

**Managing the commitment to protect children
from maltreatment: the case of child contact
centres in England.**

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Abstract

BACKGROUND: According to the guidance to the Children Act (1989 and 2004), ‘Working Together to Safeguard Children’ (2010; 2013), all organisations that work with children have a responsibility to protect children from maltreatment. However, previous research on child contact centres raises questions about how well this service is meeting the responsibility. This study seeks to explore in more detail how well contact centres manage their responsibility to protect children and what factors may influence them in this task. Research in the area of safety management has shown the limits of top-down guidance in achieving the desired level of practice. It provides a systems framework for studying how guidance is being implemented on the ground, including how it is interpreted by different actors in the system, and how they interact to produce the observed level of practice.

METHODS: Mixed methods were used to undertake a systems approach to studying the management of child protection responsibilities in contact centres. This approach aims to provide an in-depth understanding of what is happening in child contact centres, in terms of child protection, and why.

FINDINGS: Despite the introduction of reforms which aimed to improve safety in child contact centres, problematic child protection practice has persisted. It is argued that this is because common weaknesses in voluntary sector provision of human services have not been fully addressed. These weaknesses are insufficient funding, inadequate professionalization and narrow organisational focus. The findings suggest that these issues informed how actors in the system experienced and understood the practice of protecting children.

The findings suggest that the safety of children in contact centres is also affected by the persistence of problematic inter-professional working. It is argued that the tools which have been introduced to address this have not been effective because they do not in themselves address the difficulties actors face in working together. There remains a lack of capacity amongst some centres and referrers who do not necessarily

have the skills required to safely make and accept referrals. In addition, actors in the system experience role ambiguity.

Finally, the thesis suggests that although organisations that work with children are encouraged to take account of children's wishes and feelings in order to protect them, workers in child contact centres engaged with children in diverse ways. A typology of engagement, which was developed from the data, suggests that engagement can be conceptualised as ranging from 'coercive' to 'limited' to 'meaningful'. The findings suggest that workers' engagement with children was influenced not just by factors within contact centres but by individuals' personal values and the wider family justice system, which contact centres operate in.

IMPLICATIONS: This research suggests that in the empirical context of child contact centres, the 'Working Together' guidance to organisations working with children does not in itself produce predictable effects which will fulfil the guidance aims. Rather, when the guidance combines with local factors it produces unexpected effects. The meaning that actors attributed to their actions was not static. Instead, socially constructed, local rationalities influenced how actors understood and experienced the process of protecting children. The findings contribute to the growing body of research which argues that policy makers need to focus, not simply on telling organisations what do, but on enabling them to do it. In addition, the findings contribute to the systems approach literature, which suggests that safety needs to be understood within the socio-technical system that actors inhabit.

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List of Acronyms

ABH	Assault Occasioning Actual Bodily Harm
ADCS	Association of Directors of Children's Services
ADR	Alternative Dispute Resolution
DV	Domestic Violence
DVIP	Domestic Violence Intervention Programme
FHDRA	First Hearing and Dispute Resolution Appointment
FJR	Family Justice Review
FLA	Free Legal Aid
LA	Local Authority
MoJ	Ministry of Justice
NACCC	National Association of Child Contact Centres
NVQ	National Vocational Qualification
PIP	Parenting Information Programme
SCR	Serious Case Review

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Chapter 1: Introduction

Child maltreatment is recognised as a major public-health problem in high-income countries (Butchart, Phinney Harvey, Mian, Färniss, & Kahane, 2006; Gilbert, Widom, et al., 2009). Child abuse and neglect contribute substantially to child mortality and morbidity and can have long-lasting effects on mental health, drug and alcohol misuse, risky sexual behaviour, obesity, and criminal behaviour (Gilbert, Widom, et al., 2009). Research suggests that official rates for substantiated child maltreatment indicate less than a tenth of the burden. For this reason, reliable measurement of the frequency and severity of child maltreatment is not straightforward (Gilbert, Widom, et al., 2009). This empirical limitation aside, some indication of the burden of maltreatment is provided by Gilbert and colleagues' (2009) seminal review of the international literature in high-income countries. They estimated that every year around 4-16% of children are physically abused and 10% are neglected or psychologically abused. Additionally, during childhood, between 15% and 30% of children are exposed to sexual abuse (Gilbert, Widom, et al., 2009, p. 68). In keeping with these findings, a recent national prevalence survey in England suggested that 4% of under 18s had one or more experiences of physical, sexual or emotional abuse, or neglect by a parent or guardian in the past year and that 14% of children and young people had one or more experiences of physical violence, sexual abuse, emotional abuse or neglect by a parent or guardian at some point during their childhood (Radford, 2012).

These figures emphasise the need for systems to protect children from maltreatment. In England, 'heavy responsibility has rightly been placed' (Laming, 2009, p. 2) on key statutory services to achieve this but statutory services should not work alone in this task. Indeed, the guidance to the Children Act (1989 and 2004), 'Working Together to Safeguard Children' (WT) (2010), suggests that all organisations that provide services for children, parents or families or work with children have a 'commitment to safeguard and promote the welfare of children and young people' (HM Government, 2010, p. 40). It is important to note the WT guidance is not legally binding since it is not contained within statute. Nonetheless it 'represents a standard of good practice' (HM Government, 2010, p. 26).

The 2010 guidance is referred to here because the fieldwork for this study was undertaken prior to the publication of the updated guidance. However, the responsibility to protect is reiterated in the current, 2013 WT guidance:

‘Everyone who works with children - including teachers, GPs, nurses, midwives, health visitors, early years professionals, youth workers, police, Accident and Emergency staff, paediatricians, voluntary and community workers and social workers - has a responsibility for keeping them safe’

(HM Government, 2013, p. 8).

This research is particularly concerned with the sub-category of the safeguarding responsibility that is child protection:

‘the process of protecting individual children identified as either suffering, or likely to suffer, significant harm¹ as a result of abuse or neglect’

(HM Government, 2010, p. 27).

The study examines child protection practice in one type of non-statutory organisation that works with children: child contact centres. This service facilitates contact between children and parents who do not live together in a variety of circumstances, including where there is a child protection concern, where parents are in conflict and do not wish to meet, and in cases where a parent simply lacks a child-friendly, low cost/no cost place to spend time with their child (Kroll, 2000). The service is predominately used for private law cases, where parents have separated and the child lives with one parent and has contact with the other (Aris, Harrison, & Humphreys, 2002).

It is likely that contact centres are dealing with a cohort of children who are at increased risk of having suffered or are at risk of suffering maltreatment. An indication of the vulnerability of children in this service can be inferred from the fact

¹ The Children Act (1989) does not provide a definition of significant harm and ‘there are no absolute criteria on which to rely when judging what constitutes significant harm.’ (HM Government, 2010, p. 36).

that this service receives referrals from the family law courts. Aris and colleagues' survey of contact centres indicated that 62% of referrals to centres came via a recommendation by the court and a further 27% occurred through solicitors (Humphreys & Harrison, 2003c, p. 420). Similarly, Furniss' study suggested that 50% of referrals came from a court order and 80% of families had been to court (Furniss, 2000, p. 263).

Research suggests that only around 10% of all parents deciding contact arrangements after separation involve the courts (Peacey & Hunt, 2008). Around half of parents experiencing serious welfare concerns (child abuse or neglect, domestic violence, substance abuse, mental illness) do not go to court (Peacey & Hunt, 2009), suggesting that child welfare issues are not confined to litigated cases. However, the evidence suggests that cases that do go to court involve elevated rates of serious child welfare issues (Cassidy & Davey, 2011a; Hunt & MacLeod, 2008; Perry & Rainey, 2007; Trinder, Connolly, Kellett, Notley, & Swift, 2006). Indeed, Hunt and MacLeod (2008:9) found that 54% of their sample of 308 contact cases across 11 purposefully selected courts, involved allegations or concerns raised by the resident parent about 'serious welfare issues' i.e. DV (34%); child abuse or neglect (23%); drug abuse (20%); alcohol abuse (21%); mental illness (13%); parenting capacity affected by learning disability (1%) or fear of abduction (15%), including removal from the UK (8%). An additional 9% of cases involved a 'serious welfare issue' in the past. Similarly, Cassidy and Davey's (2011a) analysis of 402 private family law cases which closed in 2009 found that 53% contained allegations of domestic abuse or concerns about abduction or harm to children. Perry and Rainey (2007, p. 40) also reported that violence was alleged in half of their sample of 434 court records. Further substantiation of the vulnerability of the cohort of children in contact centres can be derived from Aris and colleagues' (2002) study, which found that while 76% of the 21 children who were interviewed said it was 'good' to see their father, two thirds said they wanted their mother 'close by' and one third said they did not feel safe or that they were unsure about their safety (Aris et al., 2002, pp. 101-104).

The National Association of Child Contact Centres (NACCC) National Standards also state that, 'significant numbers of families using child contact centres have experienced varying levels of domestic violence' (NACCC, 2003a, p. 11; 2003b, p.

7). This is also indicated by previous research (Aris et al., 2002; Thiara & Gill, 2012). Indeed, 85% of 70 resident mothers surveyed in Aris and colleagues' (2002) research reported that they were using a child contact centre due to violence or abuse from their ex-partner and 64% reported fears of or actual abduction (Aris et al., 2002, pp. 62-63). Twenty-four per cent reported child abuse and 17% said their ex-partners had convictions for violence (Humphreys & Harrison, 2003c, p. 421). In keeping with the Home Office, domestic violence (DV) is defined in this research as:

'Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.'

(Home Office, 2005)²

DV presents a child protection concern since witnessing the abuse of a parent can be considered a form of emotional abuse (Holt, Buckley, & Whelan, 2008; Jaffe, Lemon, & Poisson, 2003) and domestic abuse is correlated with physical and sexual child abuse (Appel & Holden, 1998; Buckley, Holt, & Whelan, 2007; Edleson, 1999b; Hamby, Finkelhor, Turner, & Ormrod, 2010; Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008; Hester, 2006; Holt et al., 2008; Kellogg & Menard, 2003; Osofsky, 2003; Radford et al., 2011).

Given the vulnerability of the population of children within the service, it can be suggested that contact centres play an important child protection role for the children using the service. However, previous research suggests that there may be problems in child protection practice in this service (Aris et al., 2002; Furniss, 2000; Thiara & Gill, 2012). Reforms have been introduced to address this but recent research (Thiara & Gill, 2012) suggests that the desired results may not have been achieved.

² In February 2013 the government up-dated the definition to capture coercive control and include young people aged 16 and 17. However, the 2005 definition is cited here as it was in place at the time of the field work. The new definition is as follows: *"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, emotional."* (Home Office, 2013)

The task of improving child protection practice in organisations that work with children can, drawing on safety management literature (Dekker, 2005; Rasmussen, Nixon, & Warner, 1990; Reason, 1990; Woods, Johannesen, Cook, & Sarter, 1994), be conceptualized as that of increasing safety and reducing error in a human system. This conceptualization has previously been adopted in relation to practice in the statutory child protection system, not least in the recent Munro Review (Munro, 2011). The state's articulation that organisations that work with children have a 'commitment' (HM Government, 2010, p. 40) to protect them from maltreatment focuses on telling organisations what they should do. However, research in the area of safety management has shown the limits of top-down guidance in achieving the desired level of practice (Chapman, 2004; Fish, Munro, & Bairstow, 2009; Munro, 2005b; Perrow, 1984; Dekker, 2007b; Rasmussen et al., 1990; Reason, 1997, 2000; Woods & Hollnagel, 2006). Indeed, the 'commitment' which has been articulated may underestimate the importance of the context in which the guidance is implemented. Yet if context is important but remains unaddressed, some organisations that work with children may not be able to implement their 'commitment' and children may be placed at risk of harm.

This study draws on work in safety management engineering to explore two research questions relevant to understanding child protection practice in child contact centres: firstly, 'how well do child contact centres, as organisations that work with children, manage their commitment to protect children from maltreatment?' and secondly, 'what factors seem to influence centres in managing this commitment?'. In keeping with the safety management literature, the study adopts a systems approach to explore these questions. This approach emphasizes the importance of achieving an in-depth understanding of practice on the ground. It further asserts that problematic practice should be viewed as a symptom (rather than a cause) of failure within the wider system. It therefore aims to achieve a thorough understanding of the interaction of factors that may influence practice.

1.1 Definitions of key terms

Abuse and neglect are forms of child maltreatment. The ‘Working Together’ guidance (2010) sets out that a child is abused or neglected where a person inflicts harm on them or where they fail to act to prevent harm. Abuse can take place in the family or in an institutional or community setting and the child may or may not know the abuser (HM Government, 2010, pp. 37-38). The guidance sets out the specific aspects of child maltreatment. These are defined as set out in Figure 1.1 below.

Figure 1: Definitions of specific aspects of child maltreatment
<p>Physical abuse</p> <p>Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.</p> <p>Emotional abuse</p> <p>Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or ‘making fun’ of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child’s developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyberbullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of</p>

maltreatment of a child, though it may occur alone.

Sexual abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact,

including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- Protect a child from physical and emotional harm or danger;
- Ensure adequate supervision (including the use of inadequate care-givers); or
- Ensure access to appropriate medical care or treatment.
- It may also include neglect of, or unresponsiveness to, a child's basic emotional needs

(HM Government, 2010, pp. 37-39).

1.2 The empirical context: child contact centres

Child contact centres facilitate contact between children and parents who do not live together. They may be used where there is a concern about the safety of the child if alone with the parent, in cases where parents are engaged in entrenched conflict and do not wish to meet and in cases where a parent simply requires a cost-free child-friendly place to have contact with their child (Kroll, 2000). While statutory services provide contact facilities for children in care³, there is no statutory provision for private law cases, in which parents have separated and the child lives with one of his/her parents and has contact with the other. Contact centres were set up in the mid-1980's by individuals in the voluntary sector to address this gap in service provision (Aris et al., 2002). Although contact centres are autonomous organisations, the vast majority of service providers in England, Wales, Northern Ireland and the Channel Islands are affiliated to the National Association of Child Contact centres (NACCC).⁴ In November 2010 there were 308 NACCC contact centres in England.⁵

Contact centres provide two distinct services, termed 'supported' and 'supervised' contact. It is important to differentiate between these services and to understand the concerns which prompted the establishment of each. The first child contact centres were set up by a range of voluntary agencies including churches, WRVS and the major children's charities. They were set up in response to concern that rising levels of parental separation were leaving many children without contact with their non-resident parent. This was seen as potentially detrimental to children (Aris et al., 2002). According to the Chief Executive of NACCC, contact centres primary concern was the 'emotional harm' (Halliday, 1997, p. 55) that losing contact could cause to children. This concern was one generally emanating from popular discourse at this time. Research from the United States had in the 1950's and 1960's constructed the mother as vital to the child's well-being. From the 1970's this literature began to

³ Under Part III Section 23ZA of the Children Act, 1989

⁴ Personal communication with NACCC, November 2010

⁵ Author's analysis of the NACCC November 2010 data. These data and analysis of it is discussed further Chapter 3 (Methodology).

evidence the potential detriment to children which may be caused through lack of contact with their fathers after divorce (Smart, 1991).

The early founders conceived a role for contact centres where parents might be ‘put off’ contact due to problems of finding somewhere appropriate to take the child or the cost of entertaining them. The ‘obvious answer to this dilemma’, as the founders saw it, was to provide, ‘a free service offering warm, toy-filled rooms with soft drinks and sweets on sale’ (Halliday, 1997, p. 56). Halliday (1997) also notes that centres aimed to make contact ‘less stressful’ for the child by reducing conflict between parents through ‘handovers’: a service offered by all contact centres which allows parents to exchange the child without meeting each other (Halliday, 1997, p. 56)

The first contact centres therefore only provided, what has been termed ‘supported’ contact services and most contact centres in England still only provide this service. According to the NACCC Definitions of Levels of Contact (p.1), in supported contact services:

‘Staff and volunteers are available for assistance but there is no close observation, monitoring or evaluation of individual contacts/conversations. Several families are usually together in one or a number of rooms.’

In supported services workers do not provide reports to referrers about contact sessions (unless there is a concern for the safety of the child) and contact usually takes place once a week on the weekend in community venues such as church halls or children’s centres. The service is staffed primarily by volunteers (Aris et al., 2002).

When they were established, contact centres were not aiming to deal with cases involving child protection concerns which would require one worker/one family supervision; they did not have the ‘intention, training or resources’ to provide this (Halliday, 1997, p. 53). Indeed the NACCC Definitions of Levels of Contact (p.1) suggest that supported services are only suitable for cases where, *‘no significant risk to the child or those around the child, unmanageable by the centre, has been identified during an intake procedure’*. The Children and Family Court Advisory and

Support Service (Cafcass)⁶ is more explicit about the appropriate level of risk in this service, stating that, '*supported contact centres are not suitable for any cases involving risk to children or adults...they should only be used where safe and beneficial contact for the child can clearly take place*' (Cafcass, no date -b)

Nonetheless there is some evidence that even early contact centres were facilitating cases involving child protection concerns. Halliday (1997) states that centres take on cases where, 'violence, harassment and criminal damage' (p.54) accompany handovers when parents meet, as well as cases where allegations of abuse are under investigation and cases of proven child abuse where the child is being regularly monitored by social services. Therefore, although contact centres were set up with a focus on the benefits of contact rather than the need for protection, there is evidence that from the start they were dealing with issues that indicate a child maltreatment risk.

In recognition of the need for a contact service to provide supervision in cases where there is a child protection concern, what have been termed, 'supervised' contact services were established (Aris et al., 2002). According to the NACCC Definitions of Levels of Contact, supervised contact '*should be used when it has been determined that a child has suffered or is at risk of suffering harm during contact*'. In supervised contact there is '*individual supervision of contact with the supervisor in constant sight and sound of the child*'. On request, the service can provide written reports to referrers. Previous research indicated that supervised services are more likely than supported services to have paid staff, 'some of whom may be qualified in social work or allied professions, supplemented by the involvement of volunteers' (Aris et al., 2002, p. 18). However, there may not be enough supervised provision to meet need (Aris et al., 2002; Thiara & Gill, 2012; Trinder et al., 2006).

⁶ Cafcass is a non-departmental public body. The role of Cafcass is to safeguard and promote the welfare of children, give advice to the family courts, make provision for children to be represented and to provide information, advice and support to children and their families (www.cafcass.gov.uk/about-cafcass.aspx)

Child contact centres remain predominantly voluntary sector organisations. In November 2010 89% of child contact centres in England, Wales, Northern Ireland and the Channel Islands were voluntary sector organisations; 9% were commercial organisations.⁷ However, the service's institutional position is complicated. Despite their autonomy from it, child contact centres have been described as 'integral to the better working' of the family justice system⁸. Families can be referred to centres via the courts and by a Cafcass Officer.⁹ Where a case is negotiated through solicitors, the solicitors alone can make the referral. Local authority social workers may also refer cases. This may happen in private law cases where the child has a child protection plan although he/she lives with one parent. Families may 'self-refer', although not all centres allow this. The institutional position of contact centres is further complicated by funding arrangements. Although situated outside of the public sector, contact centres can receive funding from Cafcass: NACCC accredited supported centres can receive a Cafcass grant of £3000 per year and accredited supervised services can be commissioned on a procurement basis (NACCC, 2011, p. 33). Centres become accredited when NACCC decides that they meet the NACCC National Standards (NACCC, no date -a).

1.3 Child protection practice in child contact centres

The first research question for this thesis asks, 'how well do child contact centres manage their commitment to protect children from maltreatment?' The National Association of Child Contact Centres (NACCC) recognises the 'commitment' to protect children outlined in Working Together (2010). In NACCC's 'Guidelines for Safeguarding and Child Protection' (2010) it states that 'organisations working with and supporting children and young people have a duty to keep them safe' (NACCC,

⁷ Personal communication with NACCC, November 2010. Data were not available on England alone.

⁸ Specifically Sir Nicholas Wall commented, 'Supported Child Contact Centres are integral to the better working of the wider family justice system, offering a most valuable resource to courts dealing with difficult and often acrimonious family disputes over contact' (NACCC, 2010b, p. 1). In a similar vein the Children's Act Sub-Committee of the Lord Chancellors Department (2000) report concluded, 'Contact centres will need to be an integral part of the comprehensive court based service for children and families which we envisage CAF/CASS as being' (CASC, 2000, p. 46)

⁹ Cafcass Officers typically have social work qualifications (Trinder, Firth, & Jenks, 2010, p. 51).

2010, p. 28). However, previous research suggested problematic child protection practice in some child contact centres.

Research by Aris and colleagues (2002) focused on centres' handling of DV. This focus is justified by the literature on child contact and child protection. Research suggests that contact with a non-resident parent is not itself good for children; rather it is likely the opportunity which contact presents for *quality* parenting that matters to child outcomes (Amato & Gilbreth, 1999; Dunn, 2004; Humphreys & Kiraly, 2010; Marsiglio, Amato, Day, & Lamb, 2000). Where there is no pre-existing relationship or where the relationship is of poor quality, the benefits of contact can be negated (Hunt & Roberts, 2004). Where contact places the child at risk of maltreatment, the potential benefits of contact can be outweighed by the risks (Ellis, 2000; Lamb, 2007). There are issues other than DV which can present an increased risk of child maltreatment. These include parental drug or alcohol addiction (Barnard & McKeganey, 2004; D. Forrester, 2000; Kelleher, Chaffin, Hollenberg, & Fischer, 1994), mental health concerns (Cummings & Davies, 1994; Goodman & Brumley, 1990; Rutter & Quinton, 1984) and previous or suspected child maltreatment (Fluke, Yuan, & Edwards, 1999).

However, DV is also a salient child protection issue because research has demonstrated that DV does not always end when a relationship ends, indeed it may escalate at this point (Aris et al., 2002; Hester & Radford, 1996; Holt, 2011a; Humphreys & Thiara, 2002; Stanley, Miller, Foster, & Thomson, 2010; Thiara & Gill, 2012) and the evidence suggests a link between the presence of DV and the co-occurrence of physical and sexual child abuse (Appel & Holden, 1998; Buckley et al., 2007; Hamby et al., 2010; Herrenkohl et al., 2008; Hester, 2006; Holt et al., 2008; Kellogg & Menard, 2003; McGee, 2000; Osofsky, 2003; Radford et al., 2011). Indeed, a seminal review of the research indicated that between 30 and 66 per cent of children who suffer physical abuse are living with DV (Edleson, 1999b). Exposure to the abuse of a parent can also be considered a form of emotional abuse (Holt et al., 2008; Jaffe et al., 2003), with potentially serious negative implications for children's emotional and mental health (Holt et al., 2008; Jaffe et al., 2003; Mullender et al., 2002; Strauss, 1995; Wolfe, Zak, Wilson, & Jaffe, 1986). Research suggests that

infants, children and teenagers of any age can be affected (Cleaver, Unell, & Aldgate, 1999; Graham-Bermann & Levendosky, 2011; Holt et al., 2008; Jaffe et al., 2003).

Aris and colleagues' (2002) research was undertaken in two legal jurisdictions in the north and south of England. Two-hundred centres affiliated with NACCC were surveyed (43% response rate). Observations were undertaken in six contact centres (four supported-only services, two offering both services). In addition the research included interviews with the coordinators in all centres and the workers and management committee in 'some' centres (Humphreys & Harrison, 2003b, p. 243). The study also involved the following: a focus group with 20 Court Welfare Officers (now called Cafcass Officers) and interviews with 3 judges; a survey of Court Welfare Officers, solicitors, judges, Guardians ad Litem and social workers. Most respondents were Court Welfare Officers (27), only two solicitors and two judges responded (Aris et al., 2002, p. 27). Presumably no social workers or Guardians ad Litem responded. A survey of parents using the six contact centres (n=70) was undertaken in addition to interviews with 17 parents attending one of the six centres and an interview sheet/questionnaire was used with 20 children aged 5 to 13. Although five publications are referenced below (Aris et al., 2002; Harrison, 2006, 2008; Humphreys & Harrison, 2003b, 2003c), these all relate to the same research commissioned by the then Lord Chancellor's Department. The fieldwork for this study was carried out in 2000 (Humphreys & Harrison, 2003b, p. 242).

The authors found that even cases involving significant evidence of DV were being facilitated at supported services. This included cases where non-resident parents had convictions for violence, attempted murder, non-molestation and occupation orders as well as cases where the child had a child protection plan due to abuse (Aris, et al., 2002). Indeed, of the 70 resident mothers interviewed, 86% reported they were using the centre because they had experienced DV but only 25% of these were using a supervised service (Harrison, 2006, p. 144). The levels of DV were reported to exceed supported center's expectations and the original aims of this service (Aris et al., 2002, p. 37).

The terms 'supervised' and 'supported contact' were found to have undefined meaning. In terms of monitoring in supported contact, it was reported that in some supported centres, volunteers remained in an office outside of the contact room or were not always present in the room. In addition, outdoor play areas were not always observed (Aris et al., 2002, p. 93). Survey data suggested that 50% of coordinators of supervised services did not think that 'supervised contact' involved one to one supervision (Aris et al., 2002, p. 35). The survey further suggested that in the 16 centres identified as supervised or offering both services there were many weaknesses in practice: 44% did not interview children, mothers or fathers before contact to identify child protection issues; 38% did not have separate entrances which help adult victims of abuse avoid meeting perpetrators; 88% did not have video camera surveillance at the entrances; 44% did not screen on the referral forms for DV; and 50% did not screen at interview for DV; 25% did not implement a risk assessment when DV or child protection issues were identified (Aris et al., 2002, p. 43). It was reported that staggered arrival and departure times were used by some centres (offering both supervised and supported services) to prevent parents meeting but that only 57% of centres in the survey reported having separate entrances and exits. It was suggested that for this reason, it may have been difficult for staggered arrivals to be enforced (Aris et al., 2002, p. 44). Some mothers reported that they were followed by their ex-partners after contact (Aris et al., 2002, p. 98).

The research suggested that violent incidents, which were found to occur regularly in many supported centres, did not necessarily result in assertive action by workers (Humphreys & Harrison, 2003b). In addition it was reported that despite a lack of comprehensive risk and safety assessment centres placed pressure on resident parents to move on to less supervised settings (Humphreys & Harrison, 2003b). It was also found that coordinator's knowledge that a family had a history of DV was not always passed on to volunteers; it was sometimes 'lost', especially in centres with a high turnover of volunteers (Humphreys & Harrison, 2003b, p. 244). The research further suggested that few child contact centres had services to advocate on behalf of children. Indeed this research suggested that some children 'who were clearly expressing their views and showing their distress were placed under pressure to have contact apparently against their wishes' (Harrison, 2008, p. 399).

Since this research was published a number of reforms have been introduced to improve standards of practice. In 2004/2005 NACCC, with Cafcass, introduced National Standards for supervised and supported child contact services (NACCC, 2011, p. 7). In order to become NACCC accredited centres must fulfill the criteria in the National Standards for supervised or supported services, these are reproduced in full in Appendix 1.1. As mentioned above, once accredited, supported services can receive a Cafcass grant of £3000 per year and supervised services can be commissioned on a procurement basis (NACCC, 2011). In addition, NACCC has developed Definitions of Levels of Contact (see Appendix 1.2) and Protocols for Referral for Judges and Solicitors (see Appendix 1.3). However, recent research suggested that problematic child protection practice may persist (Thiara & Gill, 2012).

Thiara and Gill's (2012) recent research, published while the fieldwork for this thesis was being conducted, concerned DV, child contact and post-separation violence, as experienced by South Asian and African Caribbean women and children. The study therefore adopts a specific focus on issues surrounding families' ethnicity as well as DV. It included a ten-page chapter on the role of child contact centres in this context and so the depth of findings was necessarily limited by the wider focus of the research which was not principally on child contact centres. The methodology involved discussions with the coordinators of seven centres (two supervised, five supported) and discussions with staff and volunteers in four contact centres in two research sites. Time was also spent in three supported centres 'to get a sense of how they operated and to identify women for interviews' (Thiara & Gill, 2012, p. 126). Interviews for the research project were also carried out with professionals from DV services (18), Cafcass (17), solicitors (7), barristers (4), judges (4), Children's Guardians (2), Children and young people and families (2). Further to this ten professionals were involved in a multi-agency group discussion (Thiara & Gill, 2012, p. 126).

The findings of this study suggested that cases involving DV continue to be referred to and accepted at supported services. Facilities in supported services also tended to:

‘differ greatly, with a minority of centres being able to offer a space conducive to fathers and children spending quality time together where contact could be properly monitored...volunteer staff [were] struggling to properly monitor all the families [and] it was difficult for women to avoid their partners, despite the best of efforts by staff.’

(Thiara & Gill, 2012, p. 127).

The findings suggested that handovers were not always adequately monitored and so women often met their abusers. Other professionals in the study reported that men sometimes followed women from the contact centre (Thiara & Gill, 2012, p. 131). Women reported that their abduction concerns were not always taken seriously by centre staff (Thiara & Gill, 2012, p. 130). It was also reported that ‘due to time pressures, there was an observable lack of, or limited, information exchange between co-ordinators and volunteers in many centres’ (Thiara & Gill, 2012, p. 128), suggesting that volunteers may not have been aware of child protection issues in the cases they were facilitating. Practice in supervised services was not observed or reported on but the study reported that women using the services felt supervised staff showed a high level of understanding of DV dynamics (Thiara & Gill, 2012, p. 127).

1.4 Influences on child protection practice in child contact centres

1.4.1 Early research

The current research base provides some evidence which is relevant to the second research question: ‘what factors seemed to influence centres in managing their commitment to protect children?’ The research by Aris and colleagues (2002), carried out in 2000 is now outdated since it is over a decade old but also because, as discussed, since this time various NACCC reforms have been introduced in an effort to improve practice.

This research suggested that a ‘pro-contact stance’ (Aris et al., 2002, p. 1) was evident in contact centres; centres tended to assume that contact was in the best interests of

the child and the authors argued that this '[made] it difficult for issues of DV to be taken seriously' (Aris et al., 2002, p. 8). Indeed Harrison (2008: 398) concluded:

'When the absence of men from children's lives is strongly, if erroneously, associated with a range of social problems, and the significance of domestic violence is underestimated, a 'contact at any cost' philosophy can flourish.'

The study reported that mothers were often labelled as deliberately obstructive to contact and were sometimes believed by coordinators to be fabricating claims of DV. Meanwhile, children's reluctance to have contact was often interpreted as due to manipulation by the resident parent rather than as potentially a response to their past experience of abuse (Humphreys & Harrison, 2003b, p. 255): children could be believed when they wanted contact but disbelieved when they did not (Harrison, 2008, p. 399). Centre workers were reported to routinely assume fathers' potential to be good fathers without reference to their responsibility for violence (Harrison, 2008, p. 397).

The authors suggested that contact centres' origins as organisations which 'emphasise the constructive role of all men as fathers and the need to encourage and facilitate opportunities for contact' (Humphreys & Harrison, 2003b, p. 341) may explain this 'pro-contact stance'. The researchers also suggested that low levels of training may have informed attitudes to DV. It was reported that volunteer training was 'uneven' (Humphreys & Harrison, 2003b, p. 254) and that there was a strong reliance on shadowing other volunteers rather than attending courses. Few volunteers or coordinators appeared to have received training on DV or the links to child abuse (Humphreys & Harrison, 2003b, p. 254).

The study reported that in 2001 only 1% of the 280 contact centres affiliated to NACCC offered supervised contact (Aris et al., 2002, p. 18) and the practice of taking on inappropriate cases was in part attributed to the insufficient provision of supervised services, which put pressure on supported services to accept more serious cases. Indeed, in this study, 63% of referrers in the sample said that they had used provision that they considered less than appropriate in terms of supervision and safety (Humphreys & Harrison, 2003c, p. 422). It was also reported that referrers were

confused about the meaning of supervised and supported contact. In addition it was reported that centres themselves did not always have screening or assessment procedures because they lacked the levels of professionalism that would be required to undertake these assessments (Humphreys & Harrison, 2003b, p. 251). Finally, although all referrers (most of whom were Court Welfare Officers in this study) reported that they screened for DV, coordinators reported that some solicitors provided inaccurate or insufficient information at the point of referral (Aris et al., 2002, p. 38). While some coordinators believed this was done by accident and was due to 'a lack of rigour' (Aris et al., 2002, p. 38) others believed it was done intentionally in order to get the centre to accept the case (Aris et al., 2002, p. 38). The study further reported that there was a lack of consensus amongst Court Welfare Officers about the levels of vigilance required in cases involving DV and that centres and referrers disagreed about the level of 'evidence' required to take DV claims seriously (Harrison, 2008).

Research by Furniss (2000) who carried out interviews with Court Welfare Officers and solicitors between 1998 and 1999 further suggested that there was ambiguity in the amount of information referrers were required to share with centres. The study also suggested that referrers were usually expected to make the decision about whether the case is appropriate to the centre but that some referrers were willing to refer all cases to contact centres while others said they would not refer cases involving, for example, DV or child abuse. However, the research did not differentiate between supported and supervised services in contact centres on this issue and so does little to explain inappropriate referrals to supported services (Furniss, 2000). In keeping with Aris and colleagues' research (2002), it was found that contact services varied greatly and that this could cause confusion for referrers, with some solicitors misunderstanding the distinction between supervised and supported contact. It was reported that children's views were rarely sought by any referrers and that while Court Welfare Officers formally screened parents through interview, solicitors relied 'more on "feel" for the case rather than specific training' and did not necessarily ask directly about safety concerns (Furniss, 2000, p. 14). In addition, some solicitors were reported to try to persuade parents to reach an agreement on contact since they expected the court to do the same (Furniss, 2000). On this basis, Furniss questioned whether it was appropriate to expect solicitors to undertake screening and assessment

and suggested that in the future this should be undertaken by Cafcass (which at the time had not yet been established).

