et al.,* 2015). Decision making in child protection is therefore receiving increased attention in the context of clinical and social care governance (Department of Health and Social Security and Public Safety (DHSSPS), 2002; Simmons, 2007; Social Care Institute for Excellence (SCIE), 2017), as issues of both quality and risk collide at the point where decisions are made (Killick and Taylor, 2009). In a climate of uncertainty, social workers in child protection are under pressure like never before to

justify their decisions and ensure they are consistent, informed and in line with regulation (Laming, 2003, 2009; Munro, 2008, 2011; Jones, 2014).

Unfortunately, however, the belief that empirical findings could provide a single actuarial-like formula so that decisions could be based on hard data, has yet to materialise (Munro, 1999; Minkhorst *et al.*, 2016). In the absence of this actuarial-like formula or unitary knowledge base, the knowledge social workers actually use to inform their permanency decisions remains largely opaque. This has left Thoburn (2010) to conclude that our present knowledge is not sufficiently clear enough to decide when a child's permanency needs would be best served by removal and when by being kept at home, resulting in low levels of agreement in such decisions Osmo and Benbenishty's (2004).

Thus we have a gap in our understanding of the knowledge social workers use to make permanency decisions. Therefore, the following research question was developed: 'What knowledge do social workers use to inform their decision regarding permanency for Looked after Children'? The findings can be used to inform social work practice, education, training and supervision, with the intention of making permanency decisions more knowledge based.

Research design and methods

Because I was interested in understanding the personal views, particular interpretations of the phenomenon and attaining an in-depth awareness of the individualistic significance of participants' experience, I used a qualitative, and by extension, phenomenological-interpretivist approach. To collect the data, an in-depth two-stage qualitative interview was used. In stage one, thinking-aloud protocols were used to explore the knowledge that the participants used to make their decision. Thinking-aloud as a research method has its roots in psychological research with Breuker and Wielinga (1987) being the earliest pioneers of the method. The thinking-aloud method is currently accepted as a useful method to gain rich verbal data about reasoning during a problem-solving task, (van Someren and Sandberg, 1994). Using thinking-aloud protocols, researchers can identify the information that is concentrated on during the problem-solving task and how far that information is used to facilitate problem resolution (Fonteyn *et al.,* 1993). From this, inferences can be made about the reasoning processes that are used during the problem-solving task.

Thinking-aloud protocols are of particular value because, as Karahasanovic (2009) points out, they enable the researcher to focus on the issues the participant has in relation to the problem under scrutiny – in this instance, the knowledge the social worker was using to make their permanency decision. Additionally, this method is especially helpful as it allows the researcher to correlate the actions and statements of the participant which Patel *et al.*, (2001) recognise as a strength of the method. Additionally, the thinking-aloud method is generally recognised as a major source of data on subjects' cognitive processes and are traditionally used to uncover the intricacies of a decision and discover data in relation to the knowledge used to inform their decision (Anderson, 1987 and Veenman *et al.*, 2003). Using the thinking-aloud method enables the researcher to get rapid, high quality, qualitative feedback, which Jungk *et al.*, (2000) state is not obtainable with questionnaires.

However, there are limitations to the thinking-aloud protocol (Jääskeläinen, 2010). Mainly, it can tell us little of what is not conscious to participants or is challenging for them to verbalise due to extraneous factors such as stress or high cognitive overload (Earle, 2004) which participants can experience (McFadden *et al.*, 2014). According to Jääskeläinen (2010), only information that is actively processed in working memory can be verbalised. Since automatic processes dominate much of everyday life (Bargh and Ferguson, 2000), this is an important limitation. However, these limitations can be abridged if one uses other complimentary processes to support the thinking-aloud protocol (Jääskeläinen, 2010) which is why I decided to use a semi-structured interview (discussed later) following the end of this stage.

In preparation for this stage and in consultation with permanency experts and guided by Taylor (2006), I designed a realistic vignette (appendix 1) outlining an archetypal case in which Claire, aged five, needed a permanency decision made. In the vignette, there are several different possible decisions that the social worker could imaginably make; none of which were so binary that they did not present their own unique challenges, requiring the social worker to have to think carefully about what option they would choose. In line with legislation, policy and practice, participants were given the five possible decisions - written at the end of the vignette - that social workers are provided with in practice and asked to make a decision regarding permanency arrangements for Claire as either:

1. Long term foster care
2. Kinship care

3. Adoption
4. Residential care
5. Return to parents.

(The final vignette was 994 words long).

Once presented with the vignette, participants were told 'imagine that you are the social worker for Claire'. You are required to make a decision regarding the permanency arrangements for Claire. I am interested in the knowledge that you use to make this decision. Please keep talking out loud as you make your decision concentrating on the knowledge you use to make this decision.'

When this stage finished naturally, an in-depth qualitative semi-structured interview took place that enabled me to follow up on points of interest that arose from the thinking-aloud protocol. The semi-structured interview therefore consisted of open-ended questions which were based on the issues that arose during the thinking-aloud stage. Each interview was recorded using a tape recorder. The interviews were transcribed verbatim in word format by me afterwards.

Sampling

Non-probability purposive sampling procedures were utilised. The inclusion criteria for the sample to be studied was:

A. Any child protection social work practitioner or manager that has experience making decisions regarding permanency arrangements for LAC and,
B. That they work within the X Health and Social Care Trust's LAC team.

The project was conducted in a local Health and Social Care (HSC) Trust area in Northern Ireland (hereafter called the Trust) that was conveniently sampled out of a total of five HSC Trusts in Northern Ireland. The total sample agreeing to be interviewed was N=19. Two participants were conveniently sampled to take part in the pilot of the study and are therefore excluded from the analysis, leaving the total included in the findings at n=17. Through piloting, I was able to recognise and correct deficiencies in the methodology, which Bazeley (2013), and Rubbin and Babbie (2015), state is a critical process when developing research protocols and processes. For example, the time given for the interviews had to be extended to 90 minutes from 75 minutes. Completing the pilot also helped assess the proposed data analysis technique which uncovered a

potential problem due to the significant amount of time required to transcribe the tapes which meant that the time for completion had to be adjusted.

Ethical Approval.

Ethical approval was sought and provided for via a successful application to the Integrated Research Approval System, which is a single system for applying for the permissions and approvals for health, social and community care research in the UK. Additional ethical approval was also sought and provided for by Queen's University Belfast Social Research Ethics Committee.

The Sample.