Previous research has also emphasised that since many referrals to contact centres come through the family justice system, the work of child contact centres is inevitably influenced by that system's handling of private family law child contact (Aris et al., 2002; Furniss, 2000). Indeed Harrison (2008, p. 389) suggested that the referral of cases involving high levels of DV and other child protection concerns to supported services demonstrated a 'pro-contact philosophy' in private law proceedings and that due to this philosophy, the significance of DV was 'persistently minimised'.

Other research provided substantiation to this claim. Under the 1989 Children Act, the welfare of the child should be the court's 'paramount consideration' in decisions regarding child contact ("The Children Act," 1989 s8(1)). The court should take certain factors into account¹⁰. However, due to the absence of specific legal guidance on what constitutes the welfare of the child, the principle embodies a large degree of judicial discretion (Bailey-Harris, Barron, & Pearce, 1999). In practice it has been found that the 'welfare principle' is susceptible to ideological inputs (Dingwall & Eekelaar, 1986) and the 'smuggling in' of other policies (Reece, 1996). Untested assumptions about what is good for children may drive the decision (Eekelaar, 1992) and legal judgements may legitimise certain discursive constructs over others (Smart, 1991).

Research suggests that until the early 2000's the legal profession interpreted the welfare principle in private law cases from a firmly pro-contact stance (Collier, 2006; Hester et al., 1994; Kaganas & Day Sclater, 2004; Lewis, 2002; Radford & Sayer,

¹⁰ These are listed in s1 (3) and are as follows:

- (a) the ascertainable wishes and feelings of the child concerned (considered in the light of his age and understanding);
- (b) his physical, emotional and educational needs;
- (c) the likely effect on him of any change in his circumstances;
- (d) his age, sex, background and any characteristics of his which the court considers relevant;
- (e) any harm which he has suffered or is at risk of suffering;
- (f) how capable each of his parents, and any other person in relation to whom the court considers the question to be relevant, is of meeting his needs;
- (g) the range of powers available to the court under this Act in the proceedings in question

1999; Smart, 1991). At this time child contact with violent fathers was, ‘not only a possibility, but [was] actively encouraged by law’ (Barnett, 2000, p.131). Mothers who objected to contact on grounds of their safety concerns were frequently positioned by the courts as ‘implacably hostile’ (CASC, 2000; Fortin, 2003; Hester, 2011; Hester & Radford, 1996; Hunt & Roberts, 2004; Neale & Smart, 1997; Radford, Hester, Humphries, & Woodfield, 1997; Radford & Sayer, 1999; Wallbank, 1998).

Nonetheless, at the time of Aris and colleagues’ (2002) research, there were indications that change may have been in the air. In particular, a move in direction was indicated by a set of appeal cases which happened in the same year as data collection for the research: (*Re L (Contact: Domestic Violence)*; *Re V (Contact: Domestic Violence)*; *Re M (Contact: Domestic Violence)*; *Re H (Contact: Domestic Violence)*)¹¹. In these, the court showed its willingness to refuse direct contact in some cases of DV.

1.4.2 Introduction of reforms and other changes

The reforms introduced since Aris and colleagues’ (2002) research would seem to have aimed to address some of the key issues identified. NACCC’s publication of ‘Definitions of Levels of Contact’ seems to strive to clarify the definition of services for both centres and referrers. The National Standards for contact centres (see Appendix 5.1) and related accreditation process would seem to aim to provide some standardization of the service provided and ensure that services are of sufficient quality and that volunteers and staff are trained. In addition, as a criterion of accreditation, centres are required to use a ‘Standard Referral Form’, which would seem to aim to regulate the information required at the point of referral. The development of ‘Protocols for Referral’ for judges and solicitors, similarly, seem to aim to clarify the roles of centres and referrers in the process and to provide additional clarity on the definitions of services.

¹¹L (a child) (contact: domestic violence); Re V (a child) (contact: domestic violence); Re M (a child) (contact: domestic violence); Re H (children) (contact: domestic violence), Re [2000] 2 FCR 404

There have also been changes in the environment in which contact centres operate: accredited centres, as discussed, can receive funding from Cafcass (NACCC, 2011); the percentage of supervised services has greatly increased, from 1% in 2001 to 26% (n=77) in November 2010¹². Cafcass was established, bringing together the family court services previously provided by the Family Court Welfare Services, the Guardian ad Litem Service and the Children's Division of the Official Solicitor's Office (Cafcass, no date -a) The courts have also been encouraged to adopt a more nuanced attitude to contact which takes increased account of child protection issues (in particular DV) (CASC, 2000, 2001, 2002; President of the Family Division, 2008). In addition, in 2005 an amendment to the 1989 Act came into effect to include in the definition of harm, 'impairment suffered from seeing or hearing the ill-treatment of another',¹³ providing increased recognition of the potential harm caused to children by witnessing DV.

However, research suggests that the courts and associated legal professionals may still operate a de facto presumption that there should be contact (Aris & Harrison, 2007; Hunt & MacLeod, 2008; Perry & Rainey, 2007; Smart, May, Wade, & Furniss, 2005; Trinder, Firth, et al., 2010). Indeed, Perry and Rainey's (Perry & Rainey, 2007) examination of 343 court orders found that use of court orders for supervised or supported contact was common as a short-term measure. However, orders for indirect contact were made only as a matter of last resort. In a similar vein, Hunt and MacLeod (2008) found that no contact and indirect contact orders were low and some courts were found to have no cases at all ending in these outcomes (Hunt & MacLeod, 2008). In 60% of court cases with serious welfare concerns about a child, staying or unsupervised contact was the outcome (Hunt & MacLeod, 2008).

Recent research suggested that there remains a broad spectrum of views amongst the judiciary, Cafcass Officers and solicitors on the relative importance of contact and safety and that implementation of some guidance on DV may be hampered not just by attitudes but by the lack of funding to underpin the increased focus on safety (Hunter & Barnett, 2013, p. 436; Radford, 2012). Indeed, 58% of the 623 respondent judges,

¹² Author's analysis of NACCC November 2010 data

¹³ Adoption and Children Act, 2002, s. 120

legal practitioners and Cafcass Officers in Hunter's (2013) research reported that in their experience the most likely outcome following an admission and/or finding of fact of DV in court cases is supported contact and reported that orders for no contact are rarely made (Hunter & Barnett, 2013).

1.4.3 Recent research

Despite the reforms introduced to child contact centres and the changes in their working environment, there is some evidence that problematic practice has persisted (Thiara & Gill, 2012). The research by Thiara and Gill (2012), provided some findings on factors which may explain the persistence of problematic practice despite the policies introduced, although this was not an explicit research question in this study. Interviews with Cafcass Officers suggested that they believe there are still not enough contact centres and in particular, not enough supervised services. It was suggested that because of this, inappropriate referrals involving DV were made and accepted at supported services. In addition, it was reported that Cafcass staff relied heavily on centres to consider the risks identified and to act accordingly (the practice of other referrers was not examined). Meanwhile, it was reported that a senior member of NACCC suggested that some centres struggled to adopt risk assessment and screening procedures and 'to get their staff to accept and use those procedures in a planned and coordinated way' (Thiara & Gill, 2012, p. 129). Centres' practice in this respect was not directly reported on. Further to this it was found that training of volunteers on DV was 'patchy' (Thiara & Gill, 2012, p. 131). Finally, professionals in this study were reported to have suggested that staff running supported contact centres may be judgemental and biased against women and assume that women use DV to obstruct contact, although no direct evidence of this was reported in the study (Thiara & Gill, 2012, p. 129).

The current study aims to provide a more in-depth investigation of child protection practice in centres and the factors that may influence centres in managing their commitment to protect children. As discussed below the study adopts a systems approach with the aim of achieving this.

1.5 Conceptual framework: a systems approach

To explore why the reform efforts in contact centres are not having the intended impact on practice, a systems approach to error investigation was adopted. This aimed to investigate not just what is happening in relation to the protection of children in child contact centres, but also why it is happening: what factors may influence practice. Systems approach is a very broad literature and this thesis does not aim to engage with the entire field; the focus here is on the systems approach developed in safety engineering and six core systems concepts are adopted to inform the research. These are: the study of normal activities, local rationalities, non-linear causality, conceptualisation of tools, feedback for learning and focus on ‘the whole’.

The safety engineering literature has emphasised that conceptually, the examination of error can be divided into two approaches, the person-centred approach and the system-centred approach (Reason, 2000). The person-centred approach focuses on the errors and procedural violations made by individuals working at the front-line of service provision (Reason, 2000). In exploring problematic practice it may, for example, conclude that practitioners strayed from guidance or violated standards (Dekker, 2002; Reason, 2000). In engineering, the ‘person-centred’ approach began to be questioned primarily because it seemed ineffective: accidents were still occurring (Rasmussen et al., 1990; Reason, 1990). More broadly there was concern that its oversimplification of the apparent ‘cause’ of undesired outcomes, led to unhelpful responses (blame and punishment) that limit learning and improvement (Woods & Cook, 2002).

The systems approach aims to go beyond the ‘first stories’ (Woods & Cook, 2002, p. 138) in the person-centred approach to discover what lies behind human error. The approach views practice ‘not as a cause, but as a symptom of failure’ (Dekker, 2002, p. 372). It therefore emphasises the importance of factors that may influence practitioners’ practice (Cook, Woods, & Miller, 1998; Dekker, 2005; Dekker, 2008; Fish et al., 2009; Helmreich, 2000; Hoffman & Woods, 2000; Leveson, 2004; Rasmussen, 2003; Reason, 2000; Woods & Cook, 2002; Woods & Hollnagel, 2006). While systems approach was initially developed to investigate accidents, it has

increasingly been recognised that since accidents occur so infrequently, ‘an examination of error under routine conditions can yield rich data for improving safety margins’ (Helmreich, 2000, p. 783). In other words, systems approach can be used to investigate every day practice, including what is working well and what is problematic (Fish et al., 2009). It is adopted for this purpose in the current study. The sections below present the six key systems concepts adopted in this study and their implications for the current research.

1.5.1 The study of normal activities

The systems approach asserts the need to, ‘study the normal activities of the actors who are preparing the landscape of accidents [or safety] during their normal work’ (Rasmussen & Svedung, 2000, p. 14). Indeed, the safety engineering literature has emphasised that accidents are not always the result of breakdowns or malfunctioning components within the system. Rather, accidents may occur because organisations ‘drift into failure’ (Dekker, 2005, p. 181). This happens through slow, incremental movements of system operations which ‘move the organisation to the edge of its safety envelope’ and is the result of an organisation not adapting effectively to the complexity of its structure and environment (Dekker, 2005, p. 181). In this situation, accidents, ‘are associated with normal people doing normal work in normal organisations-not with miscreants engaging in immoral deviance’ (Dekker, 2005, p. 184).

Therefore, in framing a response to the first research questions – ‘how well do child contact centres, as organisations that work with children, manage their commitment to protect children from maltreatment?’ - the current study focuses on providing an in-depth understanding of what constitutes ‘normal work’ in child contact centres in relation to child protection practice. This in-depth understanding is then analysed in relation to relevant child welfare literature in order to provide an analysis of ‘how well’ normal practice manages contact centres’ commitment to protect. In this respect, the conceptual framework of a systems approach aims to build on the previous research by providing a more in-depth analysis which is specific to the research questions posed.

The study explores workers' awareness of and response to child protection concerns. This not only includes their response to known risk factors or a history of maltreatment but also their awareness of and response to signs of maltreatment. In a departure from Thiara and Gill's (2012) research, it will not only explore practice in supported services, but also practice in supervised services and will analyse not just problematic practice, but also practice which, the literature suggests, is appropriate to manage the child protection risks in the cases centres are facilitating. In this respect, the study seeks to understand how centres have adapted to the reality of the work they are undertaking and co-evolved with the reforms which have been introduced (Dekker, 2005, p. 188).

In terms of providing a more in-depth understanding of child protection practice, the study will for example, strive to get behind the finding that monitoring in supported services was inadequate (Thiara & Gill, 2012, p. 127) to specifically spell out which aspects of monitoring in relation to both behavioural and verbal interactions were problematic and which were appropriate from a child protection perspective. Further to this, it will explore the thresholds at which workers intervened (or did not intervene) to address behavioural and verbal interactions. Again, the aim of this is to provide a more specific analysis of the areas of practice that may be problematic and those that may be appropriate from a child protection perspective. While previous research suggested that physical security in centres was insufficient (Aris et al., 2002), this research will not focus on physical features alone, but on the interaction between physical security and practice and the implications of this for child protection practice.

The systems approach emphasises the importance of understanding the 'information environment' (Rasmussen & Svedung, 2000, p. 14) that actors operate in. The current study therefore also aims to provide a more in-depth analysis in relation to communication of child protection-relevant information in centres. Thiara and Gill's findings echoed those of Aris and colleagues (2002) in suggesting that 'there was an observable lack of, or limited, information exchange between co-ordinators and volunteers in many [supported] centres' (Thiara & Gill, 2012, p. 128). The current research will seek to understand what information is available to centres as well as to explore what information is communicated to workers, and what is not. Additionally, building on Aris and colleagues' (2002) research, this study will seek to explore what

services are available in contact centres to build safety for children and how centres deal with the issue of moving families on to contact outside the centre.

Finally, Thiara and Gill's (2012) research did not provide any evidence relating to how contact centres currently engage with children. The current research seeks to fill this gap. Indeed, in recognition of the centrality of children to the topic of research and the importance of hearing children's voices as a major source of evidence that they are being or are at risk of being maltreated (Munro, 2011, p. 39; Willow, 2002), centres' engagement with children and the factors that may influence practice in this respect, will be examined in particular depth in a separate chapter (Chapter 6).

1.5.2 Local rationalities

The engineering safety literature also provides a number of useful concepts for the study of the second research question: 'what factors seem to influence centres in managing their commitment to protect?' A core concept in systems approach is that human behaviour is understandable (Dekker, 2008; Reason, 1997; Woods & Cook, 2002). As Dekker (2002:378) points out, 'people don't come to work to do a bad job'. Their behaviour makes sense to them at the time; if it didn't, they wouldn't do it. Therefore, people are likely to have been doing what they were doing because they believed it was the right thing to do, in that particular context. The 'local rationality' principle (Woods et al., 1994) expresses this idea. It asserts that 'people's behaviour is rational, though possibly erroneous, when viewed from the locality of their knowledge, attentional focus and strategic trade-offs' (Woods et al., 1994, p. 93). Therefore in the systems approach, the focus is on understanding why people do what they do, rather than on judging them for what we think they should have done (Fish et al., 2009; Perrow, 1984; Dekker, 2007b; Rasmussen et al., 1990; Reason, 2000; Woods et al., 1994). In other words, rather than searching for human failures, the systems approach searches for human sense-making (Dekker, 2002). This study therefore adopts in-depth semi-structured interviews with actors to provide a space for participants to describe how their work looked from their point of view: there is a focus throughout on understanding actor's 'local rationalities'.

There are many ways in which the factors important to understanding human performance could be organised (see for example Reason, 1990; Woods and Hollnagel, 2006, Fish et al, 2009, Rasumssen and Svedung, 2000). Although it is impossible to cover all potential factors here, the discussion below seeks to highlight key factors that may influence practitioners' local rationalities and their relevance to the current study.

In the search to understand local rationalities, the systems approach emphasises the importance of the influence of culture on meaning. Meaning is understood as emanating, at least in part, from social negotiations and construction within a group. Dekker (2008) emphasises the need to:

'Understand how people use talk and action to construct perceptual and social order: how, through discourse and action, people create the environments that in turn determine further action and possible assessments, and that constrain what will subsequently be seen as acceptable discourse or rational decisions. We cannot begin to understand drift into failure without understanding how groups of people, through assessment and action, assemble versions of the world in which they assess and act.'

(Dekker, 2008, p. xi)

In this sense, the systems approach asserts the social construction of error and safety and the importance of understanding what meaning people attribute to their actions (Dekker, 2007a; Helmreich & Merritt, 1998). In investigating 'local rationalities' there is a focus on the *creation* of rationality within groups, not just on their eventual presence. In this sense, the systems approach is 'a model of processes, not just a model of structures' (Dekker, 2005, p. 200)

Thiara and Gill (2012)'s recent research reported that, 'Other professionals...raised concerns about the attitude of some staff running supported contact centres, finding this to be judgemental and often biased against women' (Thiara & Gill, 2012, p. 129). However, workers' attitudes themselves were not examined. The current research will provide a direct, in-depth investigation of contact centre workers' local rationalities. It

will explicitly focus on how workers understand their child protection role, including investigating the meaning workers attach to their actions and the work of protecting children. At the group level, the research will strive to understand the culture of contact centres. It aims to understand if the ‘pro-contact’ culture identified by Aris and colleagues (2002) has been sustained, by what mechanisms this might have occurred.

The study will also adopt the systems emphasis on the importance of exploring the conflicting goals which workers may need to manage (Dekker, 2002, p. 382; Reason, 1997, p. 9). As Woods and colleagues (1994:94) point out, ‘multiple goals may be relevant, not all of which are consistent. It may not be clear which goals are the most important ones to focus on at any one particular moment in time (Woods et al., 1994, p. 94). In this approach it is not assumed that the organisational goals are necessarily explicit in written documents. Indeed, it is assumed that the messages received by workers about the organisation’s goals may be quite different from those that management acknowledges (Woods & Cook, 1999).

Resources are a further source of investigation in this study. This includes not just tangible resources but also the training, knowledge and time available to workers (Woods & Hollnagel, 2006). The focus on resources encompasses those available directly to contact centres as well as those available to referrers. It also explores the resources provided to contact centres in their relationship with the state. At all times, the potential interaction effects of attitudes and resources will be explored. For example, the research will investigate not just the levels of training received by contact centre workers but also how ‘local rationalities’ towards training may affect uptake.

The systems approach further asserts the importance of understanding how missing knowledge or misconceptions may influence worker understandings (Dekker, 2005; Rasmussen & Svedung, 2000; Woods & Cook, 1999). This will be investigated in relation to the communication of information relevant to child protection within centres and also between centres and referrers. Further to this, cognitive resources are seen as important in this study. Since people’s rationality is bounded (Simon, 1969, p. 38) they do not see everything all the time. For example, a common form of

breakdown which can occur is when an inappropriate mind-set takes hold and persists in the face of evidence which does not fit the assessment (Woods & Cook, 1999). On this point, Munro (2005a, p. 384) has pointed out that while the engineering literature has focused on cognitive elements of performance it has done so with little attention to emotions. Yet the emotional dimension is inevitably present in working with families. Workers can become emotionally involved in family dynamics and they also bring their own experiences (both constructive and not) to their work (Munro, 2005a). A focus on the emotional aspect of the working environment of child contact centres is therefore incorporated into the systems approach adopted in this thesis.

Finally, in relation to local rationalities, the systems approach asserts the potential importance of coupling in the system (Perrow, 1984). This relates to the degree of interconnectedness and can lead to effects created at a distance and side-effects of actions in one part of the system on other parts (Woods & Cook, 1999). Coupling relates to the non-linearity of the system, which is discussed below. Where there is coupling, workers may make decisions based on a particular type of knowledge gap: they may be unaware of how different parts of the system interact and therefore be unaware of the potential effects of their actions on other parts of the system (Woods & Cook, 1999). In the context of child contact centres it can be suggested that there is a high degree of coupling in the system since contact centres receive referrals from multiple referral sources. The study therefore explores how contact centres interact with these referring professionals. In particular, it seeks to understand how well actors understand the work of other parts of the system and what impact this has on their practice.

1.5.3 Non-linear causality

The 'Working Together' guidance as well as the National Standards and Protocols for Referral introduced to contact centres would seem to represent an example of the assumption that systems can be made safer through top-down guidance and control which specifies how the elements of the system should interact (Dekker, 2007a). The systems approach counters the inherent assumptions concerning control and predictability in the top-down approach. Systems thinking suggests that because human systems are made up of the actions and reactions of human beings (who unlike

inanimate objects, think and react), they have emergent properties: factors that on their own are unproblematic may become unsafe as they form a system with others.

The view of causality in the systems approach is therefore non-linear (Perrow, 1984). Certain factors do not inevitably lead to certain effects. Rather certain causes may or may not lead to effects with differing degrees of probability (Leveson, 2004; Wallace & Ross, 2006:17). Moreover, effects are rarely attributable to just one factor (Helmreich, 2000; Reason, 1990). Biologist, Richard Dawkins suggests that one way to understand the difference in causality in human systems is to compare the results of throwing a rock and a live bird. Linear models will effectively predict where the rock will end up, but are useless for predicting the trajectory of a bird, even though both are subject to the same laws of physics (Dawkins, 1986, pp. 10-11). Social and organisational systems, such as contact centres are fundamentally made up of the actions of human beings. They show adaptive and reactive behaviours and are therefore more like live birds than rocks. For this reason, the systems approach questions the idea that top-down control can be successful in prescribing action lower in the system; it refutes the presumption of control and predictability. Instead it suggests that top-down measures will combine with local factors to produce unexpected and often non-uniform effects (Chapman, 2004; Dekker, 2002).

A core assumption in the current research is that the top-down approach in the 'Working Together' guidance as well as in the National Standards and Protocols for Referral may not lead to uniform effects and that the effects may not be those that are intended. Therefore the research will explore how these top-down measures may combine with factors on the ground to produce unexpected (and potentially unwanted) effects. In contrast to Thiara and Gill's (2012) research therefore, the contact centre reforms introduced since Aris and colleagues' research are not seen as passive: rather they are themselves a subject of the research. The study will investigate whether any goal conflicts (whether explicitly or implicitly articulated) emerge from them for workers. In addition, rather than simply exploring whether workers violate the guidance, the research will explore what 'local rationalities' may lead workers to violate them. In this respect it attempts to get behind the assertion of a NACCC official, uncritically reported in Thiara and Gill's research, that problems remain

because some centres struggle, to get ‘their staff to accept and use those procedures in a planned and coordinated way’ (Thiara & Gill, 2012, p. 129).

1.5.4 Conceptualisation of tools

The study also adopts the systems focus on the tools used by actors (Dekker, 2008; Hoffman & Woods, 2000; Hollnagel, 2003; Leveson, 2004; J. R. Wilson, Jackson, & Nichols, 2003; Woods & Cook, 1999). In child contact centres, the principal tool introduced into the system of supported child contact centres since Aris and colleagues’ (2002) research is the Standard Referral Form. Under the National Standards for child contact centres, all supported services must ensure that they and referrers use this form in the process of referral (p. 4, para. 4.1 and 4.2). In addition, protocols for referral for judges and solicitors have been introduced to manage the referral process.

The systems approach suggests that reforms, and the tools they bring, may have unexpected effects. For this reason it does not treat these as neutral. Instead, the systems approach investigates how tools may influence and be influenced by factors on the ground in potentially unexpected ways. As Hoffman puts it:

‘New technology introduces new error forms; new representations change the cognitive activities needed to accomplish tasks and enable the development of new strategies; new technology creates new tasks and roles for people at different levels of a system. Changing artefacts, and the process of organisational change it is part of, can change what it means for someone to be an expert and the kinds of breakdowns that will occur.’

(Hoffman & Woods, 2000, p. 3).

In contrast to Thiara and Gill’s (2012) research therefore, the Standard Referral form and the Protocols for referral, are positioned in the current research as tools and are a specific focus of investigation.

While earlier approaches in engineering took a dualist approach to workers and tools, seeing them as separate, more recent systems thinking has recognised the interdependence between them and the influence they have on one another (Bockley, 1996; Dekker, 2008; Hoffman & Woods, 2000; Hollnagel, 2003; Pool, 1997; Reason, 1990; Woods & Hollnagel, 2006). Increasingly, humans and tools have come to be seen, not as separate units but as a human-tool system. This reconceptualization has moved the analysis away from how well people use tools to a focus on how well they interact with each other (Hoffman & Woods, 2000; Hollnagel, 2003; Leveson, 2004; Woods & Hollnagel, 2006). In other words, in the systems approach, the focus is on the interactions within the entire socio-technical system, rather than the parts taken separately (Leveson, 2004, p. 249). Therefore, in place of ‘human error’, the systems approach may speak of ‘interaction failure’: tools may need to be redesigned to take account of the reality of human capabilities (Dekker, Fields, & Wright, 1997).

Indeed, Norman (1993) has stressed the danger of tools which are not user-centred (Norman, 1993, p. 50). Further to this, it has been argued that in order to understand how tools are used, the systems approach must examine the social as well as the cognitive aspects of worker’s interaction with tools. This involves understanding the ‘relationships, collaborations and communications’ that users of the tools have with those people working closely with them in the system, such as supervisors, and those working in interconnected but distant parts of the system (J. R. Wilson et al., 2003, p. 83).

Therefore, the current research does not assume that the effect of the Standard Referral Reform or the Protocols will be positive so long as workers use them. Instead the study investigates to what extent these tools are ‘user-centred’ (Norman, 1993): whether they are designed with the capacity users (both referrers and centre coordinators) in mind and how the interaction of design and user impacts on practice.

1.5.5 Feedback for learning

This study also focuses on the systems concept of feedback for learning. As an alternative to top-down control, the systems approach advocates learning as the means to handle non-linear causality and the lack of predictability and control that come with

it (Reason, 1997; Woods & Cook, 2002). The systems approach aims to understand the mechanisms available to the organisation for feedback and learning so that it can identify and address latent issues as they emerge. As Woods (2002) puts it:

‘Feedback at all levels of the organisation is critical because the basic pattern in complex systems is a drift toward failure as planned defences erode in the face of production pressures and change’.

(Woods & Cook, 2002, p. 143)

Therefore, as soon as a reform is introduced into the system the system adapts and continues to drift such that it will not be the same as it was in the beginning (Dekker, 2008, p. 172).

Of course organisations often have mechanisms for feedback in a restricted sense. The political culture since the 1980’s has seen growing regulation and demand for accountability of publicly funded services (Anheier, 2009; Hood, 1991), exemplified by the rise of New Public Management (NPM) (Hood, 1991). At the same time, the state has increasingly played an indirect role in service provision, relying on the voluntary and private sectors to provide services which receive important levels of public funding (Hood, 1991; Kramer, 1994, 2000; Salamon, 1995; R. S. Smith & Lipsky, 1993), as in the case of contact centres. These publicly funded (but not publicly provided) services have therefore also increasingly been subject to forms of regulation and accountability to assess their performance (Kramer, 1994; Rhodes, 2000; R. S. Smith & Lipsky, 1993; R. S. Smith & Smyth, 2010).

However, in an effort to limit financial and time costs, trends in systems of accountability have tended to focus on indirect checks or indicators rather than on direct observation of practice (Hood, 1991; Hood, Rothstein, & Baldwin, 2001; Munro, 2004a; Power, 2007). There are concerns about the quality of the information collected through such systems and about the extent to which indicators provide a meaningful reflection of practice (Dekker, 2007b; Munro, 2004b; Power, 2007), particularly given the potential (discussed above) for non-linearity in human systems. Moreover, as has been demonstrated in the statutory child protection context, such an approach to feedback may influence practice in unintended and sometimes unwanted

ways (Munro, 2011). The systems approach argues that what is required instead is a systems approach to learning which continues to observe, reflect, create and act to maintain safety (Reason, 1997).

This study therefore investigates what mechanisms are available to contact centres and referrers in order to learn how their practice impacts the system. In addition it seeks to understand the potential impact on practice of the systems of feedback that do exist. The National Standards and related accreditation system are the focus in this respect.

1.5.6 'The whole'

Finally, the overall approach to analysis in this study is also influenced by the systems approach and is in keeping with the concepts discussed above. A fundamental assertion in systems approach is that safety and error are emergent properties of systems, not of their component parts (Dekker, 2005; Woods & Cook, 2002, p. 140). In the systems approach it is therefore insufficient to note specific behaviours or to report on the strategies of individual practitioners. Instead the systems approach directs our focus to exploring:

'How these more or less visible activities are part of a larger process of collaboration and coordination, how they are shaped by the artefacts and in turn shape how those artefacts function in the workplace, and how they are adapted to the multiple goals and constraints of the organisational context and the work domain'

(Hoffman & Woods, 2000, p. 3).

Of course, these factors do not appear to the researcher in tidy categories, instead they emerge as a complex web of interdependent variables. A reductionist technique would analyse the issues by simplifying this complex web into more manageable units. However, since the phenomenon of interest may be a product of the emergent whole rather than the sum of its parts, the reductionist approach may eliminate the very

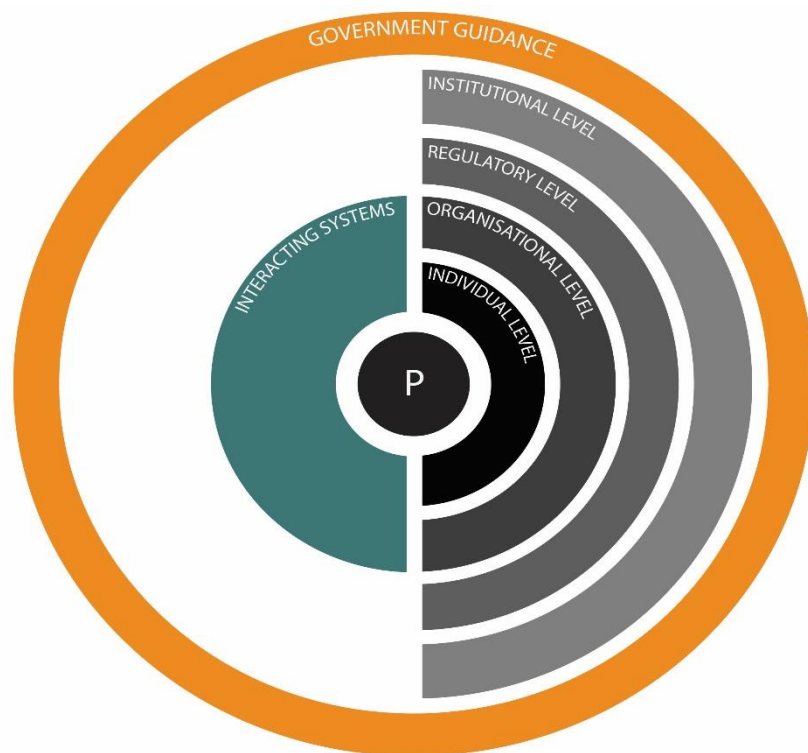
phenomenon of interest. The systems approach therefore advocates that, instead of dividing the problem up into smaller units, the system's functioning should be examined as a whole with a focus on the interactions between its parts (Dekker, 2008; Hoffman & Woods, 2000; Reason, 1997). For this reason, in the systems approach, there is a focus on the dynamics of the system and how these explain the behaviour observed. As Dekker (2005) points out, this is quite different to simply 'reminding people of context' (Dekker, 2005, p. 185). It should be noted that the focus on emergent practice based on interactions suggests from the outset that it will be difficult to identify one single cause of a problem (Leveson, 2004). This may present a challenge to policy makers since proposed solutions are unlikely to be simple.

The current study focuses on the work and local rationalities not just of contact centre workers, but also of referrers. The research positions referrers as operating in interacting sub-systems which are coupled (Perrow, 1984) to contact centres. The focus of analysis is therefore not simply on the individual parts, but on the interactions between them: how decisions in one part of the system may have (unintended) implications for other parts (Rasmussen & Svedung, 2000). This analysis seeks to provide a systems approach to the investigation of inter-professional working and its impact on child protection practice. Throughout the analysis, the approach adopted in this thesis also seeks a higher level of abstraction. The aim of this is to avoid identifying isolated 'problems' and to instead seek to see how these may be related to the functioning of the whole system. It should be noted that while the research examined both supported and supervised services, the analysis of the contribution of inter-professional working on child protection practice (presented in Chapter 5) focuses exclusively on supported services. This narrowing of focus was adopted so as to enable an in-depth examination of the issues in supported services, where inappropriate referrals are most problematic as the service is least able to manage safeguarding concerns.

Systems theorists often present graphic models of systems to demonstrate the interplay between layers in system (Cook et al., 1998; Reason, 2000; Woods & Hollnagel, 2006). These graphics are used to emphasise and model how practitioners may seem directly responsible for their actions but in acting are influenced and constrained by interactions between layers ranging up through the system. Building

on the work of previous authors (Cook et al., 1998; Reason, 2000; Woods & Hollnagel, 2006), a model of the system of contact centres is presented below in Figure 1.1. While the authors cited above presented their models as triangles, with practice at the sharp end influenced by factors ranging through to the blunt end, the model developed below adopts a circle instead. This allows for the influence of the ‘coupled’ (Perrow, 1984) or ‘interacting’ referral systems to be modelled too.