Table 1 (length of experience)

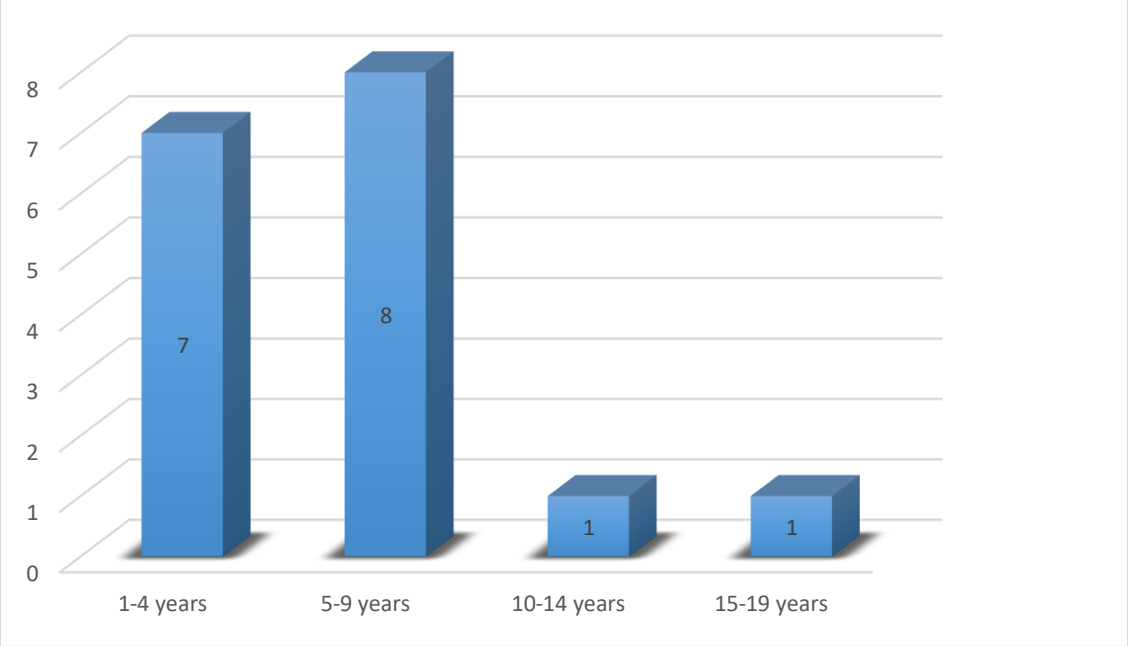


Table 2 (Job role)

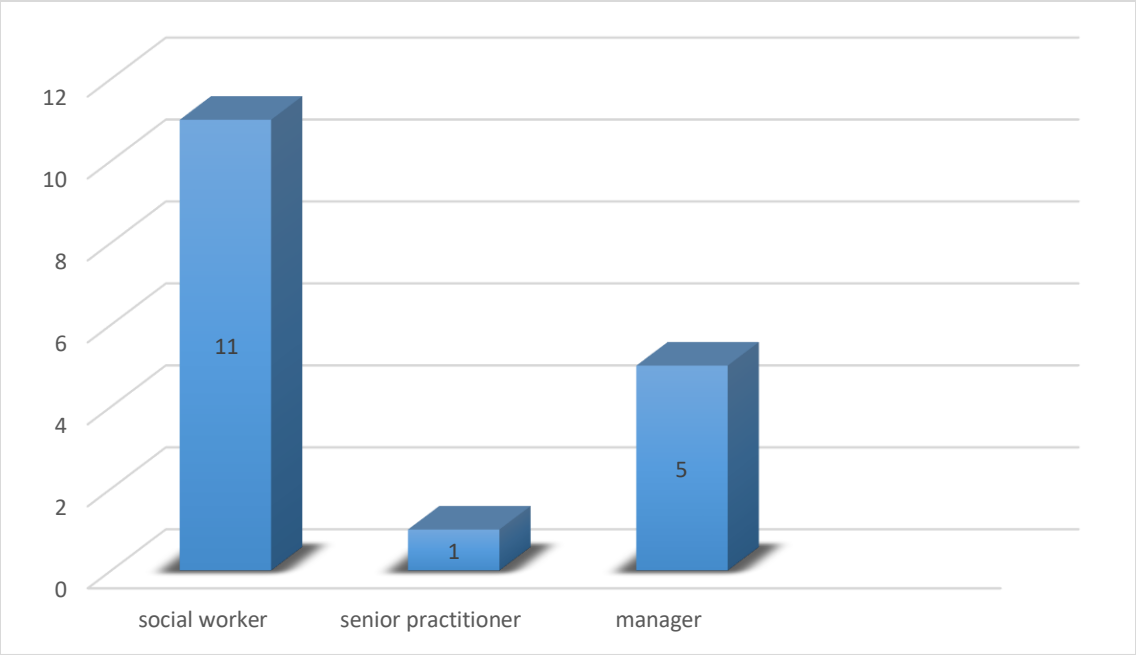


Table 3 (Gender)

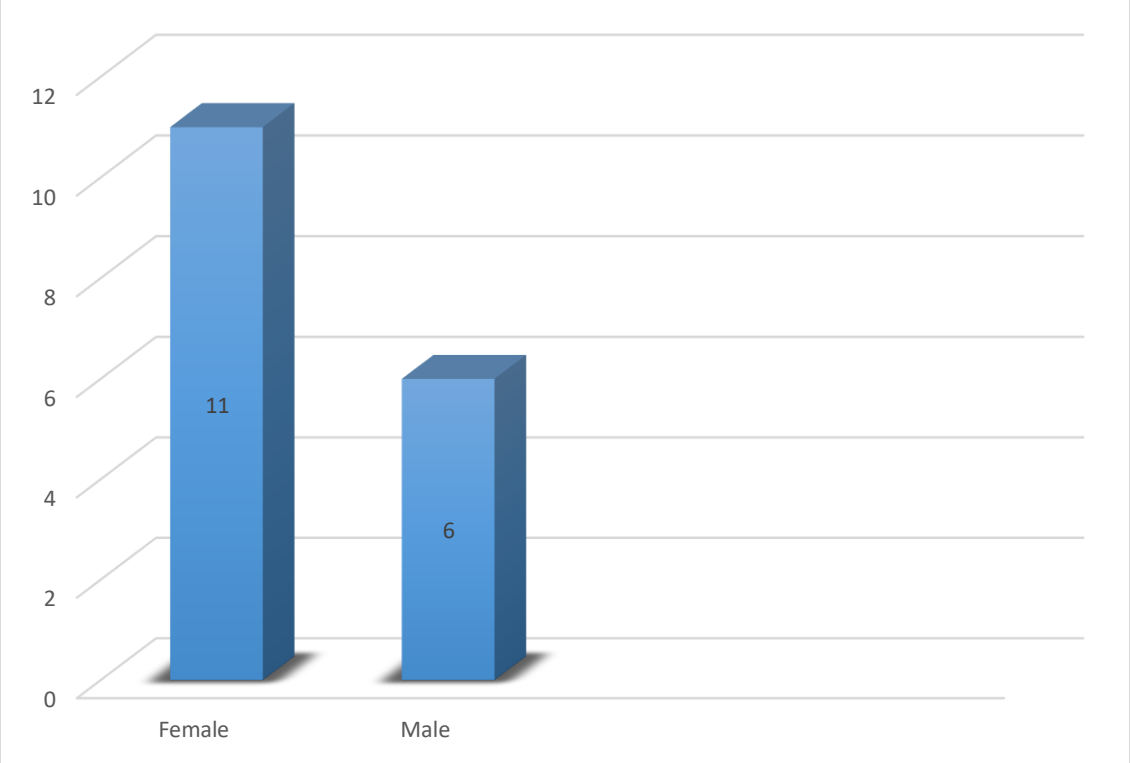


Table 4 (Number that partially or completely completed Post-Qualifying Training).

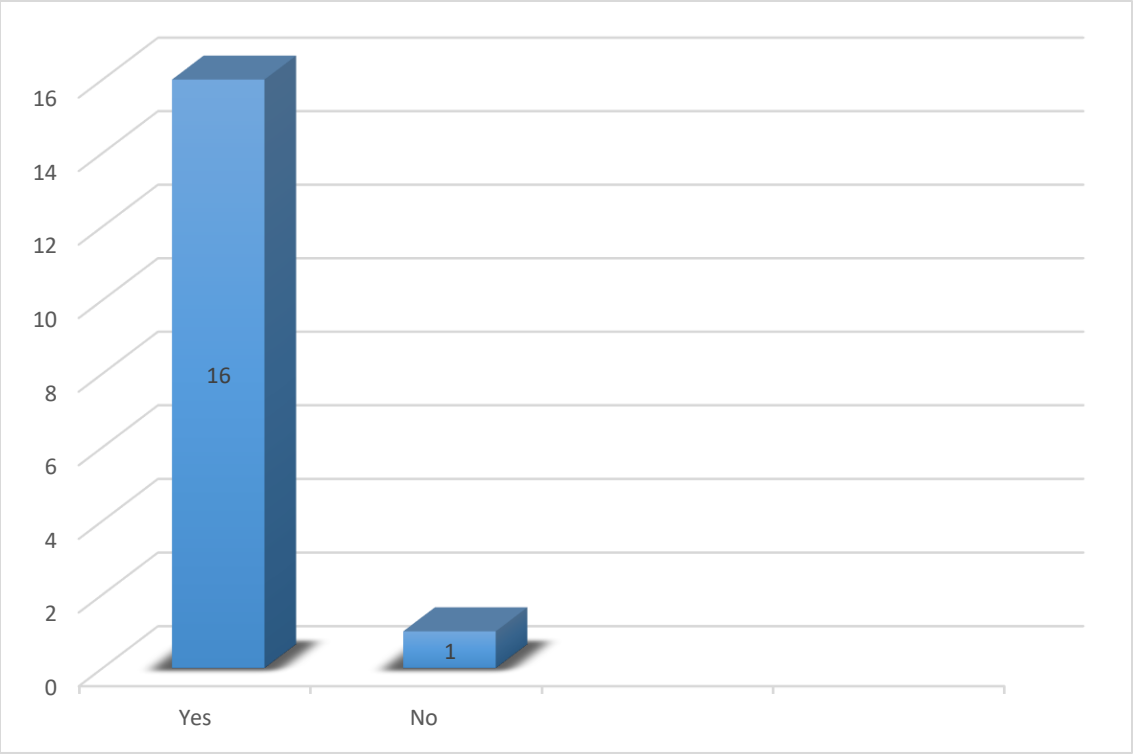
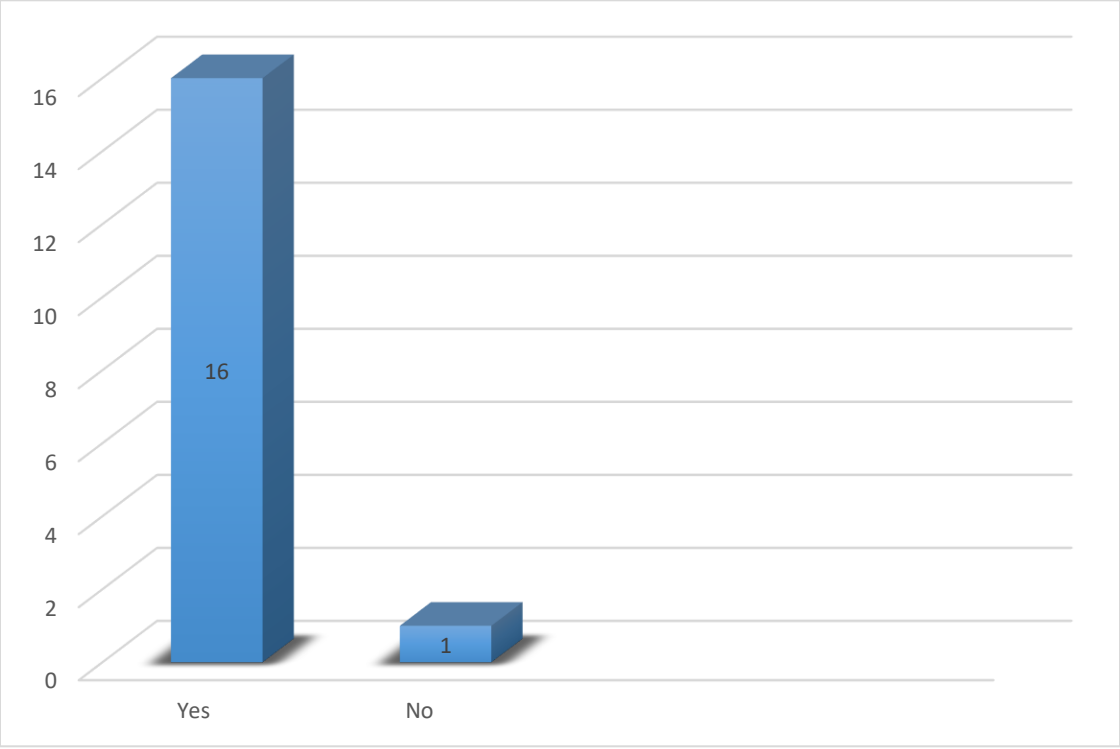


Table 5 (Number that completed in-service training within the last year)



Data Analysis

Preceding the interviews taking place, it was decided laterally with my supervisor that I would interview as many candidates as necessary, using the principle of data saturation, discussed by O'Reilly and Parker (2013) to decide when to stop interviewing. We also agreed, that in an effort to ensure the objectivity of this decision, thereby reducing any potential criticism of subjectivity that we should conjointly agree when saturation had been established and thus collectively decide when to stop interviewing. Guest *et al.*, (2006) helpfully estimate that data saturation is typically realised when there is sufficient information to replicate the study, when the ability to obtain additional new data has been attained and when further coding is no longer feasible. Numerically, Fusch and Ness (2015) hypothesize that saturation typically occurs between fifteen and twenty interviews and indeed this was the case in my study with saturation occurring at seventeen interviews.