Figure 2: Conceptual model of system components: child contact centres



As Figure 1.1 outlines, the systems approach highlights how interacting layers within the system of contact centres are likely to mediate the relationship between government guidance (i.e. The ‘Working Together’ guidance) and practice in contact centres (represented here as ‘P’ in the centre). The layers in the system of child contact centres can be conceptualised as ranging as follows: At the ‘**individual level**’, factors within the individual worker may affect practice (for example workers’ knowledge, skills or perceptions); however, the individual level may in turn be influenced by interactions with factors at the ‘**organisational level**’. This includes for

example, the resources provided to workers, the training they have received and the organisational priorities. In turn, the ‘organisational level’ may be influenced by the ‘**regulatory level**’. As discussed, the regulator, NACCC, has introduced the National Standards for child contact centres and associated accreditation system, as well as key tools used by contact centres and referrers (the Standard Referral Form and Protocols for Referral). As discussed above, these are not viewed as neutral. They may influence the organisational level with knock-on effects on practice.

The inclusion of an ‘**institutional level**’ within the model suggests that the institutional position of contact centres, outside the statutory sector and predominantly in the voluntary sector, may influence practice. As discussed, the focus in systems approach is on abstracting up rather than reducing down and so Chapter 4 of this thesis uses Salamon’s (1987) ‘voluntary failure’ thesis to provide a theoretical framework for examining how the institutional position of contact centres may interact with the other levels of the system to influence practice on the ground.

Finally, the model suggests that factors within the ‘coupled’ (Perrow, 1984) or ‘**interacting systems**’ of referrers may influence practice. This may, for example, include referrers’ perceptions, knowledge or skills. Indeed, the systems approach would suggest that referrers themselves sit within individual systems (the family justice system, the child protection system etc) and that these could also be modelled in layers ranging up. While this would likely provide a greater depth of understanding, a higher level of abstraction is beyond the scope of this research. The investigation of the influence of interacting systems on contact centres is therefore limited, by necessity, to an examination of the individual and organisational levels within these interacting systems.

As discussed below, the thesis is structured by theme however, within each empirical chapter the analysis focuses on exploring the layers within the system, outlined in Figure 1. This structuring of the thesis is important as it allows for a non-linear analysis examining multiple interacting layers within each chapter. However, the conclusions chapter (Chapter 7) returns to the systems model set out in this section and summarises the findings in terms of each interacting layer. It should also be noted

that owing to this thematic structuring, the thesis does not contain a separate literature review chapter. Instead the relevant literature is reviewed within each chapter.

1.6 Outline of the thesis

In **Chapter 2** I detail the methodology of the study: the research design, key methods used, ethical considerations and limitations of the study. The design was linked to the epistemological and ontological assumptions within systems approach. For reasons discussed in the methodology chapter, it therefore adopted a predominantly qualitative approach, with some use of quantitative data.

In the following four chapters (**Chapters 3-6**) I present the central substantive contribution of the thesis based on data collected between November 2011 and November 2012. It argues that in the empirical context of child contact centres, the ‘Working Together’ guidance to organisations working with children does not in itself produce predictable effects which will fulfil the guidance aims. Rather when the guidance combines with factors within the system it produces unexpected effects. The thesis therefore argues that policy makers need to focus, not simply on telling organisations what to do in terms of child protection, but on enabling them to do it.

Chapter 3 addresses the first research question: ‘how well do child contact centres manage their commitment to protect children from maltreatment?’ The findings suggest diversity in terms of how well child contact centres manage their commitment to protect. While supervised services generally managed their commitment to protect well, problematic practice persisted across all of the case study supported services, despite the reforms introduced by NACCC since Aris and colleagues’ (2002) research. On this basis it can be argued that the articulation in the ‘Working Together’ (2010) guidance that organisations that work with children have a ‘commitment’ to protect, did not necessarily, in the context of child contact centres, lead to effective management of this commitment.

Chapter 4 presents the first component of findings on the second research question: ‘what factors influence contact centres in managing their commitment to protect children?’ The chapter argues that in child contact centres, the process of protecting children is socially constructed in an organisational context. This presents a challenge to the notion that guidance to organisations working with children can alone be an effective mechanism to implement this policy objective. This is because in a non-linear, human system guidance is likely to combine with factors on the ground to produce unexpected and potentially undesired effects (Chapman, 2004; Dawkins, 1986; Dekker, 2008; Munro, 2011; Vaughan, 1998; Wallace & Ross, 2006).

The chapter adopts Salamon’s (1987) ‘voluntary failure’ thesis as an overarching theoretical framework for the analysis. It suggests that problematic practice in contact centres can be related to a failure to sufficiently address three common weaknesses in the voluntary sector delivery of human services: insufficient organisational funding and professionalization and narrow organisational focus. The findings suggest that insufficient funding has been provided to ensure access to supervised contact services. Not only are there no supervised services in some geographical areas but access to the services which do exist is hampered by high fees. The findings demonstrate that this affects the ‘local rationalities’ of actors who at times referred to supported services as they felt there was no alternative. The findings also suggest that the system of contact centres relies heavily on volunteerism and that this can present barriers to the attainment of training necessary for the protection of children. Volunteers did not always wish to donate additional time to receive training and did not always feel that it was necessary.

The findings further suggest that the barriers to effective management of the commitment to protect not only relate to issues of resourcing. Rather there may be psychological barriers for workers in managing the commitment to protect. The findings suggest that volunteers in supported services can experience the judgement and authority involved in protecting children as destructive. It was suggested that this was because the focus in supported services is on providing a welcoming, neutral and non-judgemental venue for parents. This can present a goal conflict (Woods & Cook, 2002) with the judgement and authority inherent in the work of protecting children. It

was suggested that the NACCC Definitions of Levels of Contact may enforce and sustain this goal conflict (Woods & Cook, 2002).

Chapter 5 presents the second component of the findings in relation to the second research question. It explores the influence of inter-professional working practices on child protection practice in contact centres. The findings suggest that inappropriate referrals to supported services persist because attempts to address the issue have focused on providing technical aids to referral but have not ensured that the appropriate level of professional training is in place to use them. In this sense, the tools are not user-centred (Norman, 1993). In addition, the findings suggest role ambiguity amongst actors. It was found that actors construct the boundaries of their responsibility based on their beliefs, attitudes, work pressures, available resources and so on. In a system of multiple interacting systems these boundaries may be constructed in such a way that holes emerge in the space between actors' constructions, leaving gaps in the child protection net.

Chapter 6 examines both research questions specifically in relation to the issue of contact centres' engagement with children. As discussed above, the in-depth focus on this topic is justified by the centrality of children to the topic of research and the importance of engaging with children in order to protect them (Munro, 2011, p. 39; Willow, 2002). The findings suggest that contact centre workers exhibit diverse practice in terms of child engagement. A typology of child engagement was developed from the data, which suggests that engagement with children can be conceptualised as lying along a spectrum from 'coercive' to 'limited' to 'meaningful' engagement. The findings suggest that guidance to contact centres alone is unlikely to inspire meaningful engagement with children. This is because the ways in which workers engaged with children seemed to be influenced by the context in which workers operated. Intrinsic issues including worker training as well as time and physical space were important influences on the type of child engagement. However, the findings suggest that practice is also influenced by interactions at the level of the wider system. Contact centre workers as well as referrer judges, solicitors and social workers demonstrated divergent understandings of children's capacity to have 'valid' wishes and feeling. Contrasting perceptions of contact centres' role were also identified. Based on these findings it is argued that in order for contact centres to

engage meaningfully with children, workers need to be empowered within the organisational context of contact centres *and* within the wider system.

Finally, **Chapter 7** presents the conclusions to the thesis. It summarises the main findings of the research and discusses the thesis' contribution to the literature in relation to each research question. The limitations of the study are noted. In addition, this chapter discusses the implications of the findings, firstly for policy and secondly for the systems approach and for research.

Chapter 2: Methodology

This research aimed to explore firstly, how well child contact centres in England manage their ‘commitment’ to protect children from maltreatment and secondly, to investigate the factors that may influence centres in managing this commitment. The research design was highly influenced by the conceptual framework adopted: systems approach. Qualitative methods were predominantly used including in-depth interviews with contact centre workers and professionals who had referred to a centre, and direct observations of practice in centres. These data were supplemented by analysis of two secondary data sources, both NACCC surveys. This chapter sets out the study’s methodology. It begins with a rationale for the research design. This is followed by an in-depth explanation of the methods used and an exploration of the ethical considerations. The chapter concludes by considering the study’s limitations.

2.1 Research design

2.1.1 Epistemological and ontological perspective

The research design was derived to address the research questions:

1. How well do child contact centres manage their commitment to protect children from maltreatment?
2. What factors may influence centres in managing this commitment?

The study was designed in keeping with the social constructivist paradigm inherent in system approach (Dekker, 2008; Helmreich & Merritt, 1998; Woods & Cook, 1999). This paradigm encompasses interconnected ontological, epistemological and methodological assumptions (Lincoln, Lynham, & Guba, 2011). From an Objectivist position it could be argued that organisations (such as child contact centres) are tangible objects and that the organisation has a reality, external to the individuals within it. It could therefore be assumed that the organisation exerts pressure on individuals to conform to the requirements of the organisation (Bryman, 2008, p. 18); people within the system of contact centres will apply rules, follow procedures and they will absorb the culture of the organisation and apply it. The ontological position

of Objectivism is in keeping with the ‘person-centred approach’ (Reason, 2000), which was set out in Chapter 1 as an alternative to systems approach.

However, in keeping with the constructivist position in systems approach, the design adopted for this research considers that social phenomena and categories can be constructed by actors within the system and are in a constant state of revision (Dekker, 2008; Helmreich & Merritt, 1998; Lincoln et al., 2011; Woods & Cook, 1999). For this reason the research design does not stop at the point of examining individuals’ reactions to organisational procedures and cultures but instead examines how the implementation of those procedures and creation of culture may be socially constructed by actors themselves. Similarly, the social constructivist position inherent in systems approach asserts that categories are not objective or external to actors but instead are socially constructed through actors’ interactions (Dekker, 2007a; Helmreich & Merritt; Lincoln et al., 2011). Within this research therefore categories such as child protection and childhood are not taken as given; rather the research was designed to explore the social construction of these categories by actors, the meaning which they attribute to the categories and the implications of this on their actions.

As well as influencing the research design, the systems approach and its associated epistemological and ontological positions inevitably also influenced the research methods adopted. The focus on achieving an in-depth understanding of the subjective meaning actors attach to social action as well as the ontological assumption that meaning and action can be socially constructed, was a key factor informing the adoption of a principally qualitative design involving six case study child contact centres. The overarching complexity of the issues relevant to answering the research questions (from complicated inter-professional working processes to understanding actors’ subjective meaning) informed the need for methods which could collect the depth of data required and which would easily allow me to clarify meaning or ask for additional detail.

The validity of the data was also an important consideration. Systems research has emphasised that there can be a gap between workers’ reported and actual behaviour (Woods & Cook, 2002, p. 139). Triangulation of data through both interviews and observation of practice was therefore required. Finally, the relatively small number of

studies on child contact centres (especially in recent times) meant that I could not answer the research questions by adopting hypotheses and testing them. Rather a flexible and evolving design was required which would allow for the investigation of unanticipated issues as they emerged. At the same time, the design attempts a level of quantification on some issues through the analysis of NACCC survey data. While the study predominantly focuses on providing theoretical generalizability (Yin, 2003, p. 10), the quantitative data further develop these findings to estimate a more precise quantification of some issues.

2.1.2 Answering the research questions: an overview

In answering the first research question the design sought to collect data which would illustrate how the case study contact centres managed their commitment to protect children from maltreatment. This was collected through ethnographic observations of practice in centres and interviews with staff and volunteers. The analysis of ‘how well’ centres manage the commitment was derived by applying findings from the broader literature regarding the safe management of child contact to the data collected. This was sourced from literature directly on the topic of child contact as well as relevant literature on related topics. This included literature on DV, drug and alcohol addiction and mental health and previous child maltreatment as well as literature on child protection risk assessment. This analysis is by no means conclusive. As the literature base for child welfare is constantly evolving, it should be seen as our best understanding of the issues at this point in time.

A number of the data collection methods were combined in order to answer the second research question. The in-depth interviews with staff and volunteers were used to answer this question as were the interviews with referrers. Interviews sought to glean an understanding of the meaning actors attached to social action and the potential impact of this on child protection practice in centres. In addition, in keeping with systems approach (Dekker, 2008; Reason, 1997; Woods & Hollnagel, 2006), the interviews aimed to explore the influence of tangible factors in the organisational context (for example, funding, worker training and tools). Where possible, the design used the NACCC survey data to provide an indication of the quantification of issues at a national level. In interviewing multiple actors the design further aimed to focus on

the interactions between parts of the system, rather than on the isolated components (Hoffman & Woods, 2000; Woods & Cook, 2002). This approach was particularly influential in informing the investigation of the influence of inter-professional working to centres' management of their commitment to protect.

As discussed in Chapter 1, systems approach strives to simplify the analysis, not by breaking phenomena down into component parts, but instead by abstracting to a higher level (Chapman, 2004). Therefore, the analysis presented in Chapter 4 endeavoured to abstract to the macro-level in order to situate the findings within the wider institutional context of child contact centres i.e. to explain how they relate to centres' relationship with the state. Throughout the empirical chapters (Chapters 3-6) the findings were analysed using relevant concepts, theories and literature. This literature was searched by relevance and so is not limited by discipline. Literature was drawn upon from the fields of political science, sociology, psychology and philosophy.

The findings in relation to Question 1 are principally explored in Chapter 3, while Chapters 4 and 5 focus on the findings and analysis of Question 2. Chapter 6 provides a separate in-depth exploration of both research questions on a particular aspect of the research questions: how well child contact centres listened to children and took their wishes and feelings into account as part of their commitment to protect children and what factors influenced centres in managing this element of the commitment. It is argued that the devotion of a full and separate chapter to this topic is justified by the centrality of children to the topic of research and the importance of engaging with children in order to protect them.

2.1.3 Researcher reflexivity and positionality

Social research involves a process in which the researcher communicates with participants and reports on and analyses the data collected. It can be suggested therefore that the researcher and the participants co-construct the data (Charmaz, 2008; Lincoln et al., 2011). For this reason it is important to understand something of the researcher who is complicit in the creation of knowledge.

A number of points are relevant in terms of my position in the research and how this may have influenced the knowledge generated. In a number of ways, my position was one of an outsider. I am neither a social worker nor a lawyer. Nor have I worked as a volunteer in a child contact centre. I do not therefore share a professional background with any of the professionals involved in the research. In supported contact centres, the vast majority of the volunteers were older than me and were often retired. Most also had children and often grandchildren. I was therefore younger than most and am not a parent.

Some authors argue that researchers should, where possible, aim to reduce ‘social distance’ between researchers and participants by seeking demographic similarities between the participant and researcher (Collumbien, Busza, Cleland, & Campbell, 2012, p. 28). This may help enrich researchers’ understandings of participants’ accounts (Lewis, 2003, p. 65) and build trust (Collumbien et al., 2012, p. 28; Hallowell, 2005, p. 24). At the same time matching the researcher with participants may have disadvantages. It may lead to shallower depth where insufficient clarification or explanation may be sought by the researcher or where participants assume the researcher shares particular knowledge or understandings. In addition, while it is possible that shared characteristic may build trust, it is equally possible that participants may hold back on frank, critical discussion with insiders (Lewis, 2003, pp. 65-66). The lack of a shared professional background could also be advantageous in the sense that as an outsider I did not share the professional culture of any of the groups. Since research has demonstrated that professional groups in this context may share cultures of child protection (Hester, 2011), it could be suggested that as an outsider I was not necessarily immersed in any one of these cultures, though that is not to suggest that I do not come with my own set of biases and assumptions.

A pragmatic approach to these issues was adopted in this research in order to minimise the possible disadvantages of the outsider position and to capitalise on the possible advantages. As Rubin and Rubin (Rubin & Rubin, 1995, p. 39) point out, if researchers and participants are not matched it is vitally important to ensure that the researcher has sufficient grasp of the context to enable communication. I had gained some understanding of the operation of child contact centres having visited centres and spoken with staff in England, Scotland and Northern Ireland for a project I was

previously employed on in the Republic of Ireland.¹⁴ Prior to the main body of fieldwork I sought to enhance my understanding of the work of contact centres in England through two scoping visits; one to a supported-only centre and the other to a centre providing both services. This included observations of practice in the supported-only service and discussion with the managers of both centres. In addition I travelled to Warwick University to discuss the last major study on child contact centres with Dr. Christine Harrison who had co-authored this work (Aris et al., 2002). When the study by Thiara and Gill (2012) was published I spoke with both authors by phone about their experiences.

I was particularly concerned to ensure that I had a good grasp of the legal context to child contact. Therefore prior to the main body of fieldwork I spoke on two occasions with a family law barrister in order to clarify and enhance my understanding of the court process in relation to contact and to identify current salient issues. I also spoke with a solicitor who had referred to a child contact centre in order to clarify my understanding of the referral process and to get a sense of relevant issues. In addition I attended a child contact court case with the barrister. This essentially involved shadowing her through the day. With the parents' and judge's permission I attended that day's hearing of the case and I sat in on the private negotiation between the two barristers. This pre-fieldwork research helped to develop my understanding of the context and to ensure that although I was an outsider, I was not ignorant and had a sound basis for developing initial questions.

While in the field, I was open about my 'outside' status. From the start I explicitly positioned the participants as the experts and asked them to patiently explain what they do and why they do it. This was useful in encouraging participants to elaborate and explain their thinking and the context of their actions. In practice, this seemed to work to a varying extent. In all contexts it seemed to establish my permission to ask multiple questions on issues which, to participants often seemed obvious. It was often these 'obvious' questions which yielded the most interesting answers. For example, I asked workers in contact centres what the purpose of contact centres is. When they

¹⁴ This research examined whether there was a need for child contact centres in the Republic of Ireland, since no system of contact centres existed at the time. It was funded by the Irish Government (Murphy & Caffrey, 2009)

mentioned that contact centres are ‘neutral’ or ‘child-centred’ venues I could ask them what they meant by that, without the assumption that I should know. At the same time, the depth of my understanding of the issues necessarily developed over the course of the fieldwork and so the questions I asked and what I looked out for developed over time.

I was wary from the start that staff and volunteers as well as referrers may feel that I was evaluating the particular centre’s practice or their practice as individuals. This may create social desirability bias which could change practice. I was anxious to explain the subtle difference between an evaluation of individual centre or individual workers (which may imply a blame-based approach) and the systems approach I was undertaking to understand how the system might impact practice. I also stressed the anonymity of centres and participants and that my interest in them was as examples of a wider system; their practice and the issues they experienced were unlikely to be unique. Despite initial and on-going explanation of this it was clear that some workers felt they were being evaluated as individuals or individual centres. This was evident from jokes that were sometimes made suggesting that I should ‘give them a good report’. The observations of practice were important in this respect in ensuring a triangulation of data collected in interviews (Woods & Cook, 2002, p. 139). Indeed, it was evident from the data that what people said they did and what they did in practice were not always the same.

2.2 Research Methods

2.2.1 Quantitative data

The objectives of the quantitative data were two fold. Firstly, to describe characteristics of child contact centres. This included frequency of service types, levels of funding, volunteerism, fees charged and additional services provided. In addition the data aimed to provide some measure of change over time from 2000-2010. These quantitative measures were used to contextualise the qualitative findings. Secondly, as discussed below in Section 2.2.2, the quantitative data were used as a

crude sampling framework for the selection of case study centres. This section describes the quantitative data sources and data analysis methods.

Two NACCC data sources were analysed. The first is an annual survey of all NACCC members in England, Wales, Northern Ireland and the Channel Islands from 2000 to 2010. The survey is completed by NACCC members who, as a condition of affiliation to NACCC, should collect information for the purpose of the survey throughout the year. From 2000-2002 the data collected referred to the calendar year. From 2003-2010 the data were collected in April each year. The data describe characteristics of the member population. The response rate for each survey is provided below. It is important to note however, that these data refer to NACCC members rather than to centres. Some members run more than one venue and so these data underestimate the number of centres. This distinction was only made clear to me very late in the process of analysis. Unfortunately NACCC did not have available data on the number of centres in each year in the real population, only the number of members.

The frequency of response, number of members in the real population and response rate for each year is presented below. It should be noted that these data refer to members in England, Wales, Northern Ireland and the Channel Islands. The number of members in the real population in England alone could not be disaggregated. However, the column on the right outlines the frequency of response for centres in England as this is the focus of analysis in the thesis.

Table 1: Response Rate NACCC Survey 2001-2010

	Frequency of response	Number of members in the real population	Response rate (%)	Frequency of response members in England
2000	165	261	63	128
2001	198	277	71	191
2002	173	273	63	165
2003/4	187	279	67	175
2004/5	193	288	67	180
2005/6	205	318	64	163
2006/7	180	314	57	163
2007/8	268	309	87	243
2008/9	252	303	83	231
2009/10	239	301	79	219

Some of these data had been previously published by NACCC in NACCC Newsletters (NACCC, 2005-2013) and in Durell, 2009. However, the analysis was of all centres in England, Wales, Northern Ireland and the Channel Islands; it was not disaggregated by country (indeed, a ‘country’ variable had to be created to do this). For the purpose of this study the data needed to be unpacked by country to examine services in England. In addition, a deeper analysis was needed, for example to compare all of the data by service type (supervised or supported services). Computation of variables was also required to create more meaningful statistics, for example to explore the percentage of centre workers comprised of volunteers/staff (as opposed to simply stating the total number of volunteers across services). In addition, this analysis sought to examine some trends across time, by comparing the data over the ten years. The data were initially in Microsoft Access and was exported to SPSS 18 (SPSS Inc., 2009) for analysis using Stat/Transfer Data Conversion Software 11 (Stat/Transfer)

There were some limitations to the data which could not be overcome. These centred on problems in the questions asked and the categories provided to respondents. For example, contact services were categorised as ‘supervised’, ‘supported’ or ‘both’ services. The category of ‘both’ is problematic in that it hides any differences between the services provided through aggregation of the data. In this sense it would perhaps have been more useful for the purpose of analysis for NACCC to request that members with both services answer questions by service rather than only by centre. Similarly, data were collected on the age of volunteers. However, the categories seemed rather arbitrary. Data were divided as follows: ‘under 18’, ‘18-50’, ‘51-75’, ‘75+’. For the purpose of the analysis it would have been interesting to understand the frequency of staff/volunteers over retirement age. Therefore a category of ‘65-74’ would have been helpful. In addition, analysis of the data suggested that the pre-determined categories for ‘centres costs’ may have disguised the range at the higher end. In the survey, members could either provide an exact figure for their costs or estimate costs by choosing one of the predetermined categories. In the case of members that provided an exact figure, the highest centre cost was £325,000. This suggests that the pre-determined category of ‘£100,000+’ may not reflect the range of centre costs at the higher end.

The qualitative findings also indicated that some of the quantitative questions hid important nuances. Referral sources were categorised in the survey as follows: ‘Cafcass’, ‘solicitor’, ‘social services’, ‘family mediation’, ‘other’. It was unfortunate that the categorisation did not differentiate cases in which there is a court order for contact at a centre from those negotiated through solicitors ‘in the shadow of the law’. Instead all of these cases were categorised as ‘solicitor’ referrals. In addition, the qualitative data suggested that Cafcass and Social Services were sometimes involved in cases which were nonetheless referred by a solicitor. Again, it is unfortunate that the data did not differentiate these cases. In both instances, had the survey provided this additional level of detail, it would have provided a much more accurate indication of the frequency with which the various professionals are involved in cases referred to contact centres. This is important because, as Chapter 5 discusses, the respective referral routes offer varying levels of support to contact centres in managing the process of referral. Due to the limitations in the data it has been used with caution. The limitations of it are highlighted throughout the analysis.

The second NACCC data source that was analysed was a short survey of all NACCC centres in England, Wales, Northern Ireland and the Channel Islands collected by NACCC in November 2010. This survey was conducted by phone and email and data were collected from 100% of centres in England (n=309). The data were analysed by NACCC and presented in its response to the Family Justice Review Interim Report (NACCC, 2011), which was published during the course of fieldwork for this thesis. The raw data were re-analysed for the purpose of the thesis for two reasons. Firstly, to disaggregate results for England and secondly, to provide an alternative analysis of two questions: the geographic distribution of supervised services and fees levied by child contact services. This re-analysis sought to visually represent additional nuances in the data on the geographical distribution of centres (discussed further in Chapter 4). The re-analysis also reported and compared data on fees in supervised services in England, where the NACCC had only provided data on supported services (NACCC, 2011, p. 34). These data were provided in InDesign (Adobe Inc, 2010) and was transferred to SPSS 18 (SPSS Inc., 2009) for analysis.

2.2.2 Qualitative data

2.2.2.1 Case study approach

A case study approach was adopted in this research for a number of reasons. An overarching rationale was that a case study approach fitted the requirements of a systems approach. Firstly, case studies provide in-depth data, which, as discussed, are required to understand ‘local rationalities’ (Woods et al., 1994, p. 93). The case study method also deliberately seeks to cover contextual conditions (Yin, 2003, p. 13). In this sense, it allows for the investigation of context in local sub-systems. Thirdly, a major benefit of the case study method is the opportunity to adopt multiple sources of data (Yin, 2003, p. 97). As discussed above, triangulation was important in order to bridge the possible gap between people’s reported and actual behaviour (Woods & Cook, 2002).

A multiple case study method was adopted for two reasons. Firstly, single case studies can be considered more vulnerable because the researcher stakes the entire study on

one case. More importantly perhaps, there are analytic benefits to having multiple cases since analytic conclusions independently arising from two cases can be considered more convincing than those emanating from a single case alone. In addition, since the contexts of the multiple case studies differ, if the same conclusions emerge from both cases, the external theoretical generalizability of the findings will be expanded, compared to a single case study (Yin, 2003, p. 53). Previous research suggested that services may differ greatly amongst child contact centres affiliated to NACCC, (Aris et al., 2002). A multiple case study approach therefore sought to explore practice in a variety of contexts. At the same time, it is recognised that the contexts chosen are not necessarily comprehensive. A larger project with additional resources could have extended the number of case studies and further theoretical generalisations may have emerged from this wider selection.

The selection of case studies was based on ‘replication logic’ rather than ‘sampling logic’ (Yin, 2003, p. 47): the cases selected do not represent a ‘sample’ and in doing a case study the aim is to expand and generalise to theories, not to statistical populations (Bryman, 2008; Yin, 2003). The primary concern therefore is the quality of the theoretical reasoning (Bryman, 2008; Yin, 2003). For this reason the cases were not chosen at random, rather each was selected to serve a specific purpose within the scope of the research questions.

The annual NACCC survey data from 2009/10 (discussed above) provided a crude sampling framework for the selection of the case study centres. The benefit of this strategy was that it allowed cases to be selected initially without the assistance of NACCC. The objective of this was to avoid any potential bias (or perception of potential bias) in the sample which could have occurred if I had been reliant on a third party gatekeeper to select cases for me. At the same time, the strategy had drawbacks: it meant that the selection was reliant on the quantitative data in this survey and that those centres which did not reply to the survey were excluded from selection, creating a potential bias. It was decided that on balance the use of the survey had benefits over reliance on a third party gatekeeper since the latter strategy posed too great a risk of bias in favour of centres that had particularly good practice.

Once the criteria for selection had been chosen there was an element of convenience in the strategy. Since in all cases multiple centres with the same quantitative characteristics existed, centres closer to the South East were favoured due to resource constraints. This may add an element of bias into the design: issues which may be specific to certain parts of England not covered in this research are unlikely to have emerged in this research. It is possible in this sense that further research may elucidate additional issues or themes. Nonetheless, the design strove for some geographical distribution: the case studies selected were not only in the South East and were spread across four different counties.

The cases were chosen based on a number of characteristics which could be identified in the NACCC data and which were hypothesised to have a potential effect on practice. The features of the six centres are outlined below in Table 2

Table 2: Characteristics of Case Study Centres

Centre	Service	Funding sources	Centre costs/family	Not for profit organisation	Staff/volunteers	Additional services
1	Supported	Cafcass Church	£50-250	Y	All volunteers	No
2	Supported	Cafcass Local and national charities trusts	£435-1087	Y	Paid coordinator	No
3	Supported	Cafcass + Church	£17-£86	Y	All volunteers	No
4	Both services	Social services Solicitors Fees	/	N	All paid staff	No
5	Supervised	Cafcass National charities Charitable trusts Social services Fees	/	Y	All paid staff	Life story contact Work with DV victims Work with DV perpetrators

						Mediation Child counselling Parenting support
6	Both services	Cafcass Church Charitable trusts Fees (supervised)	/	Y	Paid staff (supervised) Volunteers (supported)	Coaching based service to aid parents in resolving conflict

Firstly, multiple cases of centres providing supported and supervised services were selected in order to allow comparison between the two services. This selection was made on the basis that previous research suggested that resources and practice may differ both within and between the service types (Aris et al., 2002). The selection of case study centres attempted to capture some of the diversity.

Three centres providing supported-only contact were selected on the basis that the vast majority of centres only provide this service and previous research suggested that practice in supported services may be particularly problematic (Aris et al., 2002). The rationale therefore was to have three services within this category, representing a variety of characteristics. Similarly, three services providing supervised contact were selected. Amongst these, two offered both services while one only offered supervised contact.

Previous research hypothesised that the focus on the importance of family life in the organisations that set up the original contact centres, may have led centres to be less concerned with safety compared to services in other countries which were allied to DV services (Aris et al., 2002). In order to ensure a diversity of organisational types, two supported centres and one centre providing both services were selected which received funding from churches. The other supported service received funding instead from local and national charities. Amongst the supervised services, one received funding from a church; the second was a for-profit company (in contrast to all other centres which were not-for-profit) and the third received funding from charitable trusts and national charities.

Since previous research suggested that insufficient funding may affect practice in general in contact centres, supported-only centres with roughly, high, median and low levels of cost per family were selected.¹ This criterion was not used to select the centres offering supervised contact since amongst centres offering both services the cost per family using each service and the number of families in each service could not be disaggregated.

¹ The 2009/10 NACCC data suggested that the median level of funding per family was £31-152. The figure is represented as a range as centres were asked to select annual centres costs within eight range categories. This number was divided by the number of families per centre.

Previous research also suggested that centres which could employ a paid coordinator were more likely to screen cases and have families visit the centre before contact (Aris et al., 2002, p. 47). For this reason, one supported-only centre employing a paid coordinator was selected, while the other two supported-only centres relied entirely on volunteers. In the NACCC data no supervised-only services and only one centre offering both services had an unpaid coordinator. For this reason, in the case study, all of the centres providing supervised contact had a paid coordinator.

Centres offering supervised contact were also selected based on the provision/non-provision of additional services. One centre had no additional services; the second offered multiple services (including those around DV, which it might be suggested imply a focus on safety) and a third provided 'parenting support'. This criterion was selected for two reasons. Firstly, in order to gain some understanding of the services that may be provided in centres. Secondly, it was based on the proposition that the additional services provided may provide an indicator of the level of professional training in centres.

Overall the quantitative data were not expected to provide a framework for selecting the full spectrum of diversity in terms of the services that exist. Rather, the purpose of using it was firstly, as discussed, to decrease the risk of selection bias and secondly, to try to ensure that there was some diversity within the sample. In other words, the limitations of this approach were recognised from the start but on balance it was felt that it provided a better strategy than the alternatives: requesting that a gatekeeper select case study centres based on the researcher's criteria or selecting at random from the quantitative data.

The research however, revealed a further limitation to the strategy adopted. The qualitative fieldwork subsequently indicated that the 'centre costs per family' figure did not have clear meaning. Centre 1 reported that although this was their budget, they did not use all of the funding they had but rather saved it to be used in case funding dried up in subsequent years. In addition, Centre 3 had more than twice the number of families compared to the other two supported services. However, the qualitative data revealed that this was because the centre operated through two teams of volunteers who worked independently on alternative Sundays. Therefore the centre could take on

twice the capacity of families, but these families could only use the centre every second week. A more meaningful measure of the budget/family would therefore have needed to incorporate the frequency of which families used the services. This was unavailable. For these reasons, this quantitative indicator was unlikely to provide a meaningful measure of centre service costs per family. The provision of a paid coordinator and additional services seemed a more useful means to assess the resources available to centres.

In this respect, the problem encountered suggests the need for caution to be exercised where quantitative indicators are used to select case studies. While survey data provides a useful means of gathering statistically representative data on a large scale, it may not capture the depth of complexity on the ground. I attempted to check the survey data by asking the coordinators/managers of centres to verify it over the phone before centres were selected. However, a more useful strategy may have been to spend more time analysing what each quantitative question may not represent and how it could be interpreted in unexpected ways. This could then have provided the framework for a more detailed discussion with centre managers before centres were selected. Although not guaranteed to highlight problems in the quantitative data, the strategy may have made it more likely that they would have been identified.

2.2.2.2 Approaching selected centres and centre refusal

Of the centres selected, one centre offering both services had closed down. It was found that information on two centres (in both cases concerning whether the centre offered supervised contact in addition to supported) was out-dated. One centre offering supervised-only contact refused the invitation to take part. The manager reported that this was because they did not feel it appropriate for a researcher to sit in on individually supervised contacts. These centres were therefore replaced with others with the same list of characteristics.

The centres were approached by the researcher by telephone. The research and potential role of the centre was discussed with the centre coordinator/manager and it was explained that an email would follow providing this information in writing. In addition the email provided copies of the informed consent form for participants and the letter of approval from the LSE Research Ethics Committee. It was explained to

participants that NACCC was supporting the research and contact details were provided of the NACCC regional coordinator in each centre's area, should the centre manager wish to discuss the research with them. Coordinators/managers were asked to confirm their consent to their centre's participation after they had read this information.

2.2.2.3 Direct observations

Observations in this study were used to collect data on the first research question: 'how well do centres manage their commitment to protect?' They were particularly important to address the potential gap between people's self-reported behaviour (gleaned from interviews) and their action in practice (Bryman, 2008; Grey, 2004; Woods & Cook, 2002). Observations also overcome the common problems in survey and interview data of bias, poor recall and poor or inaccurate articulation (Yin, 2003, p. 92). A further advantage over the interview method is that observations offer an extremely high degree of flexibility in terms of what is observed. For this reason they can lead the researcher to issues not identified by participants or anticipated by the researcher (Bryman, 2008). Furthermore, the observer's extensive contact with the social setting allows the context of people's behaviour to be mapped out in full (Bryman, 2008). Observations provided data on a number of dimensions of practice relevant to the first research question. This included engagement with children, monitoring and intervention, intra-centre communication of information and physical features of the centre. Where possible I observed not just on-going contact but also the preparation for it in pre-visit interviews.

Frequency of observations

Across the six centres I undertook a total of 58² hours of observations. At the point of seeking access to centres I asked each manager if I could visit the centre three times. The request to visit three times was based on a number of pragmatic considerations. Firstly, in attempting to gain access to centres, I was concerned to ensure that the number of requested visits would not be seen as an excessive burden on centres.

² Including four hours of observations from scoping work

Secondly, I did not want to intrude on families more than was necessary. Thirdly, I was limited by resources. My journey time to the nearest centre was around 1 hour and the most distant centre took 3hrs 30 minutes to reach. My funding did not include fieldwork expenses and I therefore had to ensure that I worked within the resources available. Having undertaken the scoping research I was also confident that three visits would provide useful data. The number of hours spent in each centre and number of visits per centre is outlined below in Table 3 below.

Table 3: Observations		
	Hours spent	Number of visits
Centre 1	7.5	3
Centre 2	6	3
Centre 3	16	4
Centre 4	7.5 (of this, 2 hours supported contact)	2
Centre 5	6	1
Centre 6	15 (of this, 9 hours supported contact)	3

Three visits were made to each of the supported services, with the exception of Centre 4. This was because, as discussed in Chapter 3, supported contact in Centre 4 was essentially supervised contact, but without a report; it was individually supervised. In the case of Centre 3, an additional visit was made as the scoping work was undertaken at this centre.

Visits to the supervised services proved more difficult for a number of reasons. Firstly, as discussed further below, I relied on centre managers to initially approach families, explain the research and request permission for me to observe contact. Some managers of centres found this to be burdensome on their time and all (understandably) placed limits on how much they were willing to do. Secondly, given that supervised contact is often ordered in the most extreme cases, many cases were not appropriate for me to

observe. In particular where my presence could add to a child's distress the observation could not ethically take place. This limited the number of cases that I could observe. It also meant that the sample of cases I was observing was biased towards those with less serious issues and that, at times when I was in centres, there were no suitable cases for me to observe.

On the first day of observations in Centre 5 I spent six hours at the centre. Three families were due to visit, each for two hours; however, in one case a parent did not turn up and so the contact was cancelled. Of the other two cases, one was a pre-visit interview. In the other the (young) child was distressed during contact and so (as per my agreement with the centre and parents) I did not enter the room. Instead I listened from another room, with the door left ajar (with permission). Due to the child's distress the contact only lasted 30 minutes. I nonetheless spent the time when cases had been cancelled speaking with staff and observing their conversations with each other surrounding cases. I had agreed with the manager that I would visit again. However, she articulated that she could not permit another visit as she felt most of their cases were not suitable for observation due to the vulnerability of the child and that the time taken to arrange the families' consent for observations had been burdensome on staff who were already overstretched.

In Centre 6 I observed supervised contact on two visits to the centre. In total I observed six cases of supervised contact by four different supervisors. Of these, I observed three cases for the full two hour duration of the session. The other three cases were being supervised in the same room by other supervisors. On the second occasion when I had arranged to visit the centre, there were no cases suitable for me to observe and so I could only observe supported contact. In Centre 4 I observed two cases of individually-supervised 'supported contact' (each an hour long) and three cases of supervised contact. In two cases I observed the full two hour duration, while in one case I was only in the room for the first thirty minutes, although the session lasted for two hours, as a case I was observing in full was due to start.

Non-participatory observations

Observations were non-participatory. Participant observations would not have been either possible or useful in supervised services, where one trained worker supervises each family. In supported services it may have been possible to negotiate participant observation with the researcher taking on the role of a volunteer. It could be argued that this would have improved my capacity to 'see as others see' (Bryman, 2008, p. 465). Moreover, by embedding myself personally in the work of centres I may have improved the level of trust between researcher and participants potentially improving the likelihood of natural displays of behaviour and more honest discussion in interviews (Bryman, 2008, p. 466). Despite these potential benefits, I decided that non-participant observations in both services would be more appropriate for a number of reasons. Firstly, non-participation allowed me to concentrate fully on my role as observer. This enabled me to make more precise records, in particular jotting down verbatim quotes where appropriate. In addition, problematic practice in some centres was anticipated, based on the literature and the scoping work. By positioning myself as a non-participant observer I could avoid the potentially difficult situation of being asked to partake in practice which I found ethically problematic.

In supported contact services I observed the contact session by moving throughout the centre to areas where volunteers were stationed. Since I was observing the work of the centre, rather than families, I did not spend time observing areas of the centre where volunteers were not present, rather I dropped briefly into rooms to check whether they were being supervised and observed from a distance how long they were without supervision. When volunteers were observing families, I positioned myself as close to a volunteer as possible so as to get a sense of what they could see and hear.

In Centres 1 and 2 the volunteers spent most of the time sitting in one part of the centre. In these centres I sat with these groups for much of the time, listening in to conversation and taking notes. Inevitably I was also part of the conversation and these group discussions provided for an exchange of dialogue about my research and also about the centre and its work. Although this provided useful material, my presence undoubtedly altered the conversation to issues which would perhaps otherwise not have been discussed. During these discussions and indeed in observations in general I

was cautious to never give my opinion on issues relevant to the work of the centre. Similarly, I attempted to hide any facial or behavioural display of opinion in reactions to practice (Hallowell, 2005, p. 24). In all centres where there were volunteers undertaking different roles (for example, making tea in the kitchen or ticking families off a list as they arrived), I moved around the centre in order to get a sense of each role.

In some centres work took place outside of the contact sessions. This was not observed. In Centre 1 pre-visit interviews with families took place in the contact room during contact sessions. With parents' permission I observed four of these interviews in total during my time at the centre. In Centres 6 and 3, volunteer meetings were also observed. In Centre 2 these took place outside of contact session time (in volunteers' homes) and therefore were not observed.

Observational bias is a danger when collecting data by this means (Yin, 2003). The internal reliability of observational evidence may be increased (although not guaranteed) by having more than one observer making observations (Yin, 2003, p. 93). However, this approach was not an option since the solitary nature of PhD research (in which the work must be entirely the author's own) meant that I had to undertake observations alone. Therefore I adopted other strategies in an attempt to improve reliability.

The first of these was to use a small notebook while in centres. This allowed me to immediately write down quotes verbatim and to note my observations immediately or very shortly after I saw or heard them. This reduced the possibility that they could be significantly altered later through recall bias (Emerson, Fretz, & Shaw, 2001, p. 356). I found that analytical points sometimes occurred to me and I wanted to write them down. However, I was cautious to ensure that my observational notes remained separate from analytical ideas (O'Reilly, 2004, p. 99). I therefore distinguished them clearly in my notebook, starring notes that were analytical as opposed to observational. This provided a clear audit of my observational notes; the 'raw data'. Despite these attempts to improve reliability, it must be noted that it is perhaps impossible to completely remove the subjective aspect of the observational method. As the

researcher takes notes, she inevitably shapes what she sees and hears because it is impossible to record everything (Emerson et al., 2001; O'Reilly, 2004, p. 99)

Using a notebook while in centres also posed potential disadvantages which needed to be addressed. It had the potential to make participants feel uncomfortable. In particular, I was concerned to avoid the possibility that families would feel intruded upon if they saw me taking notes. Similarly, workers may feel less relaxed and therefore change their behaviour. In order to go some way towards addressing these issues I attempted to use the notebook as surreptitiously as possible. I used a small note book that could fit in my pocket. In supported services I always tried to move immediately to a quieter part of the centre or to an area where I was not so conspicuous when writing about worker's observed behaviour. This sometimes meant there was a small time delay in writing up my notes (of a few minutes) but I felt this presented a good compromise between writing up notes in front of the participants I was writing about and waiting until after the session to write up. In supervised services I wrote notes immediately but as in supported services I did this in short hand so as to limit the time I was writing for. I later typed these notes up in full.

2.2.2.4 In-depth Interviews: contact centre staff and volunteers

In-depth interviews were used to collect data on both research questions. In terms of the first question: 'how well do centres manage their commitment to protect?' the data from interviews sought to triangulate data from the observations of practice. In addition, self-reported data were collected on aspects of practice that were not observed:

- How did participants deal with memorable cases or incidents which occurred outside of the observations?
- In centres in which pre-visit interviews or staff/volunteer meetings could not be observed, did these take place and if so what did they entail?
- What additional services (if any) are available to build safety?

The interviews also provided data on the second research question, what factors influence centres in managing their commitment to protect? Data were collected on the following issues in this respect:

Resources:

- How do the resources available to the centres affect the reported local rationalities of workers?
- What funding do centres receive?
- How do centres use the funding they receive? How do workers feel about the level of funding they receive?
- How (if at all) does funding of supervised services affect the local rationalities of centre coordinators?
- What training or qualifications do workers report having received?
 - How do workers feel about training?

Responsibilities:

- How do workers understand their responsibilities/the work of the centre? What do they prioritise?
- How do workers understand child protection concerns? (DV, alcoholism, drug use, previous abuse or maltreatment abuse etc)
- Do workers feel the cases are appropriate to the centre?
- What are workers experiences of dealing with child protection concerns (especially referral to other agencies)?
- How do workers understand the position of centres within the wider system of inter-professional working?
- How much information do workers have about families? How do they feel about this?
- What meaning do workers ascribe to their interactions with families?

Children:

- How do workers understand children's best-interest?
- How do workers understand children's capacity to have wishes and feelings?
- How do workers understand their responsibility to listen to children?

- How do workers characterise their interactions with children? What meaning do they ascribe to interactions?

Inter-professional working:

- According to workers, what are the characteristics of cases at the centre?
- Do managers report using the Standard Referral form?
- How do coordinators understand their own and referrers responsibility and capacity for the following:
 - Collecting information about families
 - Analysing information about families
 - Making a decision about whether the case should be accepted

Semi-structured interviews provided a framework for discussion while allowing for probative follow-up and affording participants sufficient control to direct the discussion to issues unanticipated by the researcher (Mabry, 2008). This method also ensured that misunderstandings on the part of the interviewer or interviewee could be checked immediately (Brenner, Brown, & Canter, 1985) and the semi-structured nature of interviews provided a framework for comparison across case studies (Bryman, 2001). Importantly, in terms of the systems approach, interviews enabled the contextualisation of behaviour, values, experiences and understandings such that behaviour could be explained through an understanding of the particular context within which it took place (Bryman, 2001). In keeping with the systems approach, local rationalities were a focus of all interviews. During interviews participants were encouraged to reflect on concrete examples of cases they had experienced in order to ground data in actual behaviour. To ensure service users' confidentiality, the participants were asked to describe the case without naming the service-user (Arthur & Nazroo, 2003).

I was concerned to avoid leading participants and to avoid sounding judgemental. For this reason I did not suggest to participants that they had child protection responsibilities. Instead the interviews focused on asking participants about their understandings of their responsibilities in the various respects outlined above. Appendix 2.1 shows the interview schedule used in interviews with coordinators and

volunteers in supported-only services. Interviews in supervised services were scheduled after those in supported-only services and Appendix 2.2 shows the interview schedule for managers of supervised services and centres offering both services. The interview schedule for staff supervising contact is provided in Appendix 2.3.

Interviews with coordinators/managers of centres lasted between 1 hour 5 minutes and 1 hour 47 minutes. Interviews with staff and volunteers lasted between 42 and 57 minutes, with the exception of Centre 5 where interviews with staff lasted 26 and 31 minutes respectively. This was because the manager of the centre decided unexpectedly that she could only spare workers for this amount of time.

It was intended that interviews would be conducted in person. However, there were a number of impediments to this. In supported-only services the centres closed directly after the contact session and special arrangements would need to have been made to stay in the building. The coordinator of one centre also said she would feel responsible for our safety at the centre and was not comfortable with us being at the centre alone. Additionally, having volunteered a significant amount of time on a Saturday, volunteers tended to want to enjoy the rest of the day free from activities associated with the work of the centre. For these reasons all but one interview with volunteers was conducted by phone at a time that suited the participant. Similarly it was more convenient for staff in Centre 6 to do interviews by phone. However, staff in the supervised services in Centres 3 and 4 were more easily able to do interviews in person, since these staff were working throughout the week and an empty room was available in the centre. Therefore, of the 27 interviews with staff and volunteers in contact centres, eight were undertaken in person and 19 by phone. All interviews were sound recorded with permission and transcribed in full for analysis.

When centres were recruited it was agreed that I would interview around four workers per centre (including the coordinator/manager), all of whom I would have met during the observations. During observations I would have the opportunity to encourage particular workers to volunteer. In this way I hoped to go some (small) way towards counter-acting selection bias which was otherwise likely to result in those workers who were most confident taking part. Where more than four staff volunteered I did up to five interviews. I encourage workers to take part based on a purposive sampling

strategy, attempting to select individuals who represented differing perspectives, experiences, age groups or genders (though in some centres I did not meet any male workers). Selecting the volunteers I had met during observations allowed me to ask questions specific to practice or incidents that occurred during contact sessions. Interviews were therefore scheduled after observations. The strategy was however reliant on workers volunteering for interview and on the on-going good will of centres.

In practice access to volunteers varied somewhat between centres. In Centres 1, 2 and 4 this strategy worked to plan. As the interview guide was piloted in Centre 2 six interviews were undertaken in total to allow for some flexibility while the interview guide was in the early stages of development. In Centres 5 and 6 it transpired when I arrived that the centre manager had selected participants. It is possible that this was a misunderstanding between us or perhaps that they felt they were being helpful in doing so. It is also possible that this was a strategy to control who participated with a view to controlling the results of the research. In any case, since the individuals had agreed to take part, I did not feel that I could 'un-invite' them and request their colleagues' participation instead. Despite this selection process the data demonstrated a variety of perspectives, opinions and experiences. In Centre 3, only three staff were interviewed (including the coordinator). In this centre after observations had taken place the manager articulated that she could only spare two staff for a short amount of time and that in any case, only two staff had volunteered for interview.

All in all, the interviews highlighted the disconnect between the theory and practice of sampling strategy. Qualitative researchers usually aim to keep getting data until they reach saturation, which can be defined as sufficient depth on the full range of the phenomenon they are interested in (Baker & Edwards, 2012, p. 15). It is not possible to pre-empt when saturation point will be reached before the research begins. However, negotiating access to case study sites required firm answers to this question. In addition, in some sites it was simply not possible to recruit additional participants. The notion of saturation also presents challenges for the PhD researcher. The constraints of time and budget, where travel is required, in reality impose barriers to the process of data collection. All in all therefore, while in theory a saturation approach would have been preferable, in practice my dependence on the good-will of participants (who I was

not incentivising) to take part and my time and budget constraints meant I had to compromise.

While pre-empting the approximate number of interviews I would undertake constrained the data I could collect, I would argue that it does not compromise the quality of my findings. Rather it places limits on what I can claim from my data. For example, I do not claim any level of quantification from the qualitative data nor do I claim that it necessarily represents the full range of perspectives or experiences in the study population. In presenting my findings I have endeavoured to ensure that at all times I remain within the confines of what my data can support.

2.2.2.5 In-depth interviews: referrers to child contact centres

Interviews with professionals who had referred to a child contact centre were undertaken in order to collect data relevant to answering the second research question: ‘what factors influence centres in managing their commitment to protect children from maltreatment?’ In this regard, the data collected refer specifically to the influence of inter-professional working on centres’ practice. Data were collected on the following issues:

- What factors influence the local rationalities of referrers in making referrals to supported and supervised services respectively?
- How do referrers understand their responsibilities and those of centres in the following tasks:
 - Collecting information about families
 - Analysing information about families
 - Making a decision about whether the case should be facilitated at the centre
- How accurately do referrers understand the services provided by contact centres?
- What tools and skills are available to referrers and how do these equip them in the process of referral?
- Do referrers engage with children to understand their wishes and feelings?

- In what ways?
- How do referrers understand children's capacity and best-interest?

It was originally intended to interview solicitors, social workers, Cafcass officers and judges who had referred to one of the six case study centres. This strategy was chosen over recruiting professionals who had referred to any contact centre for the purpose of contextualising the data. In particular the contextualised data would allow me to explore referrers' understandings of the specific services they had referred to. I felt this was necessary since previous research indicated that services differ greatly (Aris et al., 2002). However, my approach changed as challenges were encountered in both access to and recruitment of professionals.

It has been suggested that when interviewing professionals who may be considered elite by virtue of their privileged position in society and influence on political outcomes, it is crucially important for the interviewer to know his/her subject thoroughly (Harvey, 2010; Richards, 1996). In order to address this point, interviews with referrers were held in the final stages of fieldwork. This allowed me to draw on my initial analysis in developing the interview guide.

I decided to conduct all of the referrer interviews by phone. Conducting interviews by phone presents disadvantages since it is not possible to read visual cues and rapport may be compromised (Novick, 2008). However, I rationalised that telephone interviews presented the best possible chance of recruitment since they would allow the maximum amount of flexibility to these professionals who were likely to be busy and may need to cancel last minute. This was also important for me since many of the referrers were located quite a distance away and last minute cancellations would incur costs in terms of wasted time and transport tickets which, if too burdensome, could jeopardise the research. In the event, I found that telling referrers that they should feel free to call or text to reschedule at the last minute made some more willing to participate. Referrers from all of the professional groups did this and seemed to appreciate my flexibility and understanding of their working schedules. I felt that this in itself was helpful in building rapport.

Solicitors

Solicitors were recruited through the case study centres. Each centre was asked to contact solicitors who had made a referral to them and provide a list of those who were willing to be contacted. Centres were provided with information about the research for this purpose. This recruitment strategy presented some disadvantages. Firstly, it presented the possibility of a biased sample since centres may only contact solicitors they have a particular type of relationship with. However, there was no evidence of this from the data. Indeed centre coordinators/managers seemed to want me to speak with both solicitors they had received inappropriate referrals from and those they had good working relationships with. The strategy may also have affected recruitment. On the one hand, solicitors may be more likely to take part having been first approached by the centre who they already had a relationship with. On the other, where centres were unexpectedly unwilling or unable to approach solicitors I was unable to recruit. Ultimately, I did not wish to place centres in a potentially awkward position by asking them to provide the names of their referrers to me without the referrers' consent.

In total 21 names were provided. I did not receive any names from two centres (Centre 4 and Centre 5). Centre 5 did not have referrals from solicitors; Cafcass or Social Services made all referrals. In Centre 4, the manager had agreed to contact referrers. However, when I called to see how this was progressing I was informed that he had resigned. The new manager was still finding her feet and did not feel she could take part in contacting referrers.

I sent an email to each solicitor and followed up with phone calls and reminder emails. Nine agreed to take part. No solicitors objected to the research per se; five responded to say that they did not have time to take part, two agreed to take part but subsequently did not respond to emails or phone calls and four did not respond to the emails or phone calls. I originally planned to request 45 minute interviews and made this request to the first five solicitors I contacted. However, after a poor response and after speaking with a solicitor I decided to change this to the following:

'The interview would ideally take 40 minutes but any time you can give to speak to me would be much appreciated; even 10-20 minutes would be helpful.'

We can do the interview by phone and I can call at a time that is convenient for you.'

In the follow-up emails and phone calls I also made the change in request clear to the five solicitors I had contacted and secured two interviews. This strategy was subsequently also used to recruit social workers. In total 9 solicitors were interviewed. The distribution across centres is outlined below in Table 4.

Table 4: Distribution of Solicitor Interviews across Case Study Centres

Centre	Solicitors interviewed
Centre 1	3
Centre 2	1
Centre 3	2
Centre 4	0
Centre 5	0
Centre 6	3
Total:	9

Some solicitors said they only had 20 minutes to speak with me but in the event the shortest solicitor interview was 31 minutes and interviews ranged up to 46 minutes. Where participants had agreed a 20 minute interview I used a short version of the interview guide (see Appendix 2.4 for both versions) and signalled that we had come to the end of the 20 minutes and that I was ready to end the interview. All participants were willing to continue speaking and I agreed with them that they would let me know when they had run out of time.

Social workers

There were effectively three gatekeepers in terms of interviewing social workers: the Association of Directors of Children's Services (ADCS) Research Group, individual Local Authorities (LAs) and individual social workers. My application to ADCS was approved with permission to interview up to twenty social workers. This meant that the

research was placed on an 'approved' list which is provided to LAs. LAs must then be approached individually for their consent to participate. As discussed below, obstacles were encountered in surpassing the second and third stages: individual local authorities and social workers.

Social workers could not be recruited from the case study supervised services. As discussed, no referrers could be recruited from Centres 4 and 5 and Centre 6 did not accept social worker referrals. The fieldwork in supported services also revealed that in some cases in which social workers are involved the referral is made by a solicitor. In these cases, centres did not necessarily hold the contact details of the specific social worker.

For these reasons recruitment through centres did not seem as though it would be a successful strategy. In any case, I would need to contact individual Local Authorities (LAs) to request permission to interview their staff. I therefore decided to contact the LAs directly. Citing the approval from ADCS and the LSE Research Ethics Committee, I contacted the LA in which each case study centre was located by email. I asked if they would take part in the research and if any of their staff, who had referred to the case study centre or been involved with a family referred, would be willing to take part in the study. I followed up non-responses by phone. Although the Directors of Children's Services were positive about the research, no social workers volunteered for interview. Following the failure of this strategy I asked if social workers, who had referred to or been involved with a family referred to any child contact centre, would be willing to volunteer for interview. Again, this did not yield any participants.

I therefore decided to change my recruitment strategy to recruit social workers who had referred to any child contact centre in England. I arranged with The College of Social Work Communities of Interest 'Knowledge Hub' to place a notice on the website which appeared in an email as an announcement to the roughly 500 members who had subscribed at this time. The notice explained the research and invited social workers who had referred to a centre or been involved with a family referred to partake in an interview under the same terms as the solicitors. I recruited one social worker through this strategy.

In addition I sent out individually titled emails to each of the 152 Directors of Children's Services. Thirty-two responses were received. Of these, 16 responded that their staff do not make referrals to private or voluntary sector contact services; 11 local authorities were willing to participate. In total, eight social workers from six local authorities identified themselves as having referred to a contact centre and volunteered for interview. Two of the social worker interviews were around twenty minutes long and the rest were over 30 minutes ranging up to 41 minutes. The interview guide is provided in Appendix 2.5.

Judges

There were four gatekeepers in the process of gaining access to interview judges. Firstly, approval was needed from the Ministry of Justice who, upon approving the proposal referred it to the Office of the President of the Family Division. The Office approved the research and recommended that I contact a list of three Designated Family Judges whose courts may make referrals to the case study contact centres, which I had specified. I then required the Designated Family Judges to contact their judges in order to ask judges who had referred to the case study centres to volunteer for interview. I contacted the Designated Family Judges by letter and each agreed to contact the judges in their jurisdiction.

When I applied to the Ministry of Justice for permission to interview judges I was told informally that only around 10% of applications are successful. One of the criterion for approval is that 'participation will not impose an undue burden on members of the judiciary' (Ministry of Justice, 2010, p. 1). I therefore decided to limit my request in the hope that it would be more likely to be approved. I requested to interview six judges, each of whom had referred to one of my case study centres or alternatively, if this was not possible, to interview six judges who had referred to any six centres in England. The research was approved with permission to interview six judges who had each referred to one of the case study centres. However, despite three attempts to contact judges, I was only successful in recruiting three judges. They had respectively referred to Centres 2, 5 and 6.

The Designated Judge in one of the jurisdictions reported at first that no judges in the area felt they could take part in interviews because, aside from making the order for contact at the centre, they did not have any further dealings with the centre. I assured the judge that the interview would still be very useful. Since I was interested in judges' expectations of the service, knowledge of the service was not a necessity. A judge in this jurisdiction then agreed to partake, after repeated reassurances of anonymity. In my follow-up attempts at recruitment in the jurisdictions where no judges had been recruited I reemphasised the commitment to anonymity and emphasised that knowledge of the centre was not necessary. However, no additional judges came forward for interview. The interview guide for judges is provided in Appendix 5.6.

Cafcass Officers

It was intended to interview Cafcass Officers who had referred to the case study centres and so I applied to the Cafcass Research Committee for approval. Following my application the committee responded with a request to clarify. I had referred to child contact centres' 'statutory responsibility' to protect children from maltreatment. However, as the committee correctly pointed out, child contact centres do not have a 'statutory responsibility'. In my response I acknowledged the mistake I had made in wording the proposal. I explicitly stated that contact centres do not have a 'statutory responsibility' and referred instead to child contact centres 'safeguarding responsibility as set out in the Statutory Guidance, 'Working Together to Safeguard Children' (2010).' This, responsibility, I suggested, stemmed from the responsibility of all organisations working with children and families to safeguard children, as outlined in paragraph 2.2 of the guidance. Despite this clarification, the Committee decided not to support my research. The email notifying me of the decision stated:

'The main reason for this decision was that the Committee does not consider that Cafcass should be associated with a research proposal that does not reflect our own understanding of the legal framework within which child contact services are provided, in particular in relation to their safeguarding responsibilities.'

For this reason Cafcass Officers were not interviewed in this research. This represents an important limitation which further research might address.

Cafcass' response is however puzzling since it seems to imply that the Cafcass research committee considered that contact centres do not have a safeguarding responsibility as set out in Working Together (2010). However, a legal academic I consulted agreed that contact centres do have such a responsibility as did the solicitors who participated in this study. The responsibility is also recognised by NACCC (NACCC, 2010a, p. 28). Moreover, the current Working Together Guidance (2013) states unambiguously that:

'Everyone who works with children - including teachers, GPs, nurses, midwives, health visitors, early years professionals, youth workers, police, Accident and Emergency staff, paediatricians, voluntary and community workers and social workers - has a responsibility for keeping them safe'

(HM Government, 2013, p. 8).

Since the change in wording from 'commitment' to 'responsibility' is not signalled as a change in guidance, it would seem to imply that the responsibility was the same in the 2010 guidance.

An overview of the qualitative data collected is provided below in Table 5.

Table 5: Overview of Qualitative Data Collection

Observations of centre practice	58 hours
Centre staff and volunteers interviews	27 interviews
Solicitor interviews	9 interviews
Social worker interviews	8 interviews
Judge interviews	3 interviews

2.2.2.6 Qualitative data analysis

All qualitative interviews were sound recorded and transcribed and field notes were transcribed into softcopy. This allowed for them to be transfer to Nvivo software for the purpose of coding. The process of analysis drew heavily on Spencer and colleagues' 'analytical hierarchy' (Spencer, Ritchie, & O'Connor, 2003). I began by coding for the purpose of applying data management techniques to reduce the mass of data into more manageable, searchable components. Therefore much of the initial coding was descriptive. This initial process was helpful in dealing with the 'messiness' of qualitative data. From this, more in-depth analysis could be applied. The data were sorted in terms of themes and concepts. Dimensions were identified and categories refined. Further up the analytical hierarchy the analysis sought to develop explanatory accounts. The process sought out patterns of association within the data and tried to account for why those patterns occurred. It further sought to apply the data to wider theory and literature (Spencer et al., 2003, pp. 213-215). The literature was reviewed prior to the fieldwork but the process continued iteratively as themes emerged from the data. The process of analysis was not linear. Rather it involved constantly moving up and down levels of abstraction on the analytical hierarchy: as categories were refined, dimensions clarified and explanations developed there was a need to revisit the original data to search for new clues, to check assumptions and to identify underlying factors. This non-linear process aimed to constantly check how well the data fitted (Spencer et al., 2003, p. 213).

An example from the empirical research may help to elucidate this process further: A typology of child engagement is presented in Chapter 6. The typology was developed through reading and re-reading of the qualitative data in conjunction with an evolving literature base. Initial data analysis was aided by prior reading of the literature on child engagement and alternative typologies of child engagement (referred to in Chapter 6 and Appendix 6.1). The data was coded, first under the theme 'child engagement' and later into descriptive sub-headings including, 'reluctant child', 'child scaffolding', 'protection from re-traumatisation', 'carrying out court order', '“rights” to contact' and 'child capacity'. Through this process I began to conceptualise the notion that some ways of engaging with children, evident in the data, could perhaps be defined as coercive while others seemed more meaningful. In order to further develop this

analysis, I sought out literature in the fields of philosophy and mental health where there is a developed theoretical literature surrounding issues of capacity, coercion and paternalism. I used this literature to define the category of “coercive engagement” and re-examined the raw data as my understanding of the literature grew. Similarly, the literature on children’s capacity to communicate, also cited in Chapter 6, was used to support the development of the categories of “limited” and “meaningful” engagement. As I developed these categories I returned to the data and re-coded using the categories in the typology.

Data analysis was closely linked to data collection in an iterative process (Bryman, 2001; Spencer et al., 2003; Yin, 2003). Interviews were transcribed as soon as possible after the interview had taken place so that an initial analysis could be undertaken. This was used to update the interview guides and also to ensure that unforeseen issues would be followed up in other interviews (Grey, 2004).

It is important to clarify the nature of the explanatory accounts offered in the thesis. In keeping with the systems approach conceptualisation of non-linear causality in human systems, the analysis presented here is highly sceptical of the assumption that it is possible to identify deterministic, Humean causes (X always follows Y) since the social world is unlikely to be governed by the same laws of physics as (may) exist in the natural world. This is not to suggest that human behaviour is entirely disordered; ‘if human behaviour is not law-like, neither is it chaotic; it displays regularities which can be identified through careful analysis.’ (Spencer et al., 2003, p. 215). Explanatory accounts can be presented which do not imply determinism. For example, Hughes (1997) suggest that social researchers should present explanations at the level of meaning rather than explanations at the level of deterministic cause. They give the example of behaviour in the vicinity of traffic lights. They argue that this behaviour can be better explained by understanding the meaning the lights have within a particular social setting, group or culture rather than by trying to specify the necessary and sufficient conditions and causal mechanism which produce a particular pattern..

Therefore in this thesis the explanatory account offered attempts to explain why behaviour has occurred. However, I assume a non-linear notion of causality. The analysis does not claim that the explanation offered is deterministic and it is explicitly

acknowledged that given the complex nature of human interaction, it is always possible that some interacting factors have not been accounted for.

2.3 Ethical considerations

The research was reviewed and approved by the London School of Economics (LSE) Research Ethics Committee. Informed consent was sought from all individuals participating in interviews (staff/volunteers in centres and referrers to centres). Each participant was provided with an information leaflet and consent form for this purpose (see Appendix 2.7 for consent forms for centre staff/volunteers and Appendix 2.8 for referrers). In supervised contact services (where each family has contact in a separate room with one or more supervisors who observe contact closely) informed consent was sought from parents having contact and from children over 16 years of age as well as from supervisors (see Appendix 2.9). Ethical guidelines that assert the need to seek assent from children often suggest that researchers should consider asking for assent from children over the age of seven years (Morrow, 2009; The World Health Organisation). Assent was therefore sought from all children over seven years of age (see Appendix 2.10). However, since ethical guidelines and research suggest that children's capacity to consent should not be assumed based on their age (The World Health Organisation), provision was made for children younger than seven years who demonstrated (through discussion with the researcher) a capacity to understand the research process to give their assent. Prior to the research I planned that where children of any age seemed to demonstrate an objection to my presence (whether behavioural or verbal) I would immediately terminate the observation. However, this did not transpire during the research.

Information leaflets and consent forms were posted to centre managers at least four weeks prior to observations. In order to ensure that families had sufficient time to consider whether or not to take part (Morrow, 2009), the manager initially approached families and provided them with the information leaflet and consent forms. I explained to managers that they should not put any pressure on families to take part. If families consented they were asked to bring along the signed consent sheet on the day of the observation. I then provided an additional verbal explanation of the research and made

it clear that they did not have to take part and that there would be no negative consequences if they decided not to take part. I also reiterated that if they did consent to the observation they could still ask me to leave at any time. This was also stipulated in the consent form which further stated that I would only observe one session of contact and that I would not ask any questions or interrupt the session in any way.

Observations in supported contact services (where many families are together in one room) posed a number of issues. Firstly I could not seek informed consent from all parents prior to the day of the contact session since it would have been unethical for centres to provide me with the names and contact details of individuals. The observations would however pose very little disturbance since, as described, my role as observer was very similar to that of the volunteers. As in the case of the supervised services, the observations were also not of parents and children themselves, but of the work of the centre. In addition, because families have contact in the same room, the refusal of one individual would mean that the observation would not be possible (even if all other parents agreed). For these reasons an 'opt-out' mechanism was used.