To analyse the data, I transferred the typed data into NVivo 11 and completed a thematic analysis using Guest *et al's.*, (2012) framework. To help disaggregate the data into meaningful themes, I initially used what Pawson *et al.*, (2003a and 2003b) describe as an intellectually defensible classification of social work knowledge (outlined in table 6).

Table 6. Pawson et al.'s (2003a and 2003b) model of knowledge.

Type of Knowledge	Organisational	Practitioner	Policy Community	Empirical Research	Service User
Characteristic	Gained from the management and governance of social care	Knowledge gained from the conduct of social care	Knowledge gained from the wider policy environment	Knowledge gained systematically with predetermined design	Knowledge gained from experience of service use and

However, I adapted Pawson *et al.*'s (2003a; 2003b) model in two ways based on findings from the pilot and messages gained from the literature. To begin with, I made the classification of '*theory,'*

identified in Drury–Hudson's (1997) model of social work knowledge (outlined in table 7) much more explicit.

Table 7. Summary of Drury-Hudson's (1997) model of knowledge.

Type of Knowledge	Theoretical Knowledge	Personal Knowledge	Practice Wisdom	Procedural Knowledge	Empirical Knowledge.
Characteristic	Concepts, that help explain, describe, predict or control the world.	Action based on a personalised notion of 'common sense'.	Knowledge gained from the conduct of social work practice.	Knowledge about the organisational legislative, or policy context within which social work operates.	Knowledge derived from research involving the systematic gathering and interpretation of data.

Table 8. New classification of knowledge used to build the thematic analysis.

Type of Knowledge	Organisational, policy & community knowledge	Practitioner knowledge	Theoretical knowledge	Research knowledge	Service user knowledge
Features	Procedural knowledge, setting boundaries and limitations on service provision.	Knowledge gained from the conduct of social care practice.	Grand policy themes from the wider policy community.	Evidence gathered systematically by prescribed methods, process and outcome data.	Knowledge gained from the experience of using services, research and reflection.

In the newly adapted model (outlined in table 8), I categorize *theory* in its own separate classificatory system because as Payne (2015) and Payne *et al.*, (2009) argues, theory is of critical importance in social work, and I therefore did not want it subsumed and possibly lost within another classification. Secondly, I combine two of Pawson's classifications into one. I combine 'organisational' knowledge with 'policy and community' knowledge. In the pilot, participants did not differentiate between the two, talking about organisational and policy knowledge as though they were one classification. I therefore thought that combining both would make the model less cumbersome and would help solidify the themes more coherently and make analysis more streamlined.

Research Findings

The findings (summarised in table 9), are presented and arranged into the main theme along with the associated sub-themes.

Table 9. Summary of the theme and the associated sub-theme.

The theme	The knowledge used to make the decision.
Sub-themes	(i) Organisational, policy & community knowledge.
	(ii) Practitioner knowledge.
	(iii) Theoretical knowledge.
	(iv) Research knowledge.
	(v) Service-user knowledge.

Sub-theme (i) Organisational, policy & community knowledge

The use of legislation, (The Children Order) as well as government policy and Trust procedures was the dominant form of knowledge used to make decisions and it was accurately cited.

Knowledge of The Human Rights Act (HRA) 1998 was also used to a lesser, but nevertheless accurate manner to inform the decision. Policy and procedures were also used and were consistently evident as part of the organisational knowledge that participants used to make their decision.

It is interesting to note however, that whilst legislation, policy and procedures were accurately cited and used appropriately to make individual decisions, its use did not result in a consistent decision for permanency agreed by all. For example, accurately citing and using knowledge of the Children Order, participant ten decided on permanency by way of adoption:

> …here the Children's Order and Claire's paramountcy needs…take precedence.

Participant twelve however decided on fostering using the Children Order:

> …Obviously you are looking at your Children's Order in terms of the welfare check list; the best interest of the child.

Whilst participant eight opted for kinship care using the Children Order:

> …I looked at…what would be in the best interest of Claire? Obviously, we work under remit of the Children Order and also looking at safety is our paramount concern.

The same issue of inconsistency arose in regards to the use and application of policy and procedures as well as the HRA, whose use, whilst accurately cited, simultaneously contributed to a diverse range of permanency decisions made. For example, citing the HRA, participant thirteen supports adoption, participant eight opted for a kinship placement, whilst participant sixteen supported foster care.

Government statistics or findings from either Case Management Reviews/Serious Case Reviews, critical incident reports, outcome reports for Looked after Children, audits or governance reports is absent altogether. This is despite the fact that this knowledge is recognised as important and legitimate organisational knowledge.

Sub-theme (ii) Practitioner knowledge.

All seventeen participants used practitioner knowledge to inform their decision. Typical of all the participants is participant seventeen's assertion that:

> …you do refer to your own practice and what you have done in previous situations, so that supports you and guides you in terms of reassuring you that you are doing the right thing.

However, due to the accusation that practice wisdom can be open to subjectivity, and consequently less reliable than knowledge derived from scientific research, its status is somewhat diminished Dybicz, 2004). Judging by the comments made by some of the participants in this study, this position could, to a certain extent, be a justifiable criticism. For example, when asked why Aunt Mary was not being considered as a viable placement for Claire, participant six cited Aunt Mary's bouts of depression, single parenthood and the fact that she already cares for two children - one who has autism – as reasons not to place Claire with her Aunt. However, no objective evidence, research or theory is offered to support this decision which appears to be based on gut instinct, which ten of the participants said they used:

> …I think as workers we all have a gut instinct and gut instinct comes for me when I have met kids and parents and I suppose *you just know* (my italics) (participant four).

Sub-theme (iii) Theoretical knowledge.

Theory, as described by Thompson and Stepney (2018), is understood to be a way of explaining a phenomena or phenomenon, thereby forming the basis of our understanding. Of the seventeen participants, only four were directly utilising theory to evidentially inform their decision and of these four, only the one theory (attachment) was used between them. Interestingly however, of the four participants that used just this one theory to inform their decision, its use did not result in the same decision being taken - three participants decided on adoption and one decided on kinship care.

The other thirteen participants were not using theory:

> …There is a mixture of everything in there but it is not something I would constantly go and say, 'while using this theory…in this way, it has made me decide', but it's in there somewhere…but I can't identify that in my head. I can't think of any (participant fifteen).

The thirteen unable to articulate theory were not oblivious to their limited theoretical knowledge and rationalised to me why they struggled:

> …You sometimes forget what theory it is you are working under (participant eleven).

> …in practice, theory isn't focused on and isn't given the attention it deserves… [so] you gradually move away from theory (participant seventeen).

Political, ideological or organizational theory was not used at all and sociological theory was cited indirectly once.

Sub-theme (iv) Research knowledge.

Research, as described by Scott (2014), is thought to be a disciplined inquiry into a subject and used to facilitate empirically based understanding and explanation, and often to inform action. All interviewees were initially saying that they used research to inform their decisions:

> …I always think it [research] strengthens a report when you refer to the research - especially recent research or recent articles that have come out in terms of children (participant seventeen).

However, what was wholly absent in any of the interviews was any specific or unambiguous reference to what *the* research was, *where* it originated from, *what* the findings were and *how* it essentially informed the decision. I explored this further, asking participants if they could be more specific about what research was used and how it informed the decision.

Participant five came closest, saying that:

> …there was that research about the impact of delay in 2014. They were saying that if children are in a permanent placement before they were one, they have the same attachment outcomes as their non-adoptive peers.

It was not until I gently probed the participants again that I began to get more direct responses in relation to *the* research being purportedly used. Responses included:

> …I am going to be honest. I know there is research. Do I read it? No (participant one)

> …the research would show…but I can't identify [it]…couldn't pin point that to anything to be honest (participant sixteen).

Additionally, when aggregated across all of the interviews, even the supposed research that was professedly used to support the permanency decision was often contradictory in nature, was used inconsistently and applied conflictingly. For example:

> …research shows us that adoption is better for looked after children than long term foster care (participant fifteen).

> …The research around fostering…there is better outcomes for [Claire]…adoptive placements are more likely to breakdown (participant three).

> …I'm going for kinship care because research tells me kids who are based within their own family do better than kids who go to adoption (participant ten).

Thus, it would appear that research was not being used in any cogent manner, despite participants initially saying that they do use research and that the research that was supposedly used was used to support a variety of different decisions.

Sub-theme (v): Service-user knowledge.

All participants agreed that listening to Claire's views was important. Nevertheless, whilst accepting Claire's expressed wishes and feelings as a significant source of knowledge, all the

participants very quickly pointed out the challenges involved with having and using this type of knowledge. This difficulty manifested itself acutely as a predicament between safeguarding Claire, whilst simultaneously listening to her wishes and feelings. Out of the seventeen interviews however, this balancing act appeared to lean resolutely towards the less risky but ultimately more restrictive options. Participants also appeared to take an adult-centric approach to safeguarding Claire, making 'safe choices' *for* her, as opposed to *with* her:

> …From an adult perspective, we need to make safe choices and decisions about keeping Claire safe (participant four).

Interestingly, participants seemingly aware of the contradiction between saying Claire's views were important but considering them unworkable, sought to rationalise their approach:

> … [a] 5-year-old is saying, 'I want to go home' - that's alright…but she doesn't fully understand from her age and stage of development…the consequences of what her wish will be (participant three).

Additionally, at times it appeared that participants were reducing Claire's individual wish to return home to a universal plea made by all Looked after Children children to go home:

> …I mean, for a service user to say they want to return home or they want to see more of their parents, is not anything new (participant seventeen).

It also became somewhat apparent that participants appeared keen to:

> …make sure that [Claire] fully understand[s] some of the rationale behind our decision making (participant eight).

The apparent implication being that the decision was by now made and that in communicating the decision *to* Claire, participants were somehow engaging *with* Claire:

> …I would be using that, not to override her saying that she wants to go home, but explain to her the reasons why she can't (participant two).

Discussion

One can see that all the participants were using the appropriate statutory legislation, policy and procedures to make their decision and that based on this knowledge, all agreed that Claire needed a permanency plan. However, whilst accurately cited organisational knowledge successfully formed the common ground of agreement that a permanency plan was needed, this unanimity dissipated when it came to deciding what the actual permanency plan itself should be. Interestingly however, despite this lack of unanimity across the range of decisions, the more interventionist decisions gained the greatest traction with the participants. Ten opted for adoption, five for foster care and two for kinship care. None favoured a return home and none opted for residential care. Although it might be unreasonable to suggest that the participants erred in any way in their decisions, given that the Department of Health's (2017) own guidance recommends reunification *where possible*, one might think that out of seventeen in-depth interviews that the least interventionist approaches would have at least been considered.

This apparent tendency to use a more interventionist prescriptive approach based on statutory knowledge, conceivably reflects current national trends by child protection agencies. In this frame, families are subjected to what Casey (2012) and Featherstone *et al*., (2014) describe as muscular state intervention plans in the hope of achieving better outcomes for children. Furthermore, there appeared to be an almost exclusive but reductive use of legislative and policy knowledge at the expense of equally valuable wider contextual organisational knowledge, (i.e. findings from Serious Case Reviews, practice guidance, audits, government reports, analysis of Trust activity and internal reviews of practice); findings echoed elsewhere by Cha *et al*., (2006) and Osmond and O'Connor (2006). This broader contextual organisational knowledge is recognised by Trevithick (2008 and 2011) as a valid and effective form of organisational knowledge that practitioners should use to make informed, reflective, balanced and consistent decisions. Having this type of knowledge may have helped inform the permanency plan, thus producing more thoughtfully constructed decisions, in which reunification was at the very least considered. The finding possibly suggests that the sample privileged more readily accessible and immediate sources of knowledge over other valid but somewhat less accessible organisational knowledge, possibly impeding their capacity to make more knowledgeable decisions.