Managers in the case study supported services were asked to provide all parents who were due at the centre on days where observations were due to take place with an information leaflet prior to the day of observation (see Appendix 2.11). Information leaflets were posted to centres a minimum of four weeks prior to the observation for this purpose. On the day of each observation I identified myself to all parents and children attending the centre, explained the research verbally and offered them the opportunity to ask any questions. Each family was also offered an additional copy of the information leaflet. If on the day any individual had objected to the observation I planned to provide them with written confirmation that I would not report on any interaction involving them (even anonymously). In the event no parents or children objected to the research.

In the informed consent forms the research was described to staff, volunteers, parents and solicitors as aiming to provide a better understanding of the work of child contact centres in England, as a service working with children. Child protection and safeguarding were not mentioned in these consent forms, leaving participants to introduce this aspect of their work and free to define the concepts as they understood

them. A more specific description of the research was required by the Ministry of Justice for judges and by ADCS for social workers. Therefore these participants were informed that the research was examining child safeguarding in child contact centres.

I tried to keep the language in these documents as simple as possible. All participants were also provided with a verbal explanation of the information on the form and an opportunity to ask questions. The consent forms made clear that all participation was voluntary and that participants were free to end their participation at any time. A guarantee of anonymity was given, stipulating that neither participants' nor centres' names would appear in the thesis nor in any publication and that any information which could identify them would be removed. All centres and participants have been anonymised. Permission to record interviews was sought from each participant.

Ethically researchers must also ensure the confidentiality and anonymity of participants by securely storing data (Bryman, 2008). All paper copies of informed consent forms were kept in a locked locker in the LSE Research Student's Office. The room itself also requires code access to enter. Truecrypt (Truecrypt, 2010) was used to encrypt the electronic data, including interview transcripts and audio-files, which were stored on a hard drive and a USB. I employed a research assistant to transcribe some interviews. For this purpose, audio files and interview transcripts were placed in a shared folder on Dropbox (Dropbox, 2007). To insure the security of the data all files stored on Dropbox were password protected using 7-ZIP software (7-ZIP, 1999). The research assistant signed a non-disclosure agreement prior to commencing employment.

Dissemination of research findings can also be considered an ethical requirement since it can be argued that doing so respects participants' contribution and their right to know what has been written. Prior to the publication of a journal article (Caffrey, 2013) on the findings presented in Chapter 6 I emailed a summary of the article (available in Appendix 2.12) to the NACCC CEO, the case study contact centre coordinators and participant referrers. In keeping with the Ministry of Justice's requirements on interviewing judges, I emailed the final draft of the article to the judges who participated as well as to the Office of the President of the Family Division. I also met with a senior member of NACCC and the Cafcass Commissioning

Officer to discuss the findings. Following examination, I will provide all participants, NACCC, MoJ and ADCS with a summary of the findings.

2.4 Limitations of the research

The research methodology adopted has a number of key limitations which should be kept in mind in interpreting the findings.

Firstly, there were limitations to the sampling strategy adopted. As discussed, staff and volunteers in Centres 1 and 6 were selected by the manager of the centre. This presents the possibility that these participants did not represent the wider population of workers at these centres. While this remains a limitation, there was diversity amongst the perspectives of these participants suggesting that they did not simply represent one point of view. In a comparable vein, the sampling strategy used to recruit solicitors, social workers and judges likely contained an element of selection bias. Given the real difficulties recruiting these professionals to the study, it is possible that those individuals who took part did not represent the full range of professional perspectives and experiences. As a result of this possible sample bias, further research may reveal more diverse or nuanced findings. Similarly the strategy used to select the case study contact centres aimed to provide some structuring to the sample, to ensure the centres represented a range of centre types. Nonetheless, as discussed, the limitations in the quantitative data used to achieve this and the limited number of indicators used to stratify the sample, suggest that the full range of centre characteristics is unlikely to be represented. Again, further research may reveal a more nuanced picture. Since this study does not claim statistical generalizability, these limitations do not invalidate the findings; rather they suggest that the findings should not be considered definitive. A more nuanced picture may emerge with further research.

There were no obvious indications that participants altered their practice in reaction to being observed. Evidence of this may have been found for example in parent's or other worker's reactions. Nonetheless, it is always possible that practice was altered in more subtle ways. It should also be noted that had a longer period of time been spent observing practice, workers' reactions to a greater diversity of experiences would

likely have been observed. Further research may provide additional nuances in terms of the findings.

Some aspects of the data collection on centres' practice relied on interview data which were not triangulated with observations of practice. For example, pre-contact visits by families to the centre were only observed in Centres 1 and 5 and volunteer meetings were only observed in Centres 3 and 6. Similarly, information regarding the level of training workers had received was triangulated in a minimal way by asking both centre managers and staff/volunteers what training they had received, but there was no way to externally validate the information received.

The research is further limited in scope. It is notable that children's and parent's voices are absent in the research design. The decision not to interview service-users was taken primarily for practical reasons. Service user's perspectives and experiences on the first research questions, 'how well do contact centres manage their commitment to protect children?' would arguably have offered a key perspective on this question which should be taken into account. However, the burden of data collection and analysis was too great for this study. In addition, there were ethical arguments, in particular against interviewing children in this context. Children are vulnerable by virtue of their age and relative lack of power. The vulnerability of the population of children attending contact centres is compounded by their increased risk of having suffered maltreatment (Aris et al., 2002; Hunt & MacLeod, 2008; Trinder et al., 2006). Interviewing children in this context is a delicate process which must aim to ensure that children are not harmed (A. Morris, Hegarty, & Humphreys, 2012; Morrow, 2009). While I am experienced in interviewing vulnerable adults, I have much less experience interviewing vulnerable children. In addition, the study did not have the resources to provide the post-interview therapeutic supports which, it could be argued are ethically required in order to ensure that if interviews have a psychological impact on children, support is available. For these reasons, the study did not include interviews with children or parents. This represents a limitation to the study since it can be argued that practice is co-constructed by service users (Chapman, 2004; Fish et al., 2009) and since only parents and children could voice their subjective experiences and perspectives on how well contact centres manage their commitment. Similarly, as discussed, Cafcass Officers could not be interviewed in this study. Since these

professionals represent a key sources of referrals to child contact centres, their absence from the study represents a gap in our understanding of the ‘system’ affecting practice. As in the case of families, the absence of Cafcass Officers from the study is a limitation which must be recognised. The area would benefit from further research to fill these gaps. As discussed in Chapter 5, other professionals also make up a small percentage of referrals to child contact centres. While interviews with these groups would contribute further to an understanding of the issues, the scope of this research was limited to the main referral groups on the basis that this would allow for a more in-depth analysis of the data collected. Further research is required to explore the issues in relation to the other referral groups.

The scope of the research is also limited in a number of other respects. Firstly, both the quantitative and qualitative data involves a sample of NACCC accredited centres. According to NACCC the vast majority of centres are NACCC accredited and so those centres excluded likely only represent a small number. Exclusion of non-NACCC centres also fits with the focus of the research which sought to explore the potential influence of the reforms introduced by NACCC. Nonetheless, further research could helpfully explore practice in non-NACCC centres.

The focus of analysis and data collection was also limited. Early on in the data scoping phase, it became apparent that children in care are also sometimes referred to child contact centres. The findings suggest that this can occur where local authorities do not have sufficient capacity within their in-house services to facilitate contact and so may use contact centres in the voluntary and private sectors. However, the findings presented in this thesis remain focused on child contact centres’ facilitation of private law cases (including those in which local authority social workers are involved as the child has a child protection plan). This focus was adopted in order to provide an in-depth analysis of these issues. The findings are generally relevant to both public and private law cases but in Chapters 5 and 6, where the findings are discussed in relation to the wider family justice system, the public law system is not explored.

Similarly, while the research investigated both supervised and supported services and both are discussed in the thesis, in Chapter 5 (which presents the findings on the impact of inter-professional working) the focus is on supported services. This focus

was adopted because inappropriate referrals are particularly problematic for supported services, which are least able to manage child protection concerns. The narrowed focus allowed for an in-depth analysis of the issue within the confines of the word limit of the thesis.

It should also be noted that the research focus is further narrowed in that the analysis did not specifically focus on the additional issues which may be experienced by Black and Minority Ethnic (BME) women and children using a child contact centre (Thiara & Gill, 2012). Research suggests that BME families are disproportionately represented amongst families involved with child protection services (Owen and Statham, 2009). In this context, statutory social work practice has been criticised for its anchoring to ‘a liberal “cultural pluralist” perspective that precludes power analysis and critical discussion of race and racism’ (Barn, 2007). This literature raises questions about power relations and the cultural sensitivity of both workers in contact centres and referrers to the service. While this is an important issue, the design of the current research was not focused on issues of ethnicity and was limited in terms of the data which could be collected on this issue.

The analysis of the quantitative data was limited by that available in the NACCC surveys. Within the case studies, very limited data was collected on the characteristics of families. Qualitative data was collected, through interviews, on the existence of safeguarding issues amongst families, as managers/coordinators should receive this information through the Standard Referral Form. However, data on, for example, the ethnicity or social class of families is not routinely collected by centres through the referral form. Given the potential burden on centres of collecting this information, as well as the sensitivity of the information, it did not seem reasonable to ask the case study centres to collect such information for the purpose of the study. Indeed, such a request, would have risked jeopardising access to centres, given the demand it would have placed on coordinators’/managers’ time. As this research cannot provide statistically generalizable data on the ethnicity of service users, it cannot infer whether BME groups are disproportionately represented amongst the service users of child contact centres.

Research also suggests that there may be important differences (as well as similarities) in the experiences of BME women and children experiencing DV, which influence their responses and those of service providers (Thiara and Gill, 2012). However, as discussed above, for various reasons, the current research did not include interviews with service users. The design was therefore not particularly sensitised to highlighting such issues. Further research could usefully explore this issue in child contact centres. Building on the recent work of Thiara and Gill (2012), it could seek to establish firstly, whether there is disproportionate representation of BME groups and secondly, how well services understand and manage issues surrounding cultural diversity, taking account of service users' experiences. Finally, it should be noted that the research findings are necessarily limited by the timing of the fieldwork. Since the data for this research were collected there have been a number of changes in the system surrounding child contact centres. In particular, the emphasis on Alternative Dispute Resolution (ADR) in the Family Justice Review and changes to Free Legal Aid are likely to affect the sources of referral to child contact centres. Nonetheless, these issues are outside of the scope of this research. This is discussed further in relation to the findings of the thesis in the conclusions chapter (Chapter 7).

2.5 Conclusions

This chapter has outlined the methodology adopted in the study. It provided a discussion of both the ontological and epistemological considerations and the methods used. In addition it highlighted the limitations to the study which must be born in mind when interpreting the findings. The following chapters (Chapters 3-6) present the empirical findings of the research. Relevant literature is discussed in each chapter, rather than in a separate literature review chapter. The following chapter presents the findings in relation to the first research question.

Chapter 3: Managing the commitment to protect

This chapter presents an analytic account of the research findings in relation to the first research question: ‘How well do child contact centres, as organisations that work with children, manage their commitment to protect children from maltreatment?’ The systems approach to this question seeks to provide an in-depth understanding of practice in this respect. This understanding is presented and analysed below in relation to relevant child welfare literature in order to make an argument regarding ‘how well’ centres manage their commitment.

The systems approach to understanding practice in child contact centres can be contrasted with the approach adopted in the NACCC accreditation process for child contact centres. As discussed in Chapter 1, the accreditation system is the principal feedback mechanism in the system of child contact centres since it is used to inform referrers and Cafcass (as funder) as to whether contact centres have reached the threshold for acceptable services (NACCC, 2003a, 2003b). In order to become accredited, centres must meet the National Standards for supervised or supported contact (NACCC). However, centre coordinators and managers reported that the accreditation system does not involve direct observation of practice. Instead it relies on the indicators outlined in the National Standards (see Appendix 1.1). To assess the indicators, a NACCC official interviews the centre coordinator/manager at the centre and examines the centre’s policies and other documentation. This is in keeping with recent trends in risk management which, as discussed in Chapter 1, have increasingly adopted indirect checks and indicators (Hood, 1991; Hood et al., 2001; Munro, 2004a; Power, 2007).

In this sense it can be suggested that the National Standards (and the accreditation system which relies on them) adopt a linear model of causality; it is assumed that the provision of certain indicators will have expected results in terms of the quality of practice. As discussed in Chapter 1, the non-linear view of causality in the systems approach challenges this contention (Dekker, 2007a; Perrow, 1984; Wallace & Ross, 2006) and so practice is investigated directly to provide an in-depth exploration of potential variations in practice.

In the process of investigation, the systems approach sought to understand how contact centres have bridged the inevitable gap between the National Standards and safe practice. Put another way, it seeks to understand how centres have adapted to the reality of the work they are undertaking and co-evolved with the reforms which have been introduced (Dekker, 2005, p. 188). As discussed in Chapter 1, the concept of ‘drift into failure’ suggests that problematic practice is often not the result of troublemakers engaging in immoral deviance. Rather problematic practice may be the result of ‘normal people doing normal work in normal organisations’ (Dekker, 2005, p. 184). Therefore, this chapter provides a study of the normal activities of actors who, the systems approach suggests, ‘are preparing the landscape of accidents [or safety] during their normal work’ (Rasmussen & Svedung, 2000, p. 14).

The chapter explores three dimensions of the centres’ child protection practice:

- a) Responses on referral to known risk factors or a history of maltreatment
- b) Response during contact to known risk factors and;
- c) Response to signs of maltreatment.

The findings in relation to each dimension are contextualised using the literature on child welfare in order to develop an argument regarding ‘how well’ centres manage their commitment to protect.

3.1 Response on referral to known risk factors or a history of maltreatment

In the context of child contact centres’ work, protecting children from maltreatment is reliant on centres’ capacity to effectively manage the known risks of harm to the child in the cases they facilitate. In other words the cases facilitated at the centre need to match the centre’s child protection capacity. Indeed the NACCC Guidelines for Safeguarding and Child Protection (2010) suggests that centres should:

‘Remain vigilant that the cases [they] accept are appropriate to the level of support that [the centre] can give them’

(NACCC, 2010a, p. 4).

As discussed in Chapter 1 previous research suggested that children and resident parents may be at risk of harm because supported services were facilitating cases which they were not equipped to manage (Aris et al., 2002; Thiara & Gill, 2012). Aris and colleagues' (2002) research had also suggested that some supervised services may at that time have been ill-equipped to safely manage their case load. The current research findings develop those of Thiara and Gill's (2012) recent study. Together these studies suggest that despite the reforms introduced since Aris and colleagues' (2002) research, problematic child protection practice persists in relation to supported services' response to known risk factors at the point of referral. The findings provide tentative evidence that supervised services may be better equipped to manage their commitment to protect. However, it cannot be assumed that all supervised services are appropriate since the research design cannot provide statistical generalizability of the findings.

As discussed in Chapter 1, the NACCC 'Definitions of Levels of Contact' defines supported contact services as suitable for families where:

'No significant risk to the child or those around the child, unmanageable by the centre, has been identified during an intake procedure'

Cafcass is more explicit about the appropriate level of risk in this service, stating:

'Supported contact centres are not suitable for any cases involving risk to children or adults...they should only be used where safe and beneficial contact for the child can clearly take place'

(Cafcass, no date -b)

However, all supported case study services in this study knowingly facilitated contact in cases involving child protection risks regularly. Cases involving domestic violence (DV) were not unusual in any of the case study centres. This substantiates Gill and Thiara's (2012:128) recent findings which suggested that referrals involving DV continued to be accepted by many supported centres. The findings of the current study

elaborate on Thiara and Gill's (2012) findings and discuss child protection risks outside of those relating to DV.

The findings indicate some variation in supported services' acceptance of DV cases. All of the case study supported services accepted cases where DV was alleged. However, Centre 2 was reluctant to take a case where the father had a conviction for DV and only did so after reassurance from the solicitor and the Cafcass Officer that this was safe. The other supported services routinely accepted cases involving convictions for DV, restraining orders and non-molestation orders. They had also accepted cases where mothers and children were living in a refuge. Across the supported services, there were cases involving high levels of physical violence. For example, a mother in Centre 1 had previously been blinded in one eye by the child's father. In a separate case in Centre 1 a child had a child protection plan while the mother was in a relationship with the father. The mother had been informed that if she were to re-enter the relationship, the child would be placed back on the register. A father in Centre 3 had been convicted of DV when he pushed the mother down the stairs while she was pregnant with their son. A mother in Centre 6 alleged that the father of her child had tried to kill her and continued to threaten to do so.

It could be argued that Centre 2's differentiation between alleged and evidenced DV suggests a more stringent approach, since the policy may result in fewer cases involving DV being accepted at the centre. However, due to the private nature of the abuse, DV is notoriously difficult to evidence, particularly where the abuse is not physical (Harrison, 2008). Moreover even physical and sexual abuse often goes unreported by victims at the time of the crime. This happens for a variety of reasons including victims' feelings of shame, fears of retribution from partners or fears that their children will be taken into care (Gracia, 2004; Mullender et al., 2002; Stanley, 2011; Stanley et al., 2010). As will be discussed in Chapter 5, allegations of DV were not necessarily investigated or risk assessed by either referrers or centres prior to referral. It could not therefore be assumed that cases where DV was alleged were without a child maltreatment risk. In this sense there is an inherent contradiction in a policy which suggests that a centre can manage cases where DV is alleged, but cannot manage the risk where it is evidenced, since implicitly the maltreatment risks in these cases may be the same.

While the recent research by Thiara and Gill (2012) focused on DV cases, the current study also explored other child protection issues which child contact centres deal with. The research found that all of the case study supported services knowingly accepted cases involving abduction risk (whether or not related to DV), parental drug and alcohol addiction and parental mental health issues including depression, bi-polar disorder and self-harm on a regular basis. Centres had also accepted cases where either the child or the non-resident parent had special needs. In addition two supported services had accepted cases where the non-resident parent had been recently convicted of a violent crime. This included gun possession, obstructing an officer doing his duty, knife crime and ABH (Assault Occasioning Actual Bodily Harm). One supported centre had accepted a case where there was 'possible grooming' and two others had accepted cases where there were accusations of child abuse. The latter cases were only taken after reassurance from the Cafcass Officers involved in the cases. All services facilitated cases where there was a risk of inappropriate visitors, where the parents were in conflict and cases where children were objecting to contact.

The findings therefore build on Thiara and Gill's (2012) study to suggest that despite the introduction of reforms, the types of cases facilitated at supported child contact centres have similar child protection concerns compared to those highlighted by Aris and colleagues (2002) and decade ago. Indeed, given this profile of cases, the research indicates that a high percentage of the children in all contact centre services-supervised and supported-may have suffered or may be at risk of suffering harm or significant harm from abuse or neglect. The following section explores these maltreatment risks and the management of them during contact in both supervised and supported services.

3.2 Response during contact to known risk factors

Although the case study supervised and supported services were both managing cases involving issues which suggest a risk of child maltreatment, the services managed these cases differently. It is argued here that the structure of case study supervised services meant that this service was better able to manage its commitment to protect children. While the case study supported services were able to manage some of the

child maltreatment concerns, the structure of this service meant that it faced numerous challenges in managing the service's commitment to protect children from maltreatment. The following aspects of practice are explored below: 'handovers', monitoring of contact, intra-centre communication regarding risk factors for maltreatment, building safety and moving cases on.

3.2.1. *'Handovers'*

All supervised and supported contact services facilitated 'handovers', which enable parents to 'exchange' the child without meeting each other. They may be used where the non-resident parent is having contact at the centre, or where contact is taking place outside the centre. Effective management of handovers is important to protect children from potential exposure to high levels of parental conflict which, research suggests, can be damaging to children (Arendell, 1988; Johnston, Campbell, & Mayes, 1985). In particular, where parents use their children to express their anger, this can be considered emotional abuse (Lamb, 2007).

Handovers are also important in cases of DV. Research has demonstrated that DV does not always end when parents separate and that contact with children can be used by the abuser as a route to further abuse their former partner (Aris et al., 2002; Hester et al., 1994; Hester & Radford, 1996; Holt, 2011a; Humphreys & Thiara, 2002, 2003; Stanley et al., 2010; Thiara & Gill, 2012). In cases of DV therefore, handovers can be used to ensure that contact does not provide an opportunity for children to witness further abuse of their resident parent. To manage this risk, centres would need to ensure that an abusive parent is unlikely to meet the resident parent or to follow the resident parent and child after contact.

'Handovers' are also used to mitigate the risk of a child having contact with a non-resident parent who is under the influence of drugs or alcohol. Alcohol and substance misuse may present risks to the child during contact since misuse can limit parenting capacity, placing children at risk of neglect (Barnard & McKeganey, 2004; D. Forrester, 2000; Kelleher et al., 1994). In addition alcohol and drugs may have mood altering affects which means that children are also at risk of abuse (Ammerman, Kolko, Kirisci, Blackson, & Dawes, 1999; Kelleher et al., 1994). Finally, handovers

are important in terms of restricting access to children by wider family or other individuals who may pose a threat to children's safety or well-being. Research has suggested that this is particularly important for BME groups, who are more likely to suffer abuse from multiple family members (Thiara and Gill, 2012).

All of the case study child contact centres managed 'handovers' well in a number of respects. Both supervised and supported services strictly managed attendance at child contact centres. Resident parents were required to give permission for additional individuals to attend the contact session. Observations suggested that any individuals not listed, were not allowed to attend. Both supervised and supported contact centres primarily dealt with cases of drug and alcohol abuse by sniffing for alcohol and checking for suspect behaviour when parents arrived at the centre. In each centre parents were greeted individually by a worker as they arrived and their name ticked off the list. This provided space for a brief interaction in which the parent could be closely observed. One supported service reported that it had administered breathalyser tests in some cases, where it had been requested to do so by the court.

Workers in each centre recalled times when the centre had refused a parent access to their child due to alcohol intoxication. However, a volunteer in one supported centre recalled that a parent had been allowed to have contact while smelling of alcohol and being 'slightly out of it'. In this case, the volunteer merely monitored the father more closely. It seemed in this instance that the official policy of the centre had not been followed:

'Sometimes [parents] share stories with you like one day, been up all night, haven't been home, had to rush here and I could smell alcohol on his breath and you know and I was thinking flippy heck you know erm what's the erm, you know, what's there to do in a situation like that? They tell you. I just sort of kept an eye on him erm and there wasn't any other difficulty around it other than an awareness that he was slightly out of it.'

[Volunteer 2, Centre 3, supported-only service]

It could be suggested therefore that contact centres can effectively manage the risk of a parent having contact under the influence of alcohol or drugs. Nonetheless, as the extract above indicates this relies on individual worker's compliance with policy, which may not be universal.

Previous research did not report in detail on how centres managed handovers but interviews with mothers who had experienced DV suggested that harassment occurred both before and after contact, implying that practice may not have been sufficient to safeguard women and children in DV cases (Aris et al., 2002; Thiara & Gill, 2012). Previous research also reported that only 42% (n=36/85) of centres responding to a national survey had separate entrances. It was argued that the provision of separate entrances was integral to keeping women and children who had experienced DV safe (Aris et al., 2002, p. 44). Similarly, the National Standards for both supported (p.7-8) and supervised services (p.14) suggest that in order to take account of families who have experienced DV:

'Wherever possible separate entrances and exits should be available and if necessary used to move adults and children into and out of contact sessions. If this is not possible...every effort [must] be made to arrange for staggered arrival and departure times'

As discussed in Chapter 1, systems approach seeks an in-depth understanding of practice through direct observations and interviews with individuals on the ground (Dekker, 2002; Woods & Cook, 2002). The approach is therefore critical of indicators which seek to reduce the complexity of practice to tick-box criterion. For this reason the research sought to understand not just what physical safety features were available and what rules were declared, but how they were used and the implications for child protection practice.

Amongst the case study contact centres, only one centre offering supported contact (Centre 2) and one centre offering supervised contact (Centre 4) had two entrances. However, the findings suggested that safe handovers relied more on how handovers were managed, than on the availability of separate entrances, although it is acknowledged that separate entrances would further contribute to safety.

As a group, the case study supervised services were more homogenous in their management of handovers; they were uniformly strict and observant. All of these services ensured that non-resident parents arrived first, left last and waited at least fifteen minutes before leaving. This was in order to ensure that resident parents and children could not be followed. For example, the manager of Centre 5 explained:

'If you're coming here these are our terms and conditions, they're very rigid I know but just bear with us, you know. We expect you here thirty minutes before the sessions starts, we expect you to remain thirty minutes after. That doesn't mean at a quarter past you say you've waited long enough and you've got to go put money in your car, that means you've got to wait.'

[Manager, Centre 5, supervised-only service]

Supported services had similar rules for parents who did not wish to meet their ex-partners, although none of them expected non-resident parents to wait as long as thirty minutes before leaving. In one supported centre it seemed that these rules were closely observed where a referrer made clear that this was necessary. Discussing a particular case where the father had a conviction for DV the coordinator recalled:

'We were always very aware that we had to be sensitive about arriving and departure between the absent parent and the residential parent and we just used to say "will you just sit and have a cup of tea and wait for a couple of minutes and you know while everybody clears away the building?" and he was very happy to comply with that and that was ok so we didn't have a problem with that.'

[Coordinator, centre 2, supported only service]

The management of handovers in Centre 6's supported service however seemed particularly relaxed. On my first visit to the centre there were no rules concerning the arrival times of resident and non-resident parents; sometimes non-resident parents arrived first, sometimes resident parents arrived first. During fieldwork the centre

changed its rules so that non-resident parents were asked to arrive fifteen minutes before contact and leave when the resident parent was out of sight.

However, observations of practice suggested that these rules were not always followed and so cases were observed where non-resident parents were allowed to leave first, despite resident parents' concerns for their safety. In one case, a non-resident parent was allowed to leave first and so a resident parent was observed to ask whether her ex-partner had left. The volunteer managing the contact session said that he had but when the mother and child went to leave she noticed his van still in the car park. A resident mother who had experienced DV was also observed to report to the manager that her ex-partner had arrived thirty minutes early and met her in the car park before contact. She reported that he did not physically engage her, 'he just watched me, that's enough'. Other non-resident parents arrived late to contact and so met their ex-partners. This did not seem to be reprimanded by the centre. Further to this, a mother reported to the researcher that she had previously been physically attacked by her ex-partner in the car park. Indeed volunteers also referred to incidents which had occurred. For example:

'At the end you kind of get the mad rush of people leaving at the same time so you need to have your wits about you as to what you're doing. But it is quite easy. I mean there is always going to be occasion where you are...we've had a couple of scraps in the car park...not many but you know where one party might wait around the corner for the other. But we are quite good at looking out for cars and making sure that people have gone before we let people out.'

[Volunteer 2, Centre 6, both services]

All supported contact services reported that they had experienced incidents where parents had met and verbal altercations had ensued. In such cases the workers reported that they attempted to intervene to protect the child from conflict. For example:

'R: Sometimes it's like High Noon in the car park you know (laughs)

I: And what happens?

R: Well obviously we wouldn't allow that to happen because we always appeal to them and say you know this isn't good for the children, you know and we will try and negotiate and try and say obviously we couldn't have that, it wouldn't be good for that family and it wouldn't be good for other families at the centre at the time.'

[Volunteer 3, Centre 3, supported-only service]

Therefore supported services may at times have provided some protection to children by aiming to police interactions between parents. However, since incidents did occur, it seems the supported services were not always successful in managing contact to avoid the potential for parents to meet or for resident parents and children to be followed. Overall, it seemed that some supported services were more effective than others in protecting children in this respect.

The findings also suggested a contradiction in some supported services' practice around handovers. In some centres, when a child was refusing to stay in the contact room or was becoming distressed, workers encouraged resident parents to remain in the contact room in order to facilitate contact. For example:

'We tell parents if a child doesn't want to come and you know you've got to bring them... we'll try and get the mum away from the contact room as soon as we can but in order for the child to settle and some parents are quite good at that, they'll say "I don't want to see this parent" but they'll sit next to them on the settee because that's the only way they're going to see their child'

[Coordinator, Centre 6, both services]

It was observed that some of these cases were known to involve DV concerns. Previous research also highlighted this practice (Aris et al., 2002; Thiara & Gill, 2012) and so the findings suggest a lack of reform in this area. The practice is problematic in terms of child protection since it contradicts and undermines the emphasis on handovers which, as discussed aim to keep parents separated. Supervised services, by

contrast were not observed to engage in this practice. Indeed, a staff member in Centre 5 directly criticised the practice:

'A mother who has fled domestic violence and she has gone to a refuge and then she is...bringing the child to contact to a supported place and the workers have asked her to bring in the child into the room where the perpetrator is to settle the child. So that would be completely unheard of in this centre, you know we wouldn't let parents see each other, especially...well that's a given anyway, but especially if there is DV concerns and things like that.'

[Staff member 2, Centre 5, supervised-only service]

3.2.2 Monitoring contact

Research suggests that contact may need to be closely monitored in cases with particular risk factors. Cases of previous child abuse present a risk of child maltreatment since a history of child abuse presents a risk of future maltreatment. Indeed, research suggests that the best indicator of future behaviour is past behaviour (Munro, 2008). Studies examining abusers in treatment have reported recurrence rates ranging from 16% to 66.8% (Fluke et al., 1999). As discussed in Chapter 1, a history of DV presents a child protection concern since research has found a link between the presence of DV and the co-occurrence of child abuse (Appel & Holden, 1998; Buckley et al., 2007; Hamby et al., 2010; Herrenkohl et al., 2008; Hester et al., 1994; Holt et al., 2008; Kellogg & Menard, 2003; Osofsky, 2003; Radford et al., 2011). Research has also demonstrated the potentially harmful effects on children of exposure to DV.

At its most basic level, DV can be considered a form of emotional abuse, with potentially serious negative implications for children's social, emotional, behavioural, cognitive and general health functioning and relationships (Chan & Yeung, 2009; Edleson, 1999a; Holt et al., 2008; Margolin & Vickerman, 2007; Moylan et al., 2010; Mullender et al., 2002; Stanley, 2011; Strauss, 1995; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003; Wolfe et al., 1986). Babies, children and adolescents of any age can be affected (Cleaver et al., 1999; Graham-Bermann & Levendosky, 2011; Holt et al., 2008). Contact can also be used as an opportunity for the abuse of children

(Buckley et al., 2007; Hester et al., 1994; Hester & Radford, 1996; Holt, 2011a; Mullender et al., 2002). During contact an abusive parent may use the children to manipulatively force the abused parent to return. Children may be used to convey threats and abusive message to their mothers (Aris et al., 2002; Hester & Radford, 1996) or be pressured to carry out violent acts against their mothers (Hester & Radford, 1996). Contact post-separation can also provide a context for violent men to murder their children or former partners (Saunders, 2004). Indeed research by Women's Aid demonstrated that in the decade preceding 2004, twenty-nine children were reported in the media to have been killed by their non-resident parent during contact (Saunders, 2004). Research has also shown that DV is a factor in the family backgrounds of two-thirds of Serious Case Reviews (SCRs), which are used to investigate cases where a child in England has died from abuse or neglect (Brandon, 2010). In this sense, unmonitored conversations between children and non-resident parents in this context can present a risk of emotional abuse to the child during contact and a risk of physical harm where contact provides an opportunity for an abusive parent to gain information concerning the child and resident parent's whereabouts (Aris et al., 2002).

Monitoring may also be required where the non-resident parent has a mental health problem since some mental health problems can make parents withdrawn and neglectful of their children's needs (Cummings & Davies, 1994; Goodman & Brumley, 1990). Additionally depression can make parents irritable and angry with children and a personality disorder can influence the ability to control emotions (Rutter & Quinton, 1984). All in all however, these maltreatment risks are broad categories and risks will depend on the particular case. Indeed, it must be noted that while risk factors increase the risk of maltreatment, these problems may not necessarily affect parenting capacity (Gorin, 2004). Contact centres' awareness of and vigilance to the particular risks involved in the cases they facilitate, will likely be important in determining the ability of the centre to protect children.

By definition, supported and supervised services provide different levels of monitoring. NACCC's 'Definitions of Levels of Contact' (p.1) states that in supported contact services;

'Staff and volunteers are available for assistance but there is no close observation, monitoring or evaluation of individual contacts/conversations. Several families are usually together in one or a number of rooms'.

According to the guidance (p.1), the level of monitoring in supervised contact is higher. It involves;

'Individual supervision of contact with the supervisor in constant sight and sound of the child, which in turn requires that they have the support of a nearby colleague.'

The findings suggest that practice in the six case study child contact centres was broadly in keeping with these definitions. However, in practice the definitions were interpreted in varying ways by centres with implications for centres' management of their commitment to protect children. While supervised and supported services could be clearly differentiated from each other across the case study centres, services were not standardised. It is argued that practice, while appropriate to address some child protection concerns, was not always sufficient to address the maltreatment concerns in the cases which were being facilitated in supported services.