Clearly this finding is significant if one considers the impact of removing a child and placing them in out of home care, without first having significant and eclectic organisational knowledge upon which to inform that decision. Consequently, the use of policy and procedures whilst corporately precise, may not unequivocally serve to best protect Claire's permanency long term, without bearing in mind all the available organisational knowledge available. It may therefore be conceivable to argue that there is a possible relationship between an over dependence on organisational knowledge and the more restrictive interventionist approach and style to making decisions identified here and elsewhere e.g. Drury-Hudson (1997) and Rosen (1994). Lane *et al.,* (2016) also posit convincingly that modern social work organisations, fearful of making mistakes and driven by proscriptive rules in an attempt to *get it right*, imbue their staff principally with knowledge of the legislation, policy and procedures. The organisational hope is that staff avoid making the mistakes of the past by closely following *the rules*. Thus, the emphasis on learning and development in the modern world of practice leans towards legalistic technical knowledge; so much so that it has now become deep-rooted in their knowledge psyche Munro (2010), producing what Lane *et al.,* (2016: 2) describe as "practitioners addicted to compliance".

The use of practitioner knowledge was equal only to organisational knowledge in its use. This type of knowledge, recognised as more naturalistic and having real-world validity in the field (Cook, 2016; McDermott *at al.,* 2017), was used by all seventeen participants to make their permanency decision. In this the practitioner intuitively knows (Dreyfus and Dreyfus, 1986) or is unconsciously aware of what to do (Osmond, 2005). In time limited, uncertain situations where rationality is bounded by the cognitive limitations of the decision maker (Gigerenzer and Gaissmaier, 2011) practitioners make what Taylor (2017a) and O'Sullivan (2011) call *satisficing* or *good enough* decisions. In this way the decision could be said to be the correct one from the practitioner's point of view, established as it were on the knowledge gained from making decisions in analogous cases, where interventions were either positive or not. Nonetheless, it is acknowledged by writers such as Burton (2009), Helm (2010), Collins and Daly, (2011) Holland (2011), and Spratt *et al.,* (2015), that such thinking comprises various biases and heuristics, which are outlined in table 10 and taken from Taylor (2006).

Table 10. Heuristics and biases (adapted from Taylor, (2017).

Bias type	Heuristic type.
Adjustment bias	Judgements that are influenced by initial information that shapes our gathering and perspective on subsequent information. New information is selectively processed to support judgements already made may be influenced
Compression bias	A tendency to overestimate the likelihood of rare but serious undesirable events and underestimate the frequency of common undesirable events.
Confirmation bias	A tendency to search for and interpret information consistent with one's prior beliefs, knowledge and experience.
Credibility bias	We may be more inclined to accept a statement for someone we like.
Framing	The wording used to describe a situation may influence the way in which a decision is perceived, and this may influence the judgement made.
Hindsight bias	A tendency to view past events as being more predictable than they seemed to people at the time.
Omission bias	The preference for harm caused by omissions over equal or lesser harm caused by acts.
Optimism bias	An incorrect expectation of positive outcomes.
Prejudice	Making decisions based on unconscious or conscious stereotyping.
Repetition bias	A willingness to believe what we have been told most often and by the greatest number of different sources.

These biases can potentially predispose the decision maker to disproportionally favour one option over another, irrespective of the decision maker's expertise (Fiske *et al.*, 2007; Zeijlmans *et al*., 2019). So, despite the fact that Claire is undoubtedly safeguarded, it is possible to hypothesise that the decision taken could potentially have been biased and there does appear to be possible evidence to suggest that it was.

Take for example the decision made by fifteen participants to rule Aunt Mary out. As identified earlier, practitioners were already imbued with organisational knowledge, possibly predisposing them to favour a more interventionist approach. It is worth considering the possibility therefore that practitioners, already possibly predisposed to removal, are now in search of explanations to confirm their decision to rule Mary out. Without subsidiary knowledge of objective research, neutral theory or confirmable evidence to support this decision, the decision possibly remains an unsubstantiated subjective opinion. Recognised by Helm (2011), the absence of this type of knowledge impedes objectivity and the type of critical thinking that is required to make analytical assessments and plan care systematically, impartially and neutrally. Considering this is important as it possibly leaves the practitioner vulnerable to the social, political and economic influences of the day, which in Anglo-Saxon oriented countries are rules based and interventionist in orientation (Spratt, 2001; Beckett, 2007; Munro, 2011; Davies and Duckett, 2016). Therefore, routinely using this more technical, legalistic type of knowledge, especially if it is a principal form of knowledge used, may inexorably lead to privileging an increasingly interventionist culture. This culture can then become part of the history and narrative of practitioners and organisations, becoming increasingly embedded and routinized in their practice narrative. Void therefore of the critical thinking that Helm (2011) refers to, practitioners may make increasingly risk averse decisions that are acculturated through repetition but do not meet the individual needs of service users. This has particular implications for the next generation of social workers entering the profession who may quickly assimilate decision making norms and values.

With regards to the use of theory, of the seventeen participants interviewed, only four used theory in any lucid manner and of those four, only one theory – the psychological theory of attachment – was used in a well-applied manner. This finding is somewhat in line with findings from Gordon *et al*., (2009) who found that social workers in their study also struggled to articulate or expand on different theories to inform practice. However, scholars such as Sheldon and Macdonald (2010),

Beckett and Horner (2016), Deacon *et al.*, (2017) and Hothersall (2018), strongly suggest that the well-informed social worker is one who appreciates other auxiliary theories and who can self-assuredly apply them to decision-making to help them understand and explain a phenomenon or set of phenomena. Such theories include sociological, social policy, political, organisational and philosophical, *as well* as psychological theory (Thompson, 2018) but these theories were absent.

Of added interest to the finding that psychological theory was privileged above all other theories is the fact that even when using attachment theory as the primary theory, its use did not lead to the same decision vis-à-vis the permanency plan. Citing Claire's need for attachment, three participants decided that adoption was best and one decided that foster care was best. Of the remaining thirteen none either cited, or applied theory unequivocally, acknowledging that they either did not know or were unaware of the applicable theory that would lend weight to their decision. The closest any of the remaining thirteen got to discussing theory was to purely mention the theoretical term 'attachment'. However, simply *mentioning* a theory is not the same as *using* a theory because if theory is to be valuable, it must be applied consciously, deliberately, objectively and with purpose (Beckett and Horner, 2016). Consequentially, it could be assumed that the decision of the remaining thirteen was in essence, *theoryless*, a term coined by Thompson (2018).

This is a significant finding from this study representing as it does seventy-five per cent of the sample not using theory to inform their decision. Theoryless practice can result in practitioners constructing their understanding of singular phenomena in practice situations on stereotypes and prejudiced conventions thus reconstructing oppressive and counterproductive outcomes through possibly misguided interventions (Deacon and Macdonald, 2017). This contention perhaps adds strength to my previous point that it is conceivable to imagine that Claire did not receive an objective, wholly evidence informed/based decision regarding her welfare, given the almost universal privileging of the interventionist option despite other options being available.

With regards to research knowledge, the participants in this study categorically stressed that they were using research to inform their decisions. The decision therefore appeared to have some evidentiary scientific basis, taking on a virtually indisputable demeanour. However, when exploring the particular research that was supposedly used and why, participants' responses became increasingly opaque: a finding recognised elsewhere in the literature (e.g. Joubert, 2006; Wade and Newman, 2007; Sanders and Munford, 2008; Beddoe, 2011). The incongruity of

asserting that research *was* used but not being able to specify the *what, why* and *how* it was used, possibly contributes to a situation in which the participant was in danger of using what Sheldon and Macdonald (2010) describe as knowledge clichés.

This incongruity resonates with Morrison's (2006) conception of the authoritative and the authoritarian social worker. The authoritative social worker is one who demonstrably uses research astutely and considerately, employing it professionally to make evidence based/informed decisions. Decisions made in such fashion are as a consequence, more reliable, impartial and are ultimately based on the principles of social justice and social work values (Dolgoff *et al.*, 2012). Conversely, the authoritarian social worker will "pretend to be scientific while being pseudoscientific (to include the trappings of science without the substance). 'The "trust me" group' of pseudoscientists… 'rely on authoritarian (e.g. consensus, status) rather than evidentiary criteria' to make decisions" (Gambrill, 2001: 166).

Being disengaged from the research to make decisions is a finding also replicated in other research (e.g. McDermott and Henderson, 2017). However, what is different in this study is that unlike the participants in McDermott and Henderson's study who freely acknowledged that they avoided using research due to their lack of confidence, the participants in this study initially and confidently stated they were using research. However, it was only when I explored the issue of research further that I became increasingly aware that research was not in fact being used as the participants said it was. In fact, we reached the point further into the semi-structured interview where participants began to acknowledge that in reality they rarely used research, found it too difficult to decipher, felt they lacked research skills, did not have managerial support to use research and lacked the time to search for articles.

To the untutored and inexperienced, the decision, ostensibly based on *the* research, may be accepted as a categorical fact and go unchallenged in decision making fora. Children and families already disadvantaged by power and status structures within decision making fora (Winter, 2010; 2015) and lacking what Bourdieu (1992; 2005) calls cultural capital, may therefore acquiesce and defer to *professionals* who are using *the* research to support their views. Of additional significance here is the fact that *the research* that was apparently cited to support decisions, generally favoured the more interventionist options. Discounting rehabilitation is also a decision but no attempt was even made to suggest that *research* supported the decision not to rehabilitate Claire home. So even

though the participants couldn't consciously recall specific research to support their interventionist decisions, they unconsciously imagined and quite confidentially stated that whatever research existed, supported their interventionist view. So, if this decision, apparently grounded on *the* research went unchallenged by Claire and her parents, it would have left her without much chance of ever being rehabilitated home.

Based on this finding it is not inconceivable to argue that Claire's permanency decision was affected by what Davidson-Arad and Benbenishty (2010), Enosh and Bayer-Topilsky (2015) and Spratt *et al.,* (2015) call confirmation bias. Here decision makers seek out confirmatory research to support their own view, which as I have already suggested favoured the more risk averse protectionist stance. As a result, the possibility that the decisions taken by these participants was made on the basis of pseudoscientific research, confirming the more protectionist predilections of the participants, cannot be ruled out.

Pawson *et al.,* (2003) recognise that service user knowledge is a key source of knowledge and should therefore be harnessed, enabling practitioners to make fully rounded decisions. This idea is supported by others (e.g. Duffy, 2008; Collins, 2010; Dill *et al.*, 2016; Beresford and Croft, 2016; Duffy and Duffy *et al.*, 2017) who feel that service users possess vital knowledge gained from first-hand usage of, and reflection on, interventions. In this study, it appeared at first that all the participants were wholly engaged and unswerving in their commitment to ensuring Claire's voice was heard in their decisions. However, all the sample very quickly moved to stress the challenges of balancing listening to what Claire wanted and safeguarding her. This resulted in a curious but subtle volte-face, where the sample accentuated the need to safeguard Claire as their overriding priority, seemingly resulting in a diminution of Claire's wishes to return home.

To this end, whilst the sample were wedded to the principle of listening to Claire's voice, this dedication did not appear to translate into practice reality, which resonates with similar findings by Diaz and colleagues (2019a) in their study of participation in Care Reviews. As with this study, Diaz and colleagues similarly found a difference between the legislative mandate for participation, policy and guidance and the actual reality of participation. What appeared to happen in this study, was that despite affirming their belief in participation, that the sample went on to make the decision *for* Claire instead of *with* her, and justified this on the grounds that it was in her own best interests. This disjunction between what the participants said they believe they do, and what they actually

do, also resonates with the early pioneering work of Argyris and Schon (1974). These scholars developed a learning theory for action based on the distinction between *espoused theory* and *theory-in-use*. They define espoused theory as the world view and values people believe their behaviour is based on, and theory-in-use, as the world view and values implied by their behaviour, or the maps they use to take action. Here, the difference between the two theories, translates into the workers stating that they believe in children's participation, but the practice reality is different.

I'm not suggesting that the decision would or should have been different after consultation, but according to Thomas (2007) and Lundy (2007), from a legal and moral point of view it is imperative that children are at least given the opportunity to be listened to. It is undeniably challenging working with vulnerable children in capricious and often unpredictable worlds to get it right every time (Barnes, 2012; McCafferty, 2017, Pert, 2017). As such, this *adult knows best* paternalistic approach, recognised by Featherstone *et al.,* (2014) and possibly replicated in this study, is perhaps somewhat understandable. Yet it also cannot be denied that the approach of the participants runs contrary to the mandated principle and practice of listening to the voice of the child as a valuable source of knowledge for social workers.

Therefore, a finding of this research is that the voice of Claire became subsumed within an adult centric child protection ethos, as the urge to protect overrode the obligation to listen. Similar findings are echoed elsewhere in the literature (e.g. Goodyer, 2016; 2011 and Mateos *et al.,* 2017), leading Balsells *et al.,* (2017) and Diaz, (2019b) to conclude that the practice reality of the child protection system is that it leans towards a lack of attention to the voice of children in decision-making processes and fora.

Implications and recommendations.

A possible implication arising from this research, is that children and young people subject to permanency decisions, are not being afforded the benefit of fully informed decisions that are based on all the knowledge available to social workers. Furthermore, there is a potential connection between privileging organisational and practice knowledge over other sources of knowledge and making excessively protectionist decisions. Participants also acknowledged that they were not aware of or were consciously using research or theory to support their decisions. This could lead staff to making decisions uncritically and mechanistically based on the most easily retrieved and

understood knowledge whilst ignoring alternative knowledge that may lead to more critically informed decisions.