The research by Aris and colleagues suggested that mothers were concerned that some areas of contact centres were not monitored at all times and that outdoor play areas were sometimes left unattended (Aris et al., 2002, p. 94). In addition, survey data from the study suggested that half of the co-ordinators who ran supervised services thought that supervised contact involved a 'high' ratio of staff to families, but not one-to-one supervision (Aris et al., 2002, p. 36). The recent research by Thiara and Gill (2012) suggested that staff in supported services were 'struggling to properly monitor all families' (Thiara & Gill, 2012, p. 127) but provided no further details. In keeping with the systems approach (Dekker, 2005; Woods & Hollnagel, 2006), the current study sought to provide a more in-depth understanding of how centres monitored contact. The findings presented below detail evidence outlining the level of monitoring provided in the case study centres and offer an analysis of the implications in terms of child protection.

3.2.2.1 Supervised services

In the case study supervised contact services each case was supervised by at least one worker who listened to conversation and closely observed behaviour at all times. Supervisors, rather than parents, always accompanied young children to the toilet. In the case study supervised services, in cases where families did not speak English, supervisors were required to speak the language families were using, in order to monitor conversation. It was reported that interpreters would be used if the language was not available amongst the staff. As supervised services needed to have staff who could speak the language of service users, observations in the case study centres indicated that there may have been more staff from BME groups in supervised services, compared to supported services. However, this is very much a tentative finding, which would require substantiation through statistically generalizable data.

All supervised services operated tight security which would have made it difficult for a child to be abducted by a parent simply running out of the building: the doors to the centres were always locked during contact. Two of these centres (Centres 5 and 6) had outdoor play areas and these were secured by high railings. In Centre 5, personal alarms were also available to staff. This ensured that when a staff member was supervising a family alone in a room, they could call for help if necessary. All of the supervised services had a dedicated staff member in reception that could respond to problems and let families in and out of the centre as appropriate. However, in Centre 6, staffing shortages meant that at times this member of staff was not available as they were sometimes required to supervise contact.

3.2.1.2. Supported services

In keeping with the definitions of services, levels of monitoring and intervention in supported services were lower. The NACCC National Standards for supported contact stipulate that every child contact centre *'must set a minimum number of volunteers/staff to be on duty at all times. This must never be less than three'* (NACCC, 2003b, p. 2). In keeping with this, the case study centres never had less than three workers at a time and often had four or, sometimes five. However, as discussed below, observations of practice found that three people were not always present in the

room where families were having contact. For this reason the number of workers available was not a particularly good indicator of the level of monitoring; this largely depended on the way the workers managed contact.

The supported contact service in Centre 4 differed dramatically from that provided in the other centres. It will therefore be dealt with first. This centre primarily provided a supervised contact services but at times provided what they termed ‘supported contact’ for a fee. The centre manager reported that as the centre did not have a large room available to accommodate multiple families they instead used the same set up as for supervised contact, with one staff member per family supervising contact in a small room. The staff facilitating contact were the same in the supervised and supported service. Effectively the difference between supported and supervised contact in this centre then, was that in supported contact reports, were not written. Given that supervised services occupy the minority of provision and that this description differs from the definition of supported contact provided by NACCC, it seems likely that the type of supported service provided in Centre 4 is unusual. As the supported service in this centre was effectively the same as the supervised contact services described above, without the reports, it is an exception to the issues discussed below in relation to the other four supported services.

Two of the supported services held contact in one large room. In these centres between eight and ten families were observed to have contact at a time. At times only one or two workers were present in the contact room as others moved throughout the centre. As these rooms were large it was not possible for workers to constantly observe the behaviour of all families. A volunteer’s description fitted well with observations of practice:

‘[The contact centre] is very laid back...well I sometimes find...when I say sometimes eh probably em every other volunteering session that I’m actually in the playroom on my own for a period of time and that is basically because quite a number of the volunteers know each other, they may be chatting at the front, they may be chatting in the kitchen, they may be, not be necessarily aware of what is going on elsewhere.’

[Volunteer 1, Centre 1, supported-only service]

The other two supported services had multiple rooms available which families could move between. A worker was not always present in each of these rooms and so parents were sometimes left completely alone with children. An instance of exception to this practice was provided in Centre 2 where it was recalled that when the centre accepted a case involving suspected child abuse, it was agreed with the referrer that the parent had to remain in the main room where volunteers sat.

Workers in all supported services chatted amongst themselves during contact and were not closely observing the room. Centre 2 had less than ten families during observations but reported that they could take up to fourteen families at a time while Centre 6 was observed to have up to nineteen families due for contact at a time. Five volunteers were scheduled to run that particular contact session. Therefore, aside from the fact that it was not policy to closely observe families in supported centres, the ratio of families to workers could also make this practically impossible.

Unlike in the supervised services, in the supported services volunteers generally did not take young children to the bathroom; non-resident parents did this, unsupervised. Centre 1 was an exception to this. In this centre the expectation was that volunteers, rather than parents would take children to the bathroom. Observations of practice suggested that this was somewhat more relaxed in practice. Parents sometimes took children to the bathroom but volunteers stood outside the bathroom door.

In supported services workers, in keeping with the definitions of contact services, did not monitor conversations. However, workers in two supported services reported that they sometimes listened 'out for' problematic conversation where they were made aware of the risk in a particular case:

'A couple of times I've been asked if, you know, could you just sort of keep an eye and ear in this room and if you hear dad ask questions or ask this or that, could you encourage him not to or distract him to change the subject? ...Usually it's things around if the parent is in a refuge and the contact parent isn't allowed to know where they are or even if they have moved and there is a court order where the contact parent isn't allowed to know the

address or the phone number then you have to ensure...cause sometimes they will ask the children what school they are at and they will ask the children various questions and we might be asked to ensure initially that doesn't happen.'

[Volunteer 3, Centre 6, both services]

As the volunteer suggests in the latter part of the quote, this did not involve close observation but instead entailed 'keeping an eye and an ear' on the room. Observations also suggested that this practice was not common in the centre; the cases in the centre at the time of fieldwork which involved DV concerns or a specific concern of inappropriate conversation, were not observed to be monitored more closely. Families were asked to speak English during contact sessions. However, in some supported services families from BME groups were at times observed to speak in other languages, with no intervention from staff.

The findings suggest that practice in supported centres was not sufficient to ensure that inappropriate conversation did not take place. Since inappropriate conversations were reported in Aris and colleagues' (2002) research, the findings indicate that this issue has persisted. In the current research, workers in all supported services reported that parents sometimes complained that their children had become upset after contact because of the conversation they had had with their non-resident parent. An interview with a young adult volunteer who had previously been a child at the centre seemed to substantiate this finding. This was a DV case and her father was at the time of the interview subject to an indefinite barring order against her and her mother:

'In the contact centre we are now you can, you know, bring in food, eat, talk about whatever you want to talk about and the volunteers don't really have much of an idea what's going on, only that the situation is calm....even when I was in the contact centre he was still making remarks about my mum or saying that this isn't good enough.... Even though you are at a contact centre he doesn't put the feelings of animosity behind him and just get on with the contact instead he keeps on about other family members and what he can do to them and things like that.'

[Volunteer 4, Centre 1, Supported only service]

The findings strongly suggest therefore that practice in supported services was not sufficient to protect children from emotional abuse during contact. Additionally, children and resident parents could be placed at risk of physical harm since unmonitored conversation presents an opportunity for an abusive parent to discover information relating to where the child is living.

In terms of physical security, two of the supported services (one of which also housed a supervised service) had a secure outdoor play area. However, two other supported-only services had insecure outside areas with low-level fencing. Although the policy was for a volunteer to stand outside when families went out to play, it was observed that this did not always happen in practice. Ultimately regardless of a volunteer presence, a physically insecure area can present an opportunity for child abduction. A volunteer described the situation:

'There are some volunteers who are very good, you know as soon as somebody says 'can we go outside to play' will immediately go out and watch that it's safe, because the area at [Centre] is not secure. As you probably noticed when you visited there is a very very low fence so if somebody wanted to abscond with a child it would be very easy to do so em. So we do have somebody sitting outside or certainly sitting by the door watching what's going on there.'

[Volunteer 1, Centre 1, supported-only service]

3.2.3 Intra-centre communication

The systems approach asserts the general importance of studying the 'information environment' in which actor's behaviour is shaped (Rasmussen & Svedung, 2000, p. 14). In the specific context of child contact centres, the child welfare literature also suggests that in order to effectively manage the risk of maltreatment, workers should be aware of both the identified risks of maltreatment in each case and the history of the case. This awareness is necessary because 'the best predictor of future behaviour is past behaviour' (Munro, 2008, p. 93). Awareness would enable workers to tailor their practice to manage any particular risks in each case. Further to this, an understanding of the case history would enable workers to develop a more family-specific

understanding of what abusive behaviour may constitute in a particular case. This is important because an emotionally abusive interaction may be abusive due to its context and the history of that particular family. A thorough understanding of the family's history is also crucial since an incident may take on wider significance when viewed as part of a pattern of behaviour (Munro, 2008). Therefore it can be suggested that where workers are aware of risk factors and the case history, they may be better enabled to identify subtly abusive behaviour. Further to this, risk assessment is inherently fallible and should therefore be open to revision in an on-going process (Munro, 2008, p. 94). Observed interactions between the child and the parent in the contact centre may add to the existing risk assessment where workers can build on what is already known.

Aris and colleagues (2002:40) research found that 'staff in contact centres were not always given all of the information necessary to ensure the appropriate level of vigilance, either at the start of the contact or as the situation changed over time'. Thiara and Gill's (2012) findings seemed to suggest that this issue persists, reporting that 'due to time pressure, there was an observable lack of, or limited, information exchange between co-ordinators and volunteers in many centres' (Thiara & Gill, 2012, p. 128). However, no further details were provided on this issue in either research report. In keeping with the systems approach (Reason, 1990; Woods & Hollnagel, 2006) an in-depth understanding of practice was sought in the current study.

3.2.3.1 Supervised services

In supervised services, the staff member supervising the family received child protection-relevant information on the case, although the amount of information received by staff differed between centres. A supervisor in Centre 6 explained what information staff in this centre receive and do not receive:

'Supervised you get the whole file and you read the file. But when I say the whole file it's not like, you know, the last eight years of this child, this is what's happened. There is a referral form for either the solicitor or from Cafcass and it says on there whether there is any sort of...there is standard questions like, is there a risk of abduction, has the child been subject to a child protection plan,

are there any high risks, can they take photos...what the score is with toilet, with photos and gifts and if there are any allergies.'

[Staff member 2, Centre 6, both services]

Only staff in Centre 5 received a full case history detailing the chronology of the case. In addition to information sought from the referrer, this involved a two hour pre-visit interview with each member of the family, including children (discussed further in Chapter 6). The manager of this centre explained:

'R: Each person gets an allocated set of cases and their role is as they get it, they read their referral form, read their chronology and they start to formulate their plan, what would be needed just on paper [for the family to move on from the centre]? Now I've met them how has that shifted? What's the additional information that I got that wasn't in this? Those kinds of things.

I: Ok and why is that...it might seem like a really obvious question to you, but why is it so important for them to have that information?

R: Because its important with regards to risk assessing, it's important with regards to...a child could be traumatized by a red book, that was used to hit him with, and that parent comes in with the red book, why have you brought that book? It's about the subtle messages that you kind of don't always get'

[Manager, Centre 5, supervised-only service]

While all staff in supervised services received information relevant to child protection, there was a fundamental difference in the way this information was managed in Centre 5 compared to the other two supervised services. Centre 4 and Centre 6 were essentially focused on receiving the conclusions of risk assessment; the end process of analysis. They sought information from referrers that would tell them how to manage the case; what the risks were and how to deal with them. They did not therefore conduct pre-visit interviews with a view to collecting additional information from families. Indeed, the information staff in Centre 4 and 6 provided to referrers in their

reports was also different. They provided 'contact notes' which detailed the interactions between staff and children. They did not provide an analysis of the case.

Centre 5 on the other hand, focused on ensuring that the centre had access to information which would allow the supervisor to continuously analyse risk and need. Analysis was the focus of the reports provided to referrers. As the extract above indicates, in Centre 5 the individual chronology was considered to be an integral part of this. Workers sought to understand abusive behaviour from the perspective of the individual child, rather than assuming a generalised understanding of what constitutes maltreatment. They also analysed and collected information constantly, rather than relying only on the assessment made by the referrer.

It seems likely therefore that, compared to the other supervised services, practice in Centre 5 would be better able to identify subtly abusive behaviour and to identify maltreatment risks which may not have been noted in the referral process.

3.2.3.2 Supported services

Intra-centre communication about cases was very different in supported services, again with the exception of Centre 4, where practice was in keeping with that of a supervised service, without the provision of reports to referrers. In the other four supported services the centre coordinators/managers had access to the information on each case which was provided by referrers through the Standard NACCC Referral Form. It included for example, information on previous convictions, involvement of social services or Cafcass, DV and child abuse allegations, abduction concerns, mental health issues and drug or alcohol misuse. As in the case of supervised services with the exception of Centre 5, a full case history was not sought.

While this information was held by the managers of supported centres, it was not routinely communicated to volunteers. Volunteers were usually only given information if a referrer requested that a specific task be undertaken. For example, volunteers were sometimes asked to check on arrival that a parent was not intoxicated or, in some cases, where there was an accusation of child abuse, to ensure that the parent did not

spend time alone with the child. Outside of this, however, volunteers were given little to no information about maltreatment risks or case history. For example:

I: In your experience, what are the reasons that the families are using the centre?

R: This is not our remit at all, we are just presented with situations where someone has been granted access, possibly by a court order, to have access to the children for two hours a day or three hours once a month or something like that, you know. Ours are not to question why. They are people who are referred to us by different authorities.'

[Volunteer 3, Centre 2, supported-only service]

I: Would you know the circumstances of the families at the centre, about why they are at the centre?

R: Em...I think for some...I've only ever been told this is a sticky situation or this is more delicate or maybe if drugs or drink are involved you might get told there has been a problem with drugs that's why the relationship has broken down but we never know the specific details.'

[Volunteer 4, Centre 1, supported-only service]

'Em...I don't actually know fully what the issues have been because [manager] does tend to keep a lot to himself [laughs]. Em so em yeah I think most of the time it's just that for whatever reason they can't actually see each other without being quite hostile to one another for whatever reason'.

[Volunteer 1, Centre 6, both services]

Observations suggested that the supported services differed in the opportunities volunteers had to access case information. A pre-contact meeting between volunteers took place in one supported service, Centre 3, and lasted around ten minutes. In this

meeting the manager principally gave information concerning which families were likely to turn up and which children were likely to refuse contact. Occasionally there was also information concerning which parents did not want to meet each other, parents who may be ‘difficult’ with staff and parents who may need support to ensure children were not injured while playing. Similar information was verbally passed on to the ‘team leader’ (a volunteer in charge of the contact session) in Centre 6 around five minutes before the start of the contact session. Observations suggested that there was no routine discussion of the reasons why families had been referred to the centre. Similarly, Centre 2 held six-weekly volunteer meetings outside of contact session time. Here cases were discussed. However, the findings suggest that volunteers had similar levels of information compared to Centre 3.

Centre 1 was the only supported service to make case information available to all volunteers. Indeed, a book of files containing the referral form for each family as well as court orders was left with the volunteers during contact. However, observations suggested that this was not routinely consulted by volunteers. Of the workers observed at the centre, only a team leader took advantage of the opportunity to look at this information. Therefore, despite the availability of information, volunteers knew little or nothing about the background to cases.

Intra-centre communication in supported services therefore, it can be argued, represented problematic management of the commitment to protect. In the absence of such information, workers could not have tailored their practice to ensure that maltreatment risks in specific cases were addressed. Nor could workers contextualise observed behaviour within the history of the case. Indeed, workers may have been less sensitised to signs of maltreatment, since research suggests that people tend towards interpreting information in such a way as to seek coherence with beliefs they already hold (Kahneman, 2011, pp. 85-87).

3.3.4 Moving on and building safety

Aris and colleagues’ (2002) research reported that child contact centres were viewed as a short-term, temporary measure (Aris et al., 2002). This expectation of the service has since been articulated in the NACCC ‘Definitions of Levels of Contact’. In the

Definitions, supported contact is described as '*a temporary arrangement to be reviewed after an agreed period of time*' and supervised contact is described as '*time limited with a planned aim to regularly assess and review progress and the possibility of safer future outcomes*' (NACCC, p. 1). Aris and colleagues' (2002) report raised the problem of expecting families to 'move on' from contact services or to a service with a lower level of vigilance, in the absence of work with families to 'make this a realistic aim' (Aris et al., 2002, p. 113). Their research suggested that there were few services in contact centres to build safety: parenting education, counselling for family members as well as services in relation to mental health and substance abuse were limited (Aris et al., 2002, p. 122). At the same time the report of the Children Act Sub-Committee (CASC) to the Lord Chancellor's Department in 2001 called for greater access to services to support families in contact arrangements including child counselling, perpetrator programmes, information giving meetings and conciliation meetings (CASC, 2001, p. 120) and 'welcomed' the diversification of contact centres with the potential for using centres' premises for therapeutic sessions with parents (CASC, 2001, p. 16).

3.3.4.1 Moving families on

The current research suggests that, despite the description in the NACCC Definitions of Levels of Contact of services as 'temporary' and 'time-limited', practice in relation to 'moving families on' varied dramatically between centres. The case study supervised services reported that they did not encourage families to move on from the centre. Instead, the transition was managed by the referrer, usually a Cafcass Officer, social worker or the court. As discussed in the following section, in Centre 5, staff worked in partnership with referrers to achieve this.

All but one of the case study supported services reported that they 'should' move families on. Centre 6 was particularly committed to this task. The manager of the service explained that they would soon limit contact in the supported services to eight two-hour sessions per family. He explained the purpose of this:

'R: ...to encourage parents that things have got to move on, that we're only a breathing space, a stepping stone, that's our language, we can't...they've got

to resolve things themselves, we can help them to resolve but.... Some mum said to me a little while ago, her child is four, she said she didn't see her ex-partner having contact with their daughter outside of the contact centre until she was twelve. What is she thinking? Is she thinking she's going to use the contact centre for the next eight years? Is that what her daughters going to be...is that what her relationship with her dad is going to build up?

I: Do you know why the mother wanted to keep it in the contact centre?

R: Because she doesn't think he knows how to look after her, she doesn't think she's safe with him...but sooner or later she's going to have to take the risk and sooner or later I'll be informing her that.'

[Manager, Centre 6, both services]

The coordinator of Centre 1, by contrast, felt the centre should encourage families to move on but questioned whether this was the right thing to do. She was concerned by the lack of parenting and counselling services to support contact. In reality it seemed there was more flexibility in this centre:

'We are trying to be more...pushing people on a bit now, restricting the times they come. I'm not sure about that. I feel we should be there, for as long as the case needs you. It may become a habit but if this is what this particular family need, let's give it to them. But I'm a bit of a softy.'

[Coordinator, Centre 1, supported-only service]

Finally, at the other end of the spectrum, the coordinator of Centre 2 explained this centre's approach:

'While we say we will review, we never put any pressure to move on... because if they don't have an agreement between the parents, they have nowhere else to go.'

[Coordinator, Centre 2, supported-only service]

Therefore, there was great diversity in how the cases study centres managed moving families on.

3.3.4.2 Building safety

The findings suggest that in most of the case study centres, services to build safety were limited. All of the case study centres provided some informal parenting support where parents were struggling to engage with or care for children. Outside of this there were no further services in four of the six case study services. Only Centre 5 (the supervised-only service) provided a spectrum of formal services to build safety. This included a Parenting Information Programme (PIP), child and adult counselling and a DV perpetrator programme. In this service, the aim was to move families on. However, this took place in a context in which qualified workers sought to address the issues which made unsupervised contact unsafe:

‘For social services referrals it’s more to do with what social services ask us to do, you know, that’s more like keeping the child safe, more like recording information. Em but definitely with the Cafcass referrals we work in partnership with the Cafcass Officer em and the [centre’s] qualified social worker that works with each case to plan how to move this family.’

[Staff member 2, Centre 5, supervised-only service]

In Centre 5, therefore, the focus on moving families on was situated within the context of providing services to ensure that safety could be built and the case assessed by a qualified social worker to ensure that it only moved on at the point when it was safe to do so. This contrasted starkly with some of the supported services which focused on moving families on but did not have the capacity to either build safety or to professionally assess the case.

Analysis of the 2009/10 NACCC survey provides some statistical generalizability of the qualitative findings presented above. This analysis suggests that only a small minority of contact services offered any services to build safety. As Table 6 below outlines, amongst the 219 centres which responded to the survey, the most frequent

programme offered was parenting support, however, only 15% of all centres provided this service. In terms of services which work directly with children, only 11% of centres offered ‘life story work’, which involves providing information to a child about his/her family (NACCC, no date- c), and only 5% offered child counselling. Less than 3% of centres offered work with perpetrators of DV, victims of DV or anger management, indicating that adult issues of abuse could very rarely be addressed within centres. Similarly, low numbers of centres offered dispute resolution or mediation (1%). The analysis further suggests that only 8% (N=14/179) of all supported-only services provided any of the services listed below. While centres offering supervised services were more likely to provide these services, provision (particularly outside of parenting support and life story work) remained low.

**Table 6: Frequency of Additional Services by Centre Type:
NACCC Survey 2009/10**

	Total (n=219)	Supported (n=179)	Supervised (n=12)	Both services (n=28)
Parenting support	32 15%	4 2%	4 33%	24 86%
Life story work	25 11%	2 1%	5 41%	18 64%
Child counselling	10 5%	3 2%	3 25%	4 14%
Dispute resolution	5 2%	3 2%	0 0%	2 7%
Work with victims	5 2%	0 0%	0 0%	5 18%
Anger management	3 1%	0 0%	0 0%	3 16%
Perpetrator programme	3 1%	0 0%	1 8%	2 7%
Mediation	3 1%	2 1%	0 0%	1 4%

Therefore the findings suggest that despite the calls for increased diversification of services, it remains unusual for child contact centres to offer integrated services to address issues affecting contact and ensure the safety of contact in the longer term.

While families may receive such services outside of contact centres, the literature suggests that these services may also be limited (Cafcass, 2010b, p. 2; Hunter & Barnett, 2013; Stanley et al., 2010; Thiara & Gill, 2012, p. 101). Moreover, regardless of the services parents may have been receiving outside of the contact centre, where services are not integrated, it is difficult to see how contact centre workers could know whether sufficient safety has been built to enable safe contact outside of a centre. Indeed, contact centre workers articulated that they were usually unaware of whether families were receiving additional services. In this sense, it seems problematic that some supported services, which did not have integrated services, were encouraging families to move on.

The findings also provide some evidence that, in the absence of accredited services to build safety, some centres may design their own interventions. Centre 6 was in the process of developing and piloting a programme to address parental issues affecting contact, as the centre understood them. However, it could be argued that the programme was potentially problematic from a child protection perspective. The staff related that the programme was ‘based on a coaching model’ and those facilitating the programme had received training in this area. The programme would be offered to all parents attending the service. The underlying assumption in the programme seemed to be that contact problems were founded on parents’ ‘negative’ perceptions of their ex-partner. Within this paradigm, issues of child safety did not seem to be the focus:

‘The other aim here now is, primarily through [programme name], is to try and give parents the chance to create a brighter outlook; the next steps. So during their number of sessions here, which we’re going to limit with supported contact as well, they’re going to be encouraged, “the reason there’s only a certain number of sessions is to encourage you to the fact that you have to move this on.”

[Manager, Centre 6, both services]

I accompanied the manager to the waiting room, where some resident parents were waiting during a supported contact session, when he told them for the first time about the new programme. He suggested that often conflict between parents is a problem and that children can get caught in the middle. He suggested that this programme would help parents resolve these issues. Many of the parents in the room looked upset by this statement. A mother responded that while there may be some parents who are simply in conflict and some mothers who therefore make it difficult for fathers to have contact, all of the mothers here were in the centre because they were concerned for their safety and the safety of their children. She said that her family had experienced DV and the problem was not conflict between her and her former partner, but her former partner's abuse. Another mother said that her and her children had experienced emotional abuse and she did not want to become involved in anything that could be used as a tool to manipulate her. The mothers asked on a number of occasions what the purpose of the programme was. They wanted assurance that its aim was not to move them on from the centre. The manager did not answer the question concerning the aim of the programme. He conceded that some people may have experienced DV but said he did not know the background to everyone's circumstances and that while they said they had experienced abuse, their partners denied it and there was no way for him to know who was telling the truth. A mother corrected him and said that he had seen the court report in her case evidencing DV.

The assumption in the declared purpose of this programme, that parental conflict is the basis of resident parent's objections to child contact, would seem to minimise or erase child protection concerns. The assertion by the manager that parents will be 'encouraged' to 'move this on', it can be argued, may present a risk of harm to some children and resident parents where the risks of contact outside of a centre have not been addressed. In this sense, the programme would seem to raise the concern that a well-meaning intervention designed to address the lack of support for families in contact centres, may itself present a concern where the programme does not take account of the maltreatment risks in the case load it handles.

3.3 Response to signs of maltreatment

Workers in contact services reported that if they observed signs of physical or sexual abuse of a child during contact they would protect the child by ceasing contact and reporting the incident to the referrer. Across both services a number of other issues were reported to have led centres to cease contact. This included abduction attempts; cases where parents had repeatedly returned a child late after contact outside the centre; a case where a child was physically abusive to his parent and the parent responded by restraining his arms, putting him on the ground and sitting on his chest; cases where parents had disrupted sessions by becoming verbally abusive or shouting and not caring for the child and cases where parents had been abusive to staff. Where contact was stopped, centres indicated that they reported this to referrers.

The findings however suggested ambiguity surrounding the appropriate response to signs of emotional abuse. Indeed, responses to signs of emotional abuse differed between supported and supervised services. Workers in supervised contact reported that if a parent's line of conversation were 'inappropriate' they would stop contact immediately or issue a warning and stop contact if there was a reoccurrence. For example:

R: Well my main role is supervision and I'm meant to be there so that the child does not get harmed or... it's not just physical harm like sometimes parents discuss the case with them and say "well I'm here because of your father" or you know little things like that. That causes emotional distress for children so we kind of keep them away from emotional harm as well.

I: Ok and what happens if a parent does that?

R: If a parent does that we just have to take them to the side and be like "no don't discuss this with your child". And if they carry on doing that we just have to say contacts ended, send the child back now'.

[Staff member 3, Centre 4, both services]

The findings suggest that potential emotional abuse did not necessarily receive the same response in supported services. Supported service workers reported that if they happened to overhear ‘inappropriate conversation’ between a child and a non-resident parent they would ask the parent to refrain. A report would not usually be made to the referrer, since this is not in keeping with provision in supported services. Where the parent was overheard to continue, this could in some circumstances lead the centre to cease contact. For example a worker reported that contact may be stopped in the following circumstances:

‘If a parent was saying things that were totally inappropriate and when asked to stop they didn’t stop and became very aggressive. It’s rare but it does happen sometimes.’

[Staff member 4, Centre 6, both services]

However, since workers in supported services were not closely monitoring contact they were unlikely to hear incidences of emotional abuse. All supported services reported that resident parents sometimes told them that children had returned from contact upset because of something which had been said to them by their non-resident parent. This did not necessarily elicit any child protection response from centres. For example:

‘It doesn’t happen very often, yes things can be said to children and we might not be aware of it and the parent will come back, the residential parent will come back and say, you know, these kind of things are being said, and we just say, that we are not sitting on top of people and that we can’t hear and that if we are aware of anything inappropriate then we will intervene.’

[Coordinator, Centre 2, supported-only Service]

Other centres reported that if it was reported to them that children were experiencing inappropriate conversation, the coordinator would speak with the non-resident parent and ‘hover’ more:

'If we find a child will leave and perhaps tell the resident parent that father has been asking questions they would rather not answer then we would go and have a word with the visiting parent and we would hover a lot more than we would normally and intervene if we needed to.'

[Coordinator, Centre 3, supported-only Service]

It can be suggested that centres failed to protect children where they did not act to ensure that contact was safe in cases where there were signs of potential emotional abuse; whether reported indirectly through resident parents or observed directly by workers. Given that supported services do not listen closely to conversations between children and non-resident parents, they could not ensure that contact was safe in such cases. Indeed, issuing a warning to the non-resident parent in this situation would seem an ineffective means of protecting the child since supported services could not ensure that their warning was heeded. Moreover, no centres reported that they engaged with children when signs of emotional abuse emerged. In this sense, a crucial source of information would seem to have been missed. The issue of centres' engagement with children is discussed in-depth chapter 6.

The findings suggest that contact centre workers in the six cases study centres expressed good knowledge of the responsibility to protect children by referring their concerns to Children's Social Care services and the procedures for doing so. For example:

'I: Have you ever been concerned enough about a child that you've thought about reporting to children's services?'

R: (pause) erm...no...I don't...no I've never...no...I wouldn't feel that I couldn't do that if I had a lot of misgivings or something like that I would always be confident enough to say to [coordinator] "we need to raise this"And I do understand about it being everybody's business not to leave it to somebody else to you know alert things or whatever.'

[Volunteer 3, Centre 3, supported-only service]

As in the extract above, both staff and volunteers in all centres expressed a clear understanding that if they were concerned that a child was being abused, they should alert the centre coordinator/manager and if necessary, make a referral, as per the Working Together guidelines (HM Government, 2010, pp. 140-141). Centres reported incidences where non-resident parents had asserted that their child was being abused at home. In each of these cases, centres had examined the child for signs of physical abuse. The centres did not report making a referral in any of these cases as they did not find evidence of abuse, but did provide information to parents on how they could refer the case if they so wished.

In practice, the case study services reported that referrals to Children's Social Care were very rare. In supervised services, since most referrals came through Cafcass or local authorities and the centres were providing contact reports to them, centres could contact the Cafcass Officer or social worker involved in the case directly where they had concerns. This reduced the need to go through the referral process. The coordinator of one supported-only service reported that the centre had never needed to refer a case to Children's Social Care services. The other two supported-only services had sought support from Children's Social Care. The coordinator of Centre 1 contacted Children's Social Care services when she was concerned about a non-resident father who she felt was emotionally abusing his son during contact:

'Father is very critical of mother, father seemed more concerned with the younger child, the old child is the adult in this whole family, in my opinion, and he was really hard on him and didn't show much interest and just kept telling him off the whole time. I didn't feel it was right'

[Coordinator, Centre 1, supported-only service]

However she reported:

'They're not interested...social services were [already] involved...but nobody wanted to know, if you understand...they took all the details but didn't do anything'.

[Coordinator, Centre 1, supported-only service]

In this case, the centre continued to facilitate contact, although as a supported service, they were not monitoring conversations and so had limited capacity to prevent any on-going emotional abuse.

The coordinator of Centre 2 reported a qualitatively different reaction. She called Children's Social Care in the following circumstances:

'We had a child once who was very obviously unwilling to come to see a parent and the parent was a Romany Gypsy and... the residential parent had shared a lot of this with us, there had been huge physical violence in the relationship and physical violence after the relationship ended and abduction was attempted...he would jolly her along and she tried very hard to spend the time with him at the centre but I had instinctive concerns about this child'.

[Coordinator, Centre 2, supported-only service]

In this case, the contact was stopped. Although the coordinator was not told why it was stopped, long afterwards she was informed that the information she provided was helpful *'because it was like another piece of a jigsaw to put in making a picture about that child's situation'.*

Therefore, the findings suggest that where workers considered their concerns to necessitate a referral to Children's Social Care, they had a clear understanding of their responsibilities and the procedures for making a referral. Nonetheless, referrals were rare. Where centres did referred cases, the findings suggest that doing so could provide important information which was used by statutory services to protect the child. However, the findings also suggest that centres did not necessarily observe action from statutory services and in such cases contact could continue to be facilitated despite the centre's concerns and limited capacity to prevent further abuse. Moreover, while centres reported that they responded to evidence of physical or sexual abuse by ceasing contact and informing the referrer, the same response was not routinely reported in

supported services where there were signs of emotional abuse. Supervised centres, by contrast were well placed to respond to signs of emotional abuse by protecting the child.

3.4 Conclusions

This chapter examined the findings in relation to the first research question: ‘how well do child contact centres manage their commitment to protect children from maltreatment?’ The systems approach sought to provide an in-depth examination of practice as observed in centres and related in interviews with workers (Reason, 1990; Woods & Hollnagel, 2006). In keeping with the notion of ‘drift into failure’ (Dekker, 2005, p. 184), the approach sought to directly study normal work (Rasmussen & Svedung, 2000, p. 14).

The findings of this in-depth approach firstly, indicate the limitations of the linear model adopted in the National Standards. In a number of respects, the quality of practice was not captured by some indicators within the standards. This includes the provision of a number of workers, separate entrances or staggered arrival times. In this sense, the National Standards would seem to provide a poor feedback mechanism on the quality of centres’ practice. This point is developed further in Chapter 5 in relation to the implications for inter-professional working.

The findings suggest that contact centres managed some aspects of their commitment to protect well. However, problematic child protection practice persists in some centres despite the reforms introduced. It was argued that centres’ child protection practice must be appropriate to the cases they facilitate if the commitment to protect is to be managed well (Aris et al., 2002; Thiara & Gill, 2012). In this regard, the findings suggest that problematic practice persists in supported services which continue to facilitate cases involving child protection concerns. Four key aspects of practice to manage the child protection concerns identified on referral were examined: handovers; monitoring contact; intra-centre communication; and moving families on and services to build safety.

The findings suggest that both supervised and supported services could manage aspects of 'handovers' well. Mechanisms were in place to ensure that children did not have contact with parents who were under the influence of drugs or alcohol. However, exceptions in terms of managing alcohol misuse, suggests that such practice is not uniform. In other respects, while all of the supervised services strictly managed parents' departure and arrival times, practice in supported services was problematic. Rules in supported services were more relaxed and sometimes relied on referrers to specify how cases should be managed. Practice in one supported service suggested that the management of 'handovers' was so relaxed that it could routinely place some non-resident parents and children at risk of harm. There was also a contradiction in the practice of some supported services which encouraged resident parents, who said they had been abused by their former partners, to facilitate contact where children became distressed.

The findings suggest that monitoring in supervised services managed risks of emotional, physical and sexual abuse well by allocating at least one supervisor per family. The supervised services also reported back to referrers, which provided an opportunity for additional case management. Where volunteers in supported services were always present in the room with parents, the service was likely to reduce the risk of physical or sexual abuse. However, the findings indicate that this was not practiced in all centres: in some supported services parents were left completely alone with children for periods of time. In one supported service supervision of toilet visits likely reduced the risk of maltreatment; however, the findings suggest that this is not common practice in supported services.

With the exception of Centre 4, the findings suggest that practice in supported services was not suitable to manage the risk of emotional abuse to children. Despite the efforts of workers in the case study centres, the structure of supported services is such that conversations are not monitored and so emotional abuse could easily occur. The findings suggest an incompatibility in the provision of supported contact as a service which does not closely monitor contact but does, in practice, take on cases where there is a risk of emotional abuse.

The literature suggests that workers awareness of case history and child protection concerns is an important aspect of child protection practice. However, the findings suggest dramatic variation in how contact services manage intra-centre communication on these issues. In all but one of the case study supervised service staff received a risk assessment from referrers in each case but did not receive a full case history. Only workers in Centre 5 (the supervised-only service) received and collected a full case history which enabled the worker to continuously analyse risk and need. While the former approach would provide some protection to children, the literature suggests that the approach in Centre 5 would be better placed to protect children through an individualised understanding of family abuse and on-going risk assessment. With the exception of Centre 4, intra-centre communication in supported services was problematic in terms of centres' commitment to protect. While centre coordinators received a referral form detailing child protection concerns, this information was not routinely communicated to volunteers, unless referrers specifically requested action on a particular issue. As a result, the findings suggest, that volunteers routinely lacked information which would enable them to contextualise behaviour with a view to managing and identifying subtle abuse.

The findings suggest that contact centre services to build safety remain limited. Some (although not all) of the case study supported services encouraged families to move on in the absence of services to build safety or a professional assessment of whether it was safe for them to do so. It was argued that this is problematic in terms of centres commitment to protect.

Finally, the findings suggested that, while workers in all centres were clear that they should intervene if they observed signs of physical or sexual abuse, responses to signs of emotional abuse differed across supervised and supported services. In supervised services, where conversation was constantly monitored, workers viewed it as their role to protect children by stopping 'inappropriate' conversations immediately and discontinuing contact if a parent continued. In supported services, where workers happened to overhear 'inappropriate' conversations or it was reported to them by resident parents that such conversations had occurred, contact was not usually stopped. Instead, centres asked non-resident parents to refrain and sometimes 'hovered' closer. However, given that supported services do not closely monitor contact, they could not

ensure that such conversations did not re-occur. In this sense, the measures taken may have been ineffective in protecting children. Interviews suggested that workers across supervised and supported services had a good understanding of their responsibilities and the procedures for referral to Children's Social Care where they categorised behaviour as indicative of maltreatment. However, referrals in the case study centres were rare.

In sum, 'Working Together to Safeguard Children' (2010) articulates that organisations that work with children have a 'commitment' to protect. However, the findings suggest that this did not necessarily, in the context of child contact centres, lead to effective management of this commitment. Moreover, problematic practice has persisted in some centres despite the reforms introduced by NACCC since Aris and colleagues' (2002) research. The following chapters present the analytical account of the factors which seemed to influence centres in managing their commitment to protect.

Chapter 4: Factors influencing practice: the construction of child protection practice in an organisational context

This chapter sets out the first component of the analytic account of factors that seemed to influence child contact centres in managing their commitment to protect children from maltreatment. Through the exploration of ‘local rationalities’ (Woods et al., 1994) the systems approach aims to develop an understanding of how issues relevant to child protection appeared to workers and how the meaning they attached to actions may have coloured their behaviour.

In keeping with the systems approach it is argued that in order to understand practice in contact centres, the analysis must begin by abstracting upwards to examine the service within its wider institutional context. Salamon’s (1987, 1995) theory of ‘voluntary failure’ provides important insights into the types of problems that can arise when the voluntary sector delivers social services. The theory is adopted in this chapter as a meta-framework for the analysis. It is argued that the challenges contact centres face in protecting children from maltreatment can be seen as a failure to adequately address three common weaknesses of the voluntary sector, proposed in Salamon’s (1987) theory. These weaknesses are ‘philanthropic insufficiency’ (insufficient organisational funding), ‘philanthropic amateurism’ (insufficient organizational professionalization) and ‘philanthropic particularism’ (narrow organisational focus). ‘Philanthropic paternalism’ - the tendency for voluntary organisations to be shaped by the preferences, not of the community as a whole, but of its wealthy members (Salamon, 1987, p. 41)- forms part of Salamon’s original theory but does not seem relevant in the particular context of child contact centres and so is omitted from the framework adopted in this chapter.

The findings suggest that ‘philanthropic insufficiency’ (organisational funding) affects the capacity of centres to provide professional services to build safety. In addition, it affects access to supervised services. The findings indicate that the barriers to

accessing supervised services are currently more numerous and complex than previous research (Aris et al., 2002; Thiara & Gill, 2012) suggested. These barriers can influence the local rationalities of actors working within the system of child contact centres, with implications for the cases referred to supported services.

The research also presents findings on the current level of professionalization in child contact centres and the level of staff and volunteer child protection training. The findings suggest that the issue of ‘philanthropic amateurism’ (organisational professionalization) has not been sufficiently addressed to enable effective management of the commitment to protect children. As a result the service relies disproportionately on a system of volunteerism which presents challenges in terms of the level of child protection training workers have received.

Finally, the chapter argues that the issue of ‘philanthropic paternalism’ (organisational focus) has not been sufficiently addressed within supported services. As a result, supported services have maintained a focus which emphasises the need to be ‘welcoming’ to non-resident parents, ‘neutral’ and ‘non-judgmental’. It is argued that this focus can stand in conflict with the commitment to protect children since it can operate to emphasise workers’ anxiety surrounding judgment and authority, which are integral to child protection practice. In this respect, the research seeks to build on the finding of previous research which suggested that practice in contact centres was ‘pro-contact’ (Aris et al., 2002), to explore how, within ‘local rationalities’ (Woods et al., 1994), that practice made sense to workers on the ground and how the system itself may have sustained the organisational focus.

Drawing these three strands of voluntary sector weakness together, the chapter ultimately contributes to the body of research emerging in relation to the statutory child protection system. This literature argues that while issues of resourcing are important to enable the protection of children, they cannot be divorced from the psychological dimension of child protection work (Cooper, 1992; Munro, 2011; Reder & Duncan, 2003). Indeed the findings suggest that while guidance implicitly assumes that issues surrounding child protection will be interpreted in the same way by all actors, in reality the process of child protection is socially constructed in an organisational context.

4.1 The voluntary sector-state relationship

As discussed, the systems approach seeks simplification through abstraction rather than through reductionism (Dekker, 2008; Hoffman & Woods, 2000; Reason, 1990). The analysis presented in this chapter abstracts up to examine how the institutional position of child contact centres may influence the service in managing its commitment to protect children from maltreatment. The analysis draws heavily on Salamon's theory of 'voluntary failure' (Salamon, 1987, 1995). This theory provides an overarching theoretical framework for the chapter's analysis. The framework is used to simplify the analysis by grouping issues into broader (and so fewer) categories. At the same time, it provides a deeper level of analysis by linking factors which seem to influence centres' practice to a broader theoretical framework on voluntary-sector state relations.

As mentioned in Chapter 1, child contact centres are, for the most part, voluntary sector organisations. In November 2010 89% of child contact centres in England, Wales, Northern Ireland and the Channel Islands were voluntary sector organisations; 9% were commercial organisations.³ At the same time, child contact centres can receive funding from the state. Accredited, supported contact centres can receive £3000 per year from Cafcass (Cafcass, 2010b). Analysis of the NACCC 2010 data suggests that more than three quarters (76%) of supported members in that year had annual costs below £5000. It therefore seems likely that Cafcass funding is an important financial contributor in this context. Moreover, these data suggest that in that year 80% of supported members received funding from Cafcass. Cafcass also funds supervised contact, but on a procurement basis. Analysis of NACCC data suggested that in 2010 70% of centres providing supervised contact received Cafcass funding. Overall in the year 2009/10 Cafcass provided £3.75 million to contact centres (Cafcass, 2010b). The qualitative findings of this study further suggest that supervised contact services are spot-purchased by some Local Authorities and analysis of the NACCC data suggests that in 2009/10, 75% of supervised services received funding from Children's Social Care. Therefore, although child contact centres emerged through voluntary sector concern about the gap in statutory services and centres remain

³ Personal communication with NACCC, November 2010. Data were not available on England alone.

institutionally separate from the state, the evidence suggests that child contact centres now receive an important level of public funding.

In this regard, contact centres' relationship with the state is by no means unique. In his 1987 article, Salamon drew on survey data to demonstrate that government had become "the single most important source of non-profit sector income" in the United States (Salamon, 1987: 30). Indeed further research has emphasised that this relationship is evident in the provision of many services including for example, services in relation to HIV/AIDS, domestic violence (DV) and drug abuse (Anheier, 2005; R. S. Smith & Lipsky, 1993). Moreover, the relationship has since been identified outside of the United States and particularly, in parts of Europe, including the UK (Anheier, 2002). It can be suggested therefore that child contact centres represent an example of a common relationship between voluntary sector and state in which government financing is separated from service delivery (Kramer & Grossman, 1987, p. 33). Salamon (1987, 1995) termed this 'third party government' but it has been given numerous labels by other authors including 'the mixed economy', 'welfare pluralism', 'the contract state', 'the enabling state', 'non-profit federalism', 'the purchaser-provider split' and 'indirect public administration' (for a discussion see Kramer, 2000).

Salamon (1987) argued that, although the relationship between voluntary sector and state was longstanding, it had been overlooked by scholars. This, he suggested, had happened, not because of a lack of research in the area, but because of a lack of theory. Earlier theories explained the existence of the voluntary sector as market/government failure in which non-profits emerge to supply collective goods desired by one segment of the community but not by a majority (Weisbrod, 1977). Salamon (1987) argued that the weakness of such theories was their failure to account for the fact that the voluntary sector, as in the case of contact centres, may not be a substitute for the state, but a supplement to it. Salamon's 'voluntary failure' theory suggests instead that the relationship comes about because of weaknesses in the voluntary sector, which necessitate government involvement. In keeping with the voluntary sector establishment of contact centres in the early 1980's, Salamon suggests that the voluntary sector 'will be the first line of response to perceived market failures and that government will be called on only as the voluntary response proves insufficient'

(Salamon, 1987, p. 39). Salamon suggests that there are ‘voluntary failures that have necessitated government action and that justify government support to the voluntary sector’ (Salamon, 1987, p. 39). In the sections below, three of Salamon’s ‘voluntary failures’ - ‘philanthropic insufficiency’ (insufficient funding), ‘philanthropic amateurism’ (insufficient professionalization) and ‘philanthropic particularism’ (narrow organisational focus) - provide an overarching framework to understand the weaknesses experienced by contact centres in managing their commitment to protect children. As Salamon (1987) and other authors (Osborne, 2009; R. S. Smith & Lipsky, 1993) have highlighted, these weaknesses may not always be fully addressed in the relationship between state and voluntary sector. This chapter argues that despite the development of a ‘third-party government’ relationship between contact centres and the state, the weaknesses outlined in Salamon’s thesis (1987, 1995) have not been fully addressed by the state. The persistence of these weaknesses, it is suggested, influences the capacity of contact centres to manage their commitment to protect children from maltreatment.

4.1.1 ‘Philanthropic insufficiency’: contact centre funding

4.1.1.1 Centre costs

According to Salamon (1995):

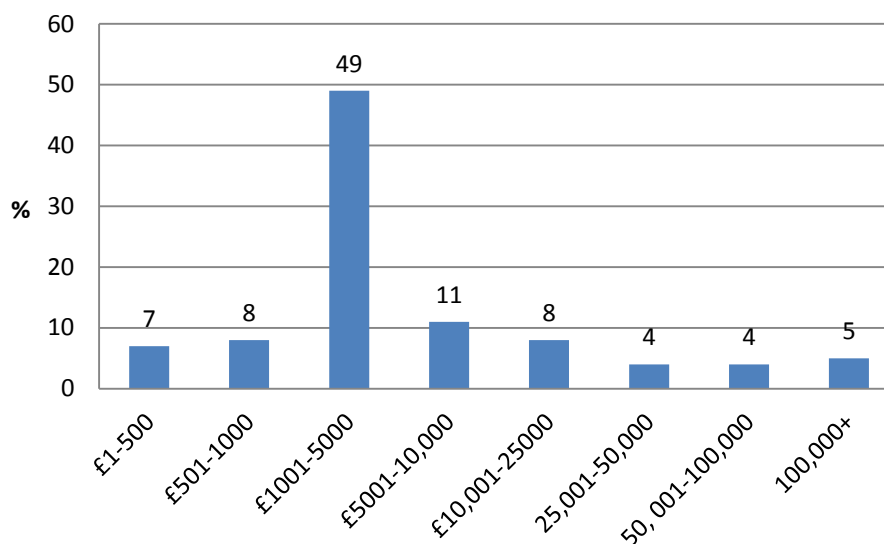
‘the central failing of the voluntary system as a provider of collective goods has been its inability to generate resources on a scale that is both adequate enough and reliable enough to cope with the human service problems of an advanced industrial society...only when contributions are made involuntary, as they are through taxation, are they... likely to be sufficient and consistent’

(Salamon, 1987, p. 39)

Analysis of the annual NACCC data provides evidence of the low level of funding which most contact centres operate on. For the year April 2009 to April 2010 64% of NACCC members had annual running costs below £5000. However, as Figure 2 below suggests, there is clear diversity in the range of running costs, from below £500 per

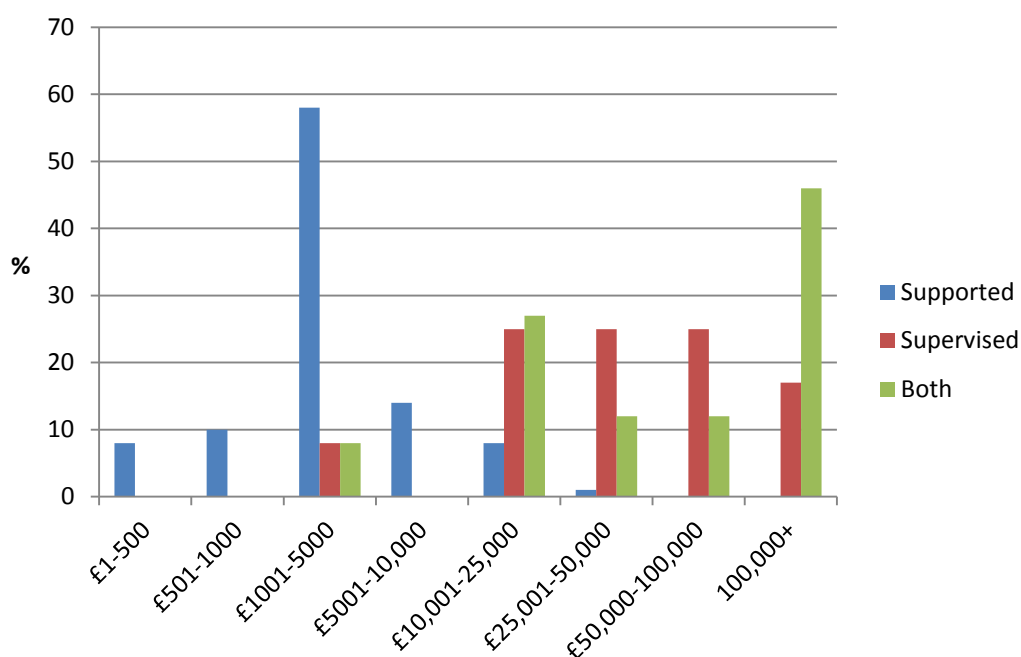
annum to above £100,000. Only 21% of members had running costs above £10,000 and only 5% had costs on or above £100,000.

Figure 3: Annual Member Costs 2009-2010



At a basic level, these data indicate that most child contact services are unlikely to be financially capable of funding professional services to build safety. When centre costs are examined by the service provided (see Figure 3 below), there is a clear distinction between costs for supported and supervised services. No members offering supported-only contact had annual costs in excess of £50,000 and only 1% (N=2) had costs above £25,000. Indeed, more than three quarters (76%) of members offering supported-only contact had costs below £5000.

In contrast only 8% (N=1) of members offering supervised contact or both services had costs below £5000. The most common budget for members offering both services was in excess of £100,000 (46%), while 92% of members offering supervised-only contact had costs in excess of £10,000 (only one centre did not) and almost a third (32%) had costs in excess of £50,000.

Figure 4: Annual Member Costs by Centre Type: 2009-2010

It could be suggested that the annual centres costs are not an accurate reflection since they do not take into account the number of families per service. However, analysis of the 2009/10 data suggests that the average number of families, while lower in supported-only services, was not low enough to account for the dramatic difference in costs between supported-only and supervised-only services. On average there were 33 families per supported-only service compared to 44 families per supervised-only service. Meanwhile, there were 74 families per member offering both services.⁴

These findings highlight the stark difference in operating costs between supported and supervised services. Moreover, it evidences that the system of contact centres as a whole operates on a small budget. A substantial increase in funding would be required to enable an increase in the number of supervised services.

⁴ The average here refers to the median. The mean number of families per service was as follows: 41 families per supported service, 71 per supervised-only service and 87 per member offering both services. One outlier amongst the supervised-only service with 370 families greatly skewed the mean amongst supervised-only services. For this reason the median has been used. If this outlier had been removed the mean number of families per supervised-only service would have been 41.

4.1.1.2 Provision of supervised services

The availability of supervised services is important because previous research suggested that there were not enough supervised services, and so families were instead being referred to and accepted at supported services, which were inappropriate to the level of child maltreatment risk (Aris et al., 2002; Furniss, 2000; Thiara & Gill, 2012). Salamon's 'voluntary failure' thesis suggests that the voluntary system:

'often leaves serious gaps in geographic coverage, since the resources are frequently not available where the problems are most severe'

(Salamon, 1987, p. 40).

In keeping with this theoretical proposition, Aris and colleagues' research, undertaken in the early 2000's reported that at the beginning of 2001 there were more than 280 contact centres affiliated to NACCC. Ninety-nine per cent of these only offered supported services; one per cent offered supervised contact. The research suggested gaps in provision of services (Aris et al., 2002, pp. 18-19).

Since then, the state has, as discussed, provided funding to establish additional supervised services (Home Office, 2003). However, in Thiara and Gill's (2012) recent research Cafcass Officers reported that inappropriate referrals were still being made and accepted at supported centres due to the lack of supervised provision (Thiara & Gill, 2012, p. 128). This finding would seem to indicate that provision may remain limited or potentially, that there are barriers to accessing the supervised services which do exist. However, the mechanisms affecting access to supervised services were not explored in this research. The findings presented below provide evidence which suggest that the number of supervised services remains insufficient. In addition there are barriers to accessing the limited services that do exist. Analysis of NACCC data suggests that in November 2010, out of a total of 308 NACCC members in England, 227 (75%) only offered supported contact while 77 (26%) offered supervised contact or both services.⁵ NACCC has suggested that there is:

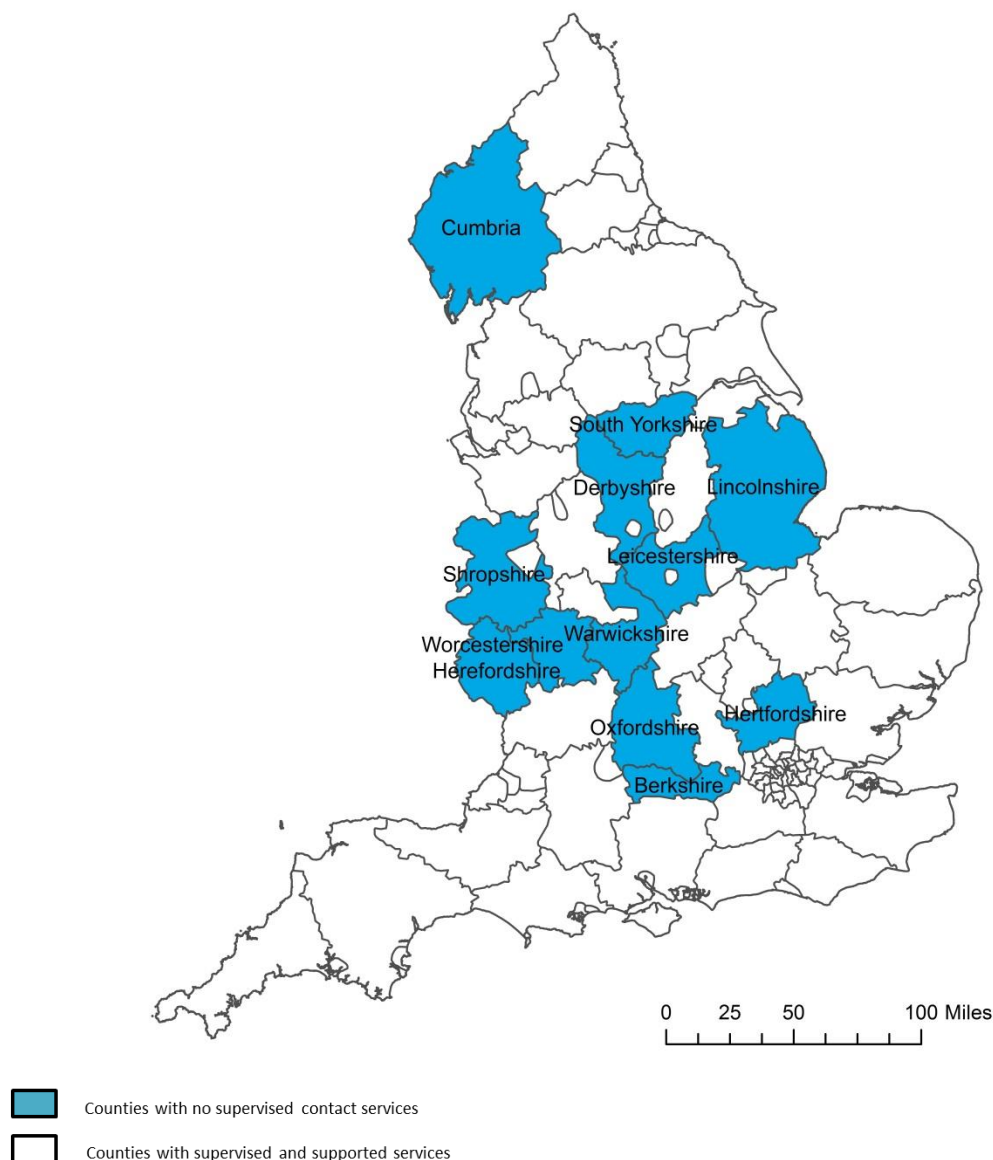
⁵ Data on the type of service provided was missing for four centres (1.3%)

‘an uneven distribution of Supported and Supervised Child Contact Centres in England and Wales with clusters around major conurbations and a paucity of provision in rural areas’

(NACCC, 2011, p. 27).

The data, from November 2010, has been re-analysed and linked to the qualitative data from the current study. The findings suggest a more nuanced and specific problem than that identified by NACCC. It is suggested that large gaps in provision of supervised services exist, particularly in rural areas, but also in some cities. In the original NACCC analysis all centres providing supported or supervised contact were mapped across the country (see Appendix 4.1), this made it difficult to appreciate the extent of the gaps in supervised provision. The data on supervised services has therefore been re-analysed and mapped below by county in order to show that some counties have no supervised services. Further to this the quantitative analysis is supplemented by qualitative data which explore actors ‘local rationalities’ in order to examine the implications for child protection practice.

Figure 5: Geographic Distribution of Supervised Child Contact Services⁶



As the map above indicates, twelve counties do not have any supervised contact services. Families who live in areas without supervised services are more likely to have to travel longer distances in order to access supervised services. This is important because the qualitative data suggest that the additional transport costs for families can act as a barrier to access. For example, a solicitor explained:

⁶ The November 2010 NACCC data were mapped to Global Administrative Areas Data (England), available here: <http://gadm.org/country> using ESRI ArcMap 9.3.1 software.

'The only centre in this area that does the supervised sessions is [Centre Six] um so that is also a barrier um... some of the families that I act for who live around [different area in same country] and those areas find it difficult to get to [Centre Six]. Even though there are regular bus services it is cost. They not only have to, obviously if they are paying for the supervised sessions, they have to get there, they also have to pay for the cost of travelling to [area in which Centre Six is located] and back. So it's quite an undertaking really.'

[Solicitor A]

In addition referrers and coordinators highlighted the practical impediments to long distance travel for families with young children.

There was some evidence that where supervised provision was not locally available, this could have an impact on the types of cases referred to supported centres in the area. The coordinator of Centre 3 reported that the closure of two supervised centres in the area (due to a lack of funding) coincided with the referral of cases involving more serious child protection concerns to her centre:

'I: Did you find that you were getting more serious cases?

R: We did. I mean a lot of the domestic violence where it was really quite horrid. I think we are getting those directly and they are agreeing to supported contact, so yes we are getting more....and drink and drugs. I think we are probably getting more than we did because there aren't the supervised centres.'

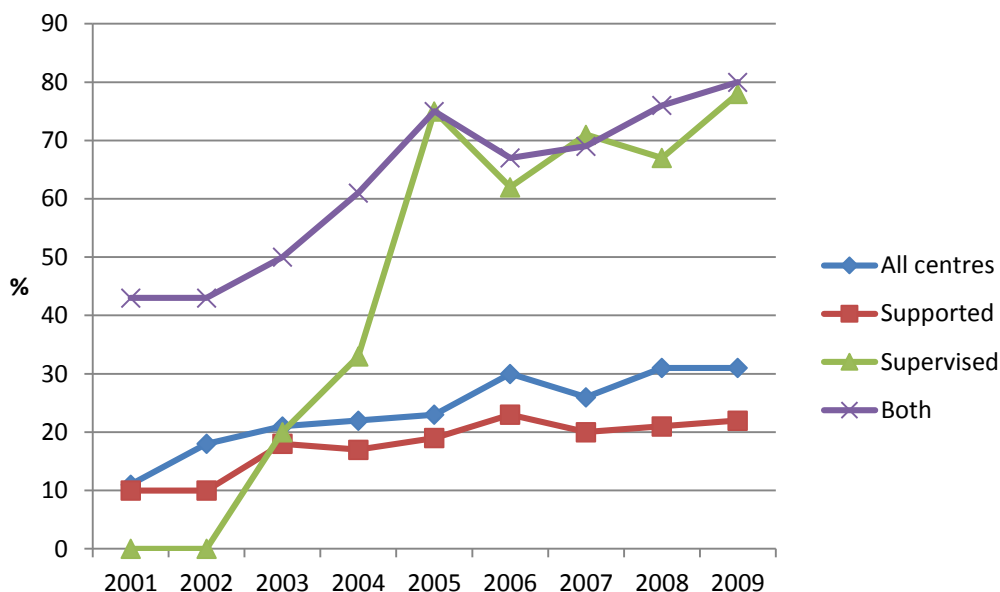
[Coordinator, centre 5, supported only service]

4.1.1.3 Contact service fees

The findings suggested a second barrier to families' access to supervised contact services, which was not identified by previous research. The findings suggest that most supervised contact services charge fees for their services which must often be met by families and that these can act as a significant additional barrier to families' access to supervised services. Analysis of the NACCC annual survey, presented below in Figure

6, suggests that there has been a growth in the number of NACCC members charging fees since the early 2000's and that this growth has been particularly stark amongst services offering supervised contact. The data suggest that fees are now the norm for supervised-only services and centres offering both services but are only charged by a minority of services which offer supported-only contact.

Figure 6: Fees by Centre Type 2001-2009⁷



Analysis of the November 2010 NACCC survey suggests that across England in this year, only six of the 77 members offering supervised contact⁸ (15%) did not charge a fee compared to 156 (74%) members offering a supported-only service. In addition four supported and one supervised service asked for donations.⁹

There is also some evidence that where members offering supported-only contact did charge a fee the sum tended to be lower than the fees charged by supervised centres.

⁷ The data from the NACCC April 2010 survey has not been included in this graph as the question changed in this year's survey and it was unclear in the dataset whether respondents who did not answer this question did not charge families or did not answer this question.

⁸ Refers to members providing supervised-only services or both services

⁹ Based on analysis of 275 centres. Data on this question was not available for 32 centres out of the total of 308 (10.4% of the sample). This was made up of 17 centres providing supported only contact, one centre providing supervised only contact, 11 centres offering both services and three centres where the services provided was unknown. It is not possible to tell from these data how many centres offering both services did not charge for supported contact as the data were collected based on charge for either service.

In the November 2010 NACCC data, details on the sum of fees charged was available for 47 of the 50 centres offering supported-only services, which charged fees. Of these, the vast majority, 76% (n=36) charged once-off registration fees of £60 or less per family. One service charged one pound per parent and another one pound per child per visit. A further four services (9%) charged less than £40 for six sessions (a session is usually 2-3 hours) of contact. Another service charged £15 per family per session. Two services charged referrers an annual fee (£50 and £75 respectively). In addition the centre charging £50 levied a fee of £15 for each family referred. One centre charged significantly more than the rest: £150 per referral and £10 per hour of contact.

Data were only available for 15 out of the 77 services (19%) offering supervised contact. The absence of data for a large proportion of centres offering supervised services is a significant limitation and implies that the results should be treated with caution. However, the tentative findings suggest that fees for supervised services may be significantly higher. As discussed below, this finding is substantiated by the qualitative data. Seven of the supervised services charged registration fees, which tended to be higher than the fees levied in supported-only services. One centre charged £50 for each referral. The other six charged between £100-150 and in addition levied more than £100 per hour of contact. In contrast to the supported services, all but one service also charged hourly rates ranging between £20-£120/hour. The range of fees in this sample indicates that while supervised services are more likely to charge fees and these fees may be higher than those for supported contact, there remains a broad range in the charges levied amongst supervised providers. Overall the quantitative data indicate that fees have become the norm for supervised services but remain relatively uncommon in supported services and that where fees are charged by supported services these may often be low compared to those of supervised services.

The qualitative findings suggest that parents are not always required to pay these fees in order to access supervised services. The data indicate that there are two routes to statutory-funded supervised contact. In public law cases supervised contact is provided by local authority in-house services or is funded by the state through local authority purchasing of contact centre services. Therefore, in public law cases the Local Authorities, rather than parents, foot the bill for supervised contact.

However, the findings indicated that, compared to cases in public law, private law cases were less likely to attract public funding where supervised contact was required. Interviews with referrers suggested that local authorities occasionally pay for supervised contact in private law cases if the local authority is involved with the family at the time of the case. However, all referrers suggested that funding through this route was extremely unusual.

It was reported that Cafcass sometimes funds supervised contact. This process is undertaken through procurement contracts with a selection of supervised contact services (Cafcass, 2010b). The findings suggest that when Cafcass funds supervised contact, it does so by procuring six two hour sessions of supervised contact, although Centres 5 and 6, which had such procurement contracts, found that a further six sessions were sometimes commissioned.

The findings cannot provide any quantitative estimate of the frequency with which Cafcass funds supervised contact where it is thought by a referrer to be required. A reply to a Freedom of Information request stated that:

‘Cafcass does not collect figures for all court ordered supervised contact as the definition is not clear’

(Cafcass, 2010a).

In the absence of this information it is not possible to determine the percentage of cases in which Cafcass funds supervised contact where it is ordered by the court. Even if this information were available, it would still exclude cases where parents agree supervised contact exclusively through solicitors. The qualitative data found that it was not clear to any centre coordinator or referrer what criteria are used by Cafcass to determine when the agency will fund supervised contact. Referrers were clear however that Cafcass funding seems to only be available in exceptional cases. Some experienced solicitors had never experienced a case in which Cafcass had funded supervised contact. The extract below from an interview with a judge also provides an indication of the rarity of this funding:

'I: In cases where [Cafcass] do fund it, where they fund the six sessions, do you have a sense of the criteria that they use for deciding when they will fund it and when they won't?

R: No. Save to say that it would be an exceptional case. For example, I deal with quite a high number of cases and I certainly haven't had an example in the last 12 months.'

[Judge B]

The data strongly suggest that the absence of sufficient public funding to cover charges for supervised contact acts as a barrier to supervised contact. This appeared to influence referrers 'local rationalities' (Woods et al., 1994) in dealing with contact cases, at times affecting how referrers considered the options in managing cases and how they presented the options to families. For example:

'I think there have been cases where we've all thought it should be at supervised but it's gone to supported because you, you already know the background, you already know the parents can't afford it, so the issues of actually supervised contact is almost never discussed. Does that make sense? It's the practice of doing it. You almost don't discuss supervised contact 'cause that will never work so why don't we try and focus on getting supported contact working.'