As such this research makes six recommendations:

1. That a model of critical thinking is embedded into the professional supervision of social workers (e.g. Osmo and Landau's (2001) model of explicit argumentation), in an effort to help both supervisors and social workers excavate the explicit knowledge used to make decisions.
2. That practitioners make greater use of reflective tools such as reflective diaries, process records and critical incident analyses which Cree and MacAulay (2000) have already found helped practitioners in identifying underpinning knowledge, skills and values. This would hopefully lead to practitioners becoming more evidence based in their thinking and practice which Hood (2016) sees as a critical component of competent practice.
3. That University providers reflect more explicitly all five sources of knowledge at qualifying and post qualifying stage, thus ensuring all students and practitioners are accustomed to making fully informed decisions.
4. That in-service training within HSC Trusts must accurately reflect the particular micro training needs of staff. These nuanced micro needs must also be reflected in any DoH attempts to script future learning and development strategies.
5. That academic staff provide research mentoring to practitioners to help expand their research skills; an initiative already successfully done by others (e.g. Bawden and MacDermott, 2012; Lunt *et al.*, 2012).
6. That what Ceatha (2018) calls Communities of Practice (CoP) be established in Trusts. CoP involve practitioners coming together to share learning, thus maximising learning in a peer environment and making best use of organisational resources and time.

Conclusion.

Judgements and decisions regarding permanency are of critical importance in child welfare (Shlonsky and Saini, 2011) as they undoubtedly impact on the lives of children and families across their lifespan (López *et al.*, 2015). Decisions in these circumstances therefore need to be of the highest quality, fully justified (Gilbert *et al.*, 2011) and knowledge based. This research has added to the body of knowledge that helps improve social work knowledge acquisition and utilisation

when making permanency decisions, helping improve the quality, consistency and defensibility of those decisions.

Appendix 1

Case study of a decision-making scenario in permanency.

Dr Paul McCafferty

Ulster University

Case Study: Claire

You are the social worker for Claire, a 5-year-old girl that you placed with foster carers unknown to Claire 7 months previously. You admitted Claire to foster care following persistent high levels of severe neglect and parental alcohol misuse over the previous three years. At the time Claire's parents, Dave and Anne refused to recognise that Claire was being neglected and they failed to engage positively with your concerns despite several repeated attempts at engagement.

Currently you feel that the foster placement is going reasonably well and the relationship with the foster carers whilst initially difficult has settled. Claire appears content and she has stated on several occasions that she is 'happy.' Claire is beginning to grow closer to the foster carers, referring to them occasionally as mum and dad. The foster carers in turn state that they 'are really very fond of Claire' and you can see a growing bond between them.

However, you are concerned about reports from school regarding ongoing worries school have about some of Claire's behaviour which the foster carers are finding difficult to cope with. Claire has had several periods of detention due to physically lashing out at other pupils and she is regularly verbally abusive to her teacher. The school also report that Claire appears to have become 'anxious and sad lately' and she has been found crying at home-time stating that she misses her family. The foster carers are committed to fostering Claire long term with support from social services but you are conscious that they do not want to adopt her. They don't feel they can make such a commitment at this time given their age (they are in their late 50s), have insecure jobs and experience sporadic health problems.

Whilst you are glad that the placement is currently meeting most of Claire's needs you are conscious about Claire's needs long term given that the foster carers are not considering adopting Claire. You also worry about the escalating behaviour at school which you think may be symptomatic, not only of Claire's abuse at home, but of Claire's deeper distress at being separated from her parents and wider family. You also worry about the foster carer's ability to cope long term with this behaviour; although

the foster carers themselves have repeatedly said they want to continue to foster Claire despite current difficulties managing Claire's behaviour.

Back home, to their credit, since Claire's admission to foster care, Dave and Anne, who are in their mid-30s, have been making some attempts at addressing issues identified by you as concerning. They have engaged with the local Alcohol Treatment Unit. They have attended 4 out of 10 parenting classes at the family center and the social worker there reports that Anne and Dave are beginning to show some signs of insight into their lifestyle and are latterly recognising how their parenting 'may have' negatively impacted on Claire. However, whilst you feel this is somewhat positive, you also share some of the concerns that the family center worker has regarding Dave and Anne's fluctuation between acceptance and denial which you feel is hampering their progress. The family center worker also states that she retains some reservations about Anne and Dave's ability to make the required longer-term changes and that a lot more work is required 'if' Dave and Anne are to make progress.

Your concerns appear to be confirmed when you get a report from the duty team about an argument between Anne and Dave that resulted in Anne visiting A&E with bruising to her face. When you make an unannounced visit, you find the house in a state of disarray with empty bottles of beer and spirits on the table. Dave and Anne say this was a one off, that they are working hard at the family center and are trying to make the changes required of them and are committed to trying to get Claire back. You acknowledge that Dave and Anne have made some positive changes, but you worry that these changes are neither sufficient nor sustainable over the longer-term limiting Dave and Anne's ability to meet Claire's long-term needs. You are also conscious however that Claire, in individual work with you, has said that she wishes to return home to her parents and would like contact to be increased despite the fact that contact has been sporadic.

Claire's maternal Aunt Mary also features strongly in Claire's life and has had contact with Claire both by phone and several visits have taken place. Aunt Mary, who is a single parent, is prepared to care for Claire on a long-term kinship basis. Claire is very close to her Aunt who has remained a positive and consistent feature in her life. Aunt Mary was willing to look after Claire at the time she was admitted to foster care, but was unable to do so due to experiencing her third bout of depression in ten years that left her struggling to cope with her own two children, a boy aged 10 – who suffers from autism and has a disability social worker involved with him and a girl aged 7. Mary is presently doing well with the support of the mental health team who state that Mary is 'currently very stable but requires long term medication to control her depressive episodes.' For her part, Mary continues to express a strong desire

to look after Claire on a long-term basis, re-affirming this to you at a recent meeting during which Mary expressed the wish to be assessed as a kinship carer. You acknowledge that Mary is a caring relative but you worry that placing Claire with Mary may cause Mary undue stress that could trigger another depressive episode. This would have negative implications not only for Mary's own two children (during the last depressive episode Mary's children had to live temporarily with their father who lives nearby) but also for Claire should she be placed there.

You are now required to make a recommendation regarding the long-term permanency arrangements for Claire. Your options are,

1. Long term foster care
2. Kinship care
3. Adoption
4. Residential care
5. Return to parents

What recommendation would you make and what knowledge would you use to make this decision?

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