[Solicitor C]

In this example, the solicitor suggests that the lack of access to supervised services leads her to 'focus on getting supported contact working'. Interestingly the option of no contact is not mentioned. This was a theme in a number of interviews with solicitors. An inherent assumption was evident in the thinking of these solicitors: referring a case to a less than ideal service was considered before the option of no contact. In some cases it seemed that the option of no contact was not considered at all. This would seem to imply that issues of funding for supervised contact services interact with individual perspectives on the importance of contact (and likely other factors) to form 'local rationalities'. For example:

I: Have you come across families who can't afford to pay the fee for supervised contact?

R: I have yes

I: And what happens in those cases?

R: [Laughs] they have to go to a supported contact centre.

I: And do they work okay in supported contact?

R: It probably doesn't work as well as it would do in a supervised centre but really, if there is no money going around, there is only one other option.

[Solicitor, E]

Such extracts indicate the non-linear effect of resources on child protection practice. The findings indicate that the availability of services is a key ingredient in explaining practice, however, attitudes mediate this relationship. Indeed the interacting effect of perceptions with resources would also seem to substantiate Dekker's overarching contention that, 'the chief engine of drift hides somewhere in this conflict, in this tension between operating safely and operating at all' (Dekker, 2005, p. 187). In this case, it seems the perceived importance of providing some contact services for families ('operating at all') can send actors on a course of drift towards making unsafe referrals (Dekker, 2005, p. 187).

Some solicitors felt that the lack of access to supervised contact had specifically affected how the court had dealt with cases:

'R: I have had a situation whereby it was suggested we use a particular centre for supervised contact, it wasn't affordable for the client and so alternative arrangements were made which are essentially supported rather than supervised. So yes it can happen that way.

I: And was that a case that came through the courts?

R: That is happening before the court yes.'

[Solicitor B]

One solicitor suggested that a Cafcass Officer was influenced by the lack of funding for supervised contact.

'I: Do you think it ever happens that a family could end up in supported contact when they should probably be in supervised contact because of the funding issue?

R: Em yes I think that probably is the case, yes. I think so...I've had one where it should have been supervised, I think it should have been supervised em and Cafcass said "well I think it should be supported" ...

I: What were the circumstances in that case why did you think it should be supervised?

R: Because there was domestic violence and abduction and the Cafcass felt that by having a Protective Steps Order and a Residence Order in mum's favour would mean that mum would be able to adequately protect the child to go to a contact centre. My opinion was that dad was, there had been risk of abduction, in fact he had taken the child before em and notwithstanding any Protective Orders that the court put in place, he was going to ignore those. He'd got a very dubious past and criminal record.'

[Solicitor F]

The Cafcass Safeguarding Framework suggests that:

'Referrals should not be made to supported contact centres, nor should referrals by solicitors be supported, when the level of risk indicates the need for supervised provision (regardless of the limited availability of the latter)'

(Cafcass, 2009, p. 69)

Moreover, as discussed in Chapter 1, Cafcass is explicit about the appropriate level of risk in supported services, stating:

'Supported contact centres are not suitable for any cases involving risk to children or adults...they should only be used where safe and beneficial contact for the child can clearly take place'

(Cafcass, no date -b)

Nonetheless, the extract above would seem to indicate that this guidance is not followed in all cases.

On the other hand, solicitors also gave examples of cases in which supervised contact had been ordered but was not affordable for the family and so the case had ended with no contact. This suggests that the lack of access to supervised contact in addition to having implications in terms of child protection, can also lead some children to loose direct contact with their non-resident parent. Indeed, as Judge B pointed out, effectively there is no provision in private law cases for children to have contact with parents where supervised contact may be required in the long-term. Children in this circumstance may therefore loose contact with a parent:

'Because in the long-term there's no point in having contact if it always has to be externally supervised to a high level if there is, and there is in our present society, no ability for that to happen in a private law case in a long-term way. So unless it's a step through to move to something else, either to some form of lesser supervision by a family member or a case that might at some stage be suitable for the contact centres, the supported centre...where the sort of difficulties come is if you've got a parent with a relapsing and remitting mental illness which can, when they're in a florid state, make them a risk to the children. You have to... it's very difficult to order contact because you can't always have it supervised. So you have to have a mechanism, or some form of mechanism, for trying to establish whether or not that parent is or is not a risk

to the child at that time before allowing any lesser form than supervised contact. And supervised contact is just not available.'

[Judge B]

Overall, the findings suggest that the lack of access to supervised services, due to gaps in provision and charges for the service, contributes to the local rationalities affecting referrers' unsafe child protection practices. As previous research has also suggested (Aris et al., 2002; Furniss, 2000), referrer's personal understandings and perceptions of the need for contact also mediated the effect. It can be argued that the inadequacy of access to supervised services relates to a failure to adequately address a predictable weakness in the provision of voluntary sector services: 'philanthropic insufficiency' (insufficient funding).

4.1.2. 'Philanthropic amateurism': training and professionalization

In keeping with Salamon's (1987) thesis, the findings suggest that the state has also inadequately addressed the issue of 'philanthropic amateurism' within child contact centres and that this has implications for child protection practice in the service.

Philanthropic amateurism refers to 'amateur approaches to coping with human problems' (Salamon, 1987, p. 42). Salamon (1987: 42) points out that agencies which stress volunteer effort and rely on charity, are unlikely to be able to provide professional personnel who can provide the level of service required to address modern social problems.

Working Together (2010) suggests that in order to uphold the 'commitment' to protect children from maltreatment, all staff and volunteers who work with families should:

'undertake appropriate training to equip them to carry out their responsibilities effectively'

(HM Government, 2010, p. 42).

This explicitly includes training on how to recognise and respond to safeguarding concerns (HM Government, 2010, p. 2). The NACCC National Standards for supervised services echo this requirement. Workers in supervised services should:

'Receive the training, support and supervision they require to work safely and effectively with referrers, families and children using the centre'

(p.3)

Staff in supervised services must also:

'receive induction training before having any direct contact with families. The training should cover the Centre's policies and procedures in relation to: safeguarding children, domestic abuse, conflict management, drug alcohol and substance misuse, health and safety, CRB, confidentiality, complaints and compliments, equal opportunities and diversity, referrals, risk assessments, contact plans/contracts, interventions/programmes of work with families, recording contact, reviews, reports, home visits, escorted visits and transporting children. Unless they already have qualifications and experience of relevance, within six months of starting work in a centre new staff/volunteers should undertake training relating to: family breakdown, working with families, working with children, the law and legal issues relating to contact.'

(p.4-5).

'All Supervised Child Contact Centres should have a rolling training programme that covers safeguarding children, domestic abuse, health and safety, conflict management and working with children.'

(p.15)

According to the National Standards for supported services, workers:

'Must receive induction training before starting work in a Centre (p.3)... All volunteers/staff must be made aware of and receive training in the area of Child Protection/Safeguarding' (p.5)... [and] domestic violence' (p.7). Each Child Contact Centre should provide a minimum of two training sessions every year. Training can either be in a group session or undertaken on a one to one mentoring process' (p.8).

However, the level of training required to work at either a supported or a supervised contact centre is not specified by NACCC and there was, prior to this research, no indication of how centres might be interpreting this responsibility. Neither was it known whether all workers receive formal training.

The findings indicate the extent to which child contact centre services rely on a model of volunteerism. The findings indicate that in April 2010, 88% of workers across all members in the sample¹⁰ were volunteers. However, only 3.5% of workers across all supported-only services in England were paid staff compared to 89% of workers across supervised-only services.¹¹ In addition, only 36% of supported-only services had a paid coordinator compared to 96% of centres offering both services and 100% of centres only offering a supervised service.

4.1.2.1 Training and professionalization in supervised services

The qualitative findings suggest that training across child contact centres varied dramatically between and across both services. Of the three case study supervised services, only Centre 5 (the specialised DV centre) required workers to have specific qualifications. This centre was managed by a qualified social worker and supervised contact sessions were led by qualified social workers. Second supervisors were qualified to a National Vocational Qualification (NVQ)¹² level four or above in social care and child development. Occasionally the service also employed final year clinical psychology students, where they had sufficient relevant experience and had received additional in-house training. All workers received in-house training on DV, safeguarding and report writing.

¹⁰ 215 members answered this question out of a total population of 308 members. This is a response rate of 70%. This included 175 supported-only members (77% response), 12 supervised-only members (52% response) and 28 members (51%) offering both services.

¹¹ 51% of workers in centres offering both services were paid staff but the data do not allow a disaggregation to explore which staff were working in which service. 96% of centres offering both services had a paid coordinator.

¹² NVQs are work-based awards in England, Wales and Northern Ireland, achieved through assessment and training. They range from Levels 1–5.

Unlike the manager of Centre 5, the managers at Centres 4 and 6 did not have qualifications or experience in the specific area of child contact or child protection before taking up their posts. The manager of Centre 6 was a former teacher while the manager of Centre 4 had previously worked in administration in the same organisation. Instead, while in post, they had received externally provided training specifically on issues relating to child contact supervision. The manager of Centre 4 was also undertaking a diploma in health and social care (NVQ level 5).

Staff in these services were not required to have any particular qualifications prior to becoming a contact supervisor. According to the managers, both of these services required all staff to attend externally provided safeguarding and first aid training. However, as the extract below suggests, there was some indication that in Centre 4 this may not always have been provided before staff started supervising. Findings suggested that in practice for some supervisors in this centre, training was largely provided in-house and, to some extent, was learnt ‘on the job’. For example:

I: I was wondering as well about the support that you get in doing the work that you do here. And did you have any training or anything when you started here?

R: We had little training books, NVQ level three, First Aid. First Aid was last week you know so yeah, yeah we have trainings like that. Before we started we all have like an interview and then the manager explains okay this is what goes on here, this is how you talk to the children, this is how you do a report, this is what you have to include in the report, how detailed it has to be. I think from experience you kind of learn as well. Because at the start you're kind like okay so it's not that important it's just a report, I just write down what happens but... afterwards when you experience things like people actually picking up the, you kind of realise that, you know, your reports are really important 'cause people actually pin pointing every little thing in there. So after like realising oh it's really important you then kind of focus more on your reports afterwards.'

[Centre 4, Staff member 3, both services]

Some staff in Centre 6 had received training from another supervised contact centre a number of years previous. Staff who had received this training now provided it in-house to new staff. On one visit to the centre a staff member was supervising contact for the first time. She had received one training session from an experienced colleague prior to supervising cases alone. Therefore, the findings suggest that in both of these supervised services training, at the point when workers began supervising contact, could be limited to one training session with a member of staff. This contrasted starkly with the qualifications and training required of staff in Centre 5 and indicates the diversity of training across supervised services.

4.1.2.2 Training and professionalization in supported services

The managers of the supported centres did not have formal qualifications relating to child contact, although two had previously worked as teachers and one had worked in a Children's Centre. All should have received some training from NACCC through 'residential' courses held annually over the course of two days. However, as will be discussed below, some managers experienced barriers to accessing this training.

In the two centres providing both services there was some overlap of staff between supported and supervised services. In Centre 4 the same staff provided both supervised and supported contact, although as discussed, 'supported' contact in this centre was, unusually, the equivalent of supervised contact, without reports. In Centre 6 supported sessions were led by 'team leaders' who usually worked in the supervised services and so had received the training described above. Training for general volunteers across the supported services varied between centres.

Volunteers in two supported services had received some formal, externally provided training. The manager reported that all volunteers in Centre 6 received safeguarding and first aid training from an external provider. Centre 2 had paid for NACCC to deliver training on specific issues to volunteers at the centre. Over the years this had included training on safeguarding, DV and issues relating to changes in the family justice system. At the time of the visit the last such session had been more than a year ago. In this centre the coordinator also cascaded training to volunteers through six weekly volunteer support group meetings held in the evening time outside of the

contact centre opening hours. Outside of this, training for volunteers in these centres was provided ‘on the job’ and through information booklets.

In Centres 1 and 3 training was exclusively provided on the job and through information booklets. For example, a volunteer reported:

T: And when you joined the centre did you have any training or how did that work?

R: I just watched in on a few of them [contact sessions] and then...obviously filled in the application form and [the coordinator] gave me a pack, I think it was a few sheets to read through.’

[Centre 1, Volunteer 4, supported-only service]

In relation to the contribution of training to child protection practice, in keeping with the systems approach, a linear view of causality is rejected in this research (Perrow, 1984; Reason, 1990; Wallace & Ross, 2006). It is acknowledged therefore that while training is likely to be an important part of enabling volunteers to protect children, in the absence of a counter-factual, it is not possible for this research to isolate the impact this factor has on child protection practice. It is possible that training interacts with other factors to produce varying effects. In other words, for training to be effective, support factors may be required (Cartwright & Hardie, 2012, pp. 61-88). It is possible, for example, that more positive attitudes towards training led workers to undertake additional training and absorb it, and so the effect of training may be mediated by attitudes. As discussed below, it is likely that while the availability of training is an important ingredient to good management of the commitment to protect, it is not a panacea. Issues around worker attitudes and organisational focus seem to intersect the dynamic.

4.1.2.3 Barriers to the attainment of training

The coordinators of Centres 1 and 3 reported that they wanted to provide additional training to volunteers but that they experienced difficulty in getting volunteers to

attend training sessions. As the extract below indicates, the coordinator of Centre 1 suggested that volunteers did not necessarily feel they needed training:

'Well I think the other people [volunteers] need training on safeguarding, perhaps they need to understand a bit more why we have the clients, why they come...why clients come to us erm...because of domestic violence or things like that. Things like that that they want to know but at the same time it's very difficult to give training to people who've been doing the job twenty-one years, who are now getting on in years and perhaps really don't want it, it's almost a bit cheeky.'

[Coordinator, Centre 1, supported-only service]

The coordinator of Centre 3 suggested that volunteers were not willing to give extra time for training:

'We find our volunteers aren't so willing to come to training sessions...they come on the Saturday and they come and they come regularly and they're fine but they don't want to give up any other time. So we decided em...at the last committee meeting we had last week...that in the 10 minutes, when we go through the register at the beginning of Saturday morning in some of the time that's available, instead of just having a chat [about the families] while we are waiting for people to come, we will actually discuss one of our policies. So that's what we will be doing when we finish having you [laughs].'

[Coordinator, Centre 3, supported-only service]

Interviews with volunteers in both centres seemed to support the assertion that some staff had negative attitudes to training. While some volunteers in each centre said that they would like additional training, interviews with volunteers in Centres 1 and 3 suggested a perception amongst some that the work they were doing was 'common sense' and that training was not needed. For example a deputy coordinator who had attended some of the coordinator training commented:

'I suppose we've had a little bit more training, I mean in the beginning we were all total amateurs. Over the years we have got...gained experience and also there have been some training courses and things. I am not a huge one for training I must admit a lot of it just goes in one ear or the other. So I'm only speaking for myself but I spent my whole life really in a sense even in my career using common senses as my guide [laughs a little] to how to deal with things you know? and experience. And other people telling me what's a better way of doing it I sometimes accept and sometimes I don't because I think anybody with half a brain by the time you get to 40 something or may be 60 something you've picked up a quite a lot of useful guidance along the way. And you've also in my case I've also had children so I've dealt with my own children you know?'

[Deputy coordinator, Centre 1, supported-only service]

For some it seemed that the attitude to training was related to how they perceived their role. In the extract below there appears to be an assumption that the role of volunteers is specifically limited to issues which are 'common sense' as their purpose is simply to 'enable' contact:

'T: Assuming that training was free, is there any kind of training that you would like to have as a volunteer, in your role?'

R: [Pause] I don't think there is particularly because, as I say, I think our role is very much em you know, just enabling. We're not there particularly to deal with em...sort of, you know, the back story or that. I mean my take is, if the courts have said you know, A and B must make a contact at the centre C, then we are just following that and trying to enable a good contact so we don't...I think sometimes the back story can get in the way, certainly for some people who might be thinking "ooh somebody is doing, you know, this that and the other...ooh you know why did that mum not look after her children?" and you know, just making up stories. Em...I think the [pause] I mean the only thing you need to know is how to...and it's much more a common sense and em an innate thing, is knowing when to go and say something or when to be bothered about a situation...that's common sense, how you teach that I don't know.'

[Volunteer 1, Centre 1, supported-only service]

In this extract the suggestion seems to be that training is unnecessary because volunteers should not make judgements about families beyond the common sense. A distrust of volunteers seems evident here in the suggestion that providing ‘the back story’ would lead ‘some people’ to ‘[make] up stories’. This is discussed further below in Section 4.1.3.3 below.

Other workers were not necessarily against training but, based on their understanding of their role, they were not sure it was necessary. Again in the extract below the perception is that volunteers were simply ‘there to be there’:

I: And have you had any of the NACCC training, while you’ve been at the centre, the training for volunteers?

R: No

I: Ok so when you came to the centre, how did it work in terms of figuring out how things worked and what your role was?

R: Erm...I was given some material to read erm...and oh gosh I’m trying to think erm...(pause) I...it’s just like taking guidance from [coordinator]. Yeah I assume that if I was doing anything wrong she would erm...have a word with me, I mean she’s never had to do that so erm...I think erm...I don’t think it comes naturally but it’s sort of erm...it’s a simple enough role, as its been explained to me, you know, erm...we’re just there to be there really erm...and help as best that we can.’

[Volunteer 2, Centre 5, supported-only service]

The findings suggested further barriers to training for the managers of the supported-only services. All three coordinators found that it was challenging for them to get to training which was provided a great distance away over the course of two days. They could not always attend. For example:

'[NACCC] want us to go to a residential place...it's during the week, two days there. Well physically I can't do that with my ...with my grandchildren because I look after them and it's very costly, for two of us it would have been over four hundred pounds.'

[Coordinator, Centre 1, supported-only service]

The findings suggested that the cost of the training was affordable to the case study supported centres in the short-term, but they perceived Cafcass funding to be unstable and so were anxious about the cost in the longer term. The amount of time coordinators were expected to volunteer to attend was also problematic, given that they had other commitments during the week. Two of the services located near a large city reported that as they could not attend, their NACCC regional coordinator arranged for training in a city near them at a later date in the year. The coordinator of the other centre, however, reported that she simply could not attend.

4.1.2.3 Implications of the level of training

The literature indicates that in the context of child protection, training is important because, as Munro (1998, p. 92) puts it 'facts on their own are silent'. Theories and knowledge are required to enable workers to attribute meaning and interpret facts (Munro, 1998; Reder & Duncan, 2004). Workers must be able to organise facts into meaningful categories of analysis (Hall & Slembrouck, 2009). Evidence in the area of child protection is also usually highly ambiguous. For this reason experience is required in order for staff to develop expertise (Munro, 1996).

As discussed in Chapter 3, amongst the supervised case study centres, Centre 5 provided a fundamentally different service to Centres 4 and 6: in the report produced by supervisors for referrers, Centre 5 provided an in-depth analysis of contact while the other two supervised services focused more on 'contact notes' which gave a description of contact for the purpose of referrers' analysis and conclusion. The level of staff training seemed to be an important factor influencing the difference in approach. As the manager of Centre 4 explained, staff would require further training in order to provide a full report:

'I call them 'contact notes' rather than reports. Just because they're not high level quality reports that we're doing, we haven't spent hours over each one; it's just a general observation and analysis of what's happened from start to finish. Just to give everyone a clear idea, obviously if there are any issues those are logged as well, but it's not really looking at a really deep, you know psychological level. We prepare the report and hopefully that's what the Guardian and the other people involved in the case should be doing...I think if the local authority were to do more training or make it more readily available then we could start incorporating you know a bigger report into, like a "court report" I think they call it, into our services'

[Manager, Centre 4, both services]

In contrast, the level of staff training in Centre 5 meant that this service could provide an analysis throughout the service from referral through contact to moving the case on. In particular this meant that the staff could challenge referrer decisions regarding contact. For example:

'We assess every case that comes in...a case can be stopped at any point if you feel the risk is too greater for instance we get the referrals in and I might see a family and think this is fine for it to start...we do what we call our pre-contact meetings...at that moment we might meet a child that's changed, there's quite a gap from when Cafcass saw them and when we've seen them and it might be that this present moment in time, having met with that child, contact can't continue and the workers are qualified enough to say, "look this is what happened during our pre-contact meeting, we're concerned about this, this and this".'

[Manager, Centre 3, supervised-only service]

The level of training and qualifications attained by staff in Centre 5 also enabled this service to develop and provide professional services to build safety.

The level of training available in centres seemed influential in terms of the capacity of all centre managers to analyse and make decisions concerning cases referred to their centre. In the absence of professional social work or equivalent training it is difficult to understand how managers could effectively screen cases and come to conclusions about them. As will be discussed further in Chapter 5, this was an important factor contributing to problems in the referral process in supported services. As will be discussed in Section 4.1.3 below, the level of training provided to volunteers may also have contributed to the ways in which some understood issues surrounding child protection.

4.1.3. 'Philanthropic particularism': organizational focus

Salamon (1987) labelled the 'tendency of voluntary organisations and their benefactors to focus on particular subgroups of the population' (Salamon, 1987, pp. 40-41) as a potential weakness of the voluntary sector. He suggested, in particular, that the voluntary sector has 'a tendency to treat the more 'deserving' of the poor, leaving the most difficult cases to public institutions' (Salamon, 1987, p. 40). This can 'leave serious gaps in coverage' (Salamon, 1987, p. 41). It can be suggested that this weakness is manifest in child contact centres in a particular way.

As discussed in Chapter 1, contact centres originally focused on providing a service to a sub-section of families who, it was assumed, were losing contact due to reasons which were not related to child protection concerns. In keeping with Aris and colleagues' (2002) proposition that the historical roots of the service influence practice, it is suggested below that this original focus remains in supported services. This is despite the profile of families which clearly indicates that some children in this cohort have experienced maltreatment and/or are at risk of maltreatment. This argument is developed here in relation to the findings to suggest that the organisational focus has implications for child protection practice in supported services, affecting how volunteers experience and understand the practice of protecting children. In this sense, the section suggests that while issues of resourcing are important in the process of protecting children (as illustrated above), they cannot be divorced from the psychological process of protecting children which, it is suggested, is not simply a mechanical process, but an emotional and psychological one.

In keeping with the systems approach, centre workers' local rationalities are explored in-depth in order to understand the meaning people attribute to their actions (Dekker, 2008; Helmreich & Merritt, 1998). In particular, the analysis sought to identify any goal conflicts workers may experience (Woods et al., 1994, p. 94) and to explore how meaning may emanate from social negotiations and construction within a group (Dekker, 2008, p. xi). In doing so, the research sought to get beyond the findings of previous research which suggested that practice was sustained by a pro-contact stance (Aris et al., 2002) to better understand how practice made sense to workers on the ground (Dekker, 2008; Rasmussen & Svedung, 2000; Reason, 2000; Woods et al., 1994) and how the focus may have been sustained.

Referring to the statutory child protection system, Cooper suggests that 'child protection work gives rise to intense anxiety in those who practice it' (Cooper, 1992, p. 117). Research within the statutory system has demonstrated the ways in which the system may unintentionally exacerbate and direct workers' anxiety, with implications for practice which may be counter-productive to the system's core functions (Cooper, 1992; Munro, 2005a). It has been argued that the current statutory child protection system has developed a culture of professional defensiveness due to blame placed on workers for the deaths of children (Munro, 2005a, 2011). Cooper (1992) suggests that as a result of this the statutory system does not enable workers to manage their own authority and so workers may feel they are 'either objects of potential persecution, or are themselves potential persecutors' (Cooper, 1992, p. 124).

The findings presented below suggest that, within the organisational context of supported child contact centres, workers struggle with their authority and responsibility to protect. The same was not found in the supervised case study services. In the context of supported services, the findings indicate that authority and judgement can be experienced negatively as destructive. It is suggested that this may be because the focus in this system is on avoiding the potential for workers' authority to operate in a fashion which *persecutes* families. In this sense, in keeping with Menzies-Lyth's, (1990) seminal study of hospital nursing, it can be suggested that the volunteers' reaction represents a 'socially structured defence mechanism' (Menzies-Lyth, 1990, p. 443), created to deal with their anxiety, which is exacerbated rather than relieved by

the system. Yet this defence mechanism is problematic since child protection work cannot be undertaken without some element of authority and judgement. In this sense, two integral parts of the work of protecting children-judgement and authority- were eschewed and in the process workers effectively disengaged, to a greater or lesser extent, from the process of protecting children.

4.1.3.1 Guidance to child contact centres

It is suggested that the national system of supported contact centres may exacerbate workers' anxiety about persecuting families by focusing on the importance of neutrality and trust building, rather than child protection, with implications for how workers perceive risk. The systemic difference in the representation of supported and supervised services can be observed in the NACCC 'Definitions of Levels of Contact'. In this guidance, the importance of neutrality is clearly evoked in reference to supported services which are described as '*neutral community venues*' where the service is '*impartial*' and it is stated that there is '*encouragement for families to develop mutual trust and consider more satisfactory family venues*' (p.1). By contrast there are no references to neutrality or trust building in the definition of supervised contact; services are not described as '*impartial*' rather the emphasis is on '*ensuring the physical safety and emotional wellbeing of a child*' (p.2).

The emphasis on neutrality within supported services would seem to be a historical artefact, emanating from assumptions made at the time when the first contact centres were established. The suggestion that families should be '*encouraged to develop mutual trust and consider more satisfactory family venues*' (p.1) would seem to assume that the contact problems experienced by families using contact centres relate to resident parents' or children's misplaced lack of trust, rather than to any founded lack of trust due to a child protection concern. The absence of a statement emphasising the importance of ensuring the child's safety would seem to reinforce this assumption. This fits with the original purpose of child contact centres and the broader societal concern at the time of their founding in the 1980's, which related to anxiety that children were losing contact with non-resident parents (Aris et al., 2002). However, this focus stands in conflict with the profile of cases accepted at supported contact centres and the empirically based concern that this sub-section of the population are at

increased risk of having experienced and experiencing child abuse during contact (Buchanan, Hunt, Bretherton, & Bream, 2001; Hunt & MacLeod, 2008; Trinder et al., 2006).

4.1.3.2 The focus of supervised contact services

The data indicate that child protection was a key focus of the case study supervised services. Workers across supervised services were clear that protecting children from physical, emotional and sexual abuse as well as neglect was a core aim of this service. For example:

I: In terms of the work that you do here what do you see as the main aim?

R: Em the well-being of the child.

I: In what way?

R: So protect the child's well-being. So developmental, physical, health and safety and yeah just be child-centred really.'

[Staff member 3, Centre 5, supervised-only service]

The emphasis across supervised services was specifically on protecting the child from emotional, physical and sexual abuse.

4.1.3.3 The focus of supported contact services

As discussed in Chapter 3, workers in supported services were aware that child protection was 'everyone's business' and they were knowledgeable about their responsibility to refer child protection concerns to Children's Social Care and the procedures for doing so. However, the findings presented below suggest that supported services also placed heavy emphasis on other goals: they emphasised the need to provide a 'welcoming' service and to be 'neutral' and 'non-judgemental'. Workers' 'local rationalities' on these issues are explored below. It is argued that the

simultaneous emphasis on these other goals presented a goal conflict (Woods et al., 1994, p. 94) for workers in managing their commitment to protect.

A ‘welcoming’ service

The findings suggest that the focus in supported services was principally to enable contact to take place and volunteers emphasised their role in creating a welcoming environment. The findings suggest that this emphasis could in practice stand in tension with the commitment to protect children from maltreatment. In this sense, it can be observed as a goal conflict experienced by workers (Woods et al., 1994, p. 94). As the extracts below demonstrate, across the supported services, practice that risked jeopardising the aim of creating a welcoming environment for non-resident parents could be positioned negatively by workers and avoided:

‘[The aim of the centre is to provide] a warm welcoming, neutral and impartial venue where people can come and feel comfortable and reassured and not feel that they are being judged or spied upon. So that’s what we do as volunteers on the day really.’

[Coordinator, Centre 2, supported-only service]

‘We are not trying to run a police state there. We are trying to make a happy environment so we don’t want to make people feel that all the time they are being watched, every moment of the time they are there. So I think probably when you were there on Saturday you saw a little bit of what I am talking about here. That we were actually most of us we were sitting down at that table in the front, and largely letting people get on with it. Now that’s not just because we’re not interested, it’s because as far as I am concerned I want the people to get on with it without feeling that they are being observed.’

[Volunteer 2, Centre 1, supported-only service]

‘I: And what’s the thinking behind that, why does the centre not provide any information on supported contact to the courts?’

R: 'Cause that's not what our remit is. I think that's probably the same for all centres, I don't know. Because it is literally...if we were going to watch everything, listen to everything and record everything, we would need a lot more staff. And it's literally sold to people that it's just a safe environment and nobody is watching you or listening to you. Now there has been occasions when there has been, you know allegations...I've had a mum come up to me and this was a mum who was visiting her daughter to say she's been told she is being hit at home so you then have to make the decision "oh my goodness, is this a referral to social services, is it not?." You would have to take full notes on that...But you are not going to make notes for things that you have overheard or you know, if it was something really bad you would have to but you know we are not going to start recording what a child eats or what a child drinks or what dad says to them or how he greets them because that's what we have told them we won't do. I think a lot of dads like that fact that we are just there to be a presence.'

[Volunteer 2, Centre 6, both services]

As the extracts above indicate, while there was some sense that close watching, listening and recording was not possible due to resource constraints, these practices were also fundamentally experienced by these workers as negative or even destructive. This is captured in the suggestion that such practice is variously analogous to 'a police state' and 'being spied upon'. By contrast, practice which does not include close watching, listening and recording was positioned as 'a happy environment', 'welcoming, neutral and impartial ...comfortable and reassured' and ultimately what 'a lot of dads like'. In this sense, while rhetoric across supported child contact centres described practice as 'child-centred' and 'focused on children', practice itself seemed to be principally oriented towards the perceived need to make non-resident fathers feel welcome.

A 'non-judgemental' service

In particular, practice which was interpreted as 'judgemental' was experienced negatively by many volunteers in supported contact centres. Indeed the avoidance of 'judgement' seemed to be an underlying rationale for practice in a number of respects.

Close observation, listening and recording could be positioned negatively because these practices were seen to imply a judgement on parents: that these practices were necessary. In addition, across all supported services, the avoidance of judgement was the explanation given for volunteers' limited knowledge about family case histories and identified risk factors. For example:

'Maybe if we discussed this a lot within the group, you might have preconceived ideas about families before they arrive and be a lot more judgmental whereas if you don't know a great deal about them, you're not erm sort of pre-determining what you're likely to think about them...I think that's quite good for the families to feel that there's a fresh slate with somebody.'

[Volunteer 1, Centre 3, supported-only service]

'If you know too much, and certainly if the volunteers know too much it could change your view of somebody. For right or for wrong you shouldn't have preconceptions but you can do sometimes so in a way we just need to know what we need to know really, and don't need to know much more. And as you get to know families you may learn more about them but as I say you might hear one side from dad and one side from mum and you never know what's the truth.'

[Volunteer 2, Centre 6, both services]

Across supported services many volunteers articulated the concern referred to above, that if they were given 'too much' information about families they may have preconceptions about families and 'change [their] views of somebody'. It was often suggested that this could make them 'a lot more judgemental', 'take sides' or be 'biased' against parents. The preference, as articulated above, was to give non-resident parents a 'fresh slate'. Again, it seems evident that these workers experienced the possibility of judging families, or coming to conclusions about cases as potentially destructive and as a result, anxiety inducing.

The suggestion in the extract above that 'you never know what's the truth' would seem to indicate the underlying problem of child protection work experienced by volunteers

in supported services: that child protection work operates in a context of uncertainty (Munro, 2010b, p. 6). In this environment workers risk either unnecessarily restricting a child's contact with a parent or, alternatively, leaving a child at risk of harm during contact. In the context of supported services it seems that in aspects of routine practice this uncertainty could be dealt with principally by avoiding the risk of denying contact, while disengaging with the possibility that this may leave children at risk of harm.

In one respect these findings challenge previous research on contact centres. The research by Aris and colleagues (2002) did not seek to explain why information was often not exchanged within centres. Indeed, Harrison (2008) criticised this practice, suggesting that it was 'less understandable' than other aspects (Harrison, 2008, p. 395). The recent research by Thiara and Gill (2012) suggested that information exchange may have been limited in supported services due to 'time pressure' (Thiara & Gill, 2012, p. 128) but direct evidence of this from workers' local rationalities was not provided. By contrast, the in-depth examination of workers' 'local rationalities' presented above suggests that this practice was not an accident due to resource constraints but rather intentional, 'normal work' (Dekker, 2005) based on the meaning workers attached to the process of exchanging information about families.

A 'neutral' service

As Cobb (1997) suggests, our capacity to witness and to recognise abuse is dependent on the discourse we use to identify, classify, and evaluate it. The evidence presented below suggests that the emphasis on the importance of 'neutrality' in supported child contact centres was in some instances associated with a minimisation of child maltreatment risk as it could be interpreted to imply an assumption that families' use of the centre was due to parental conflict. In this way, the discourse of neutrality could legitimate a diversion of workers' attention away from the child and onto the relationship of the child's parents. Protection could then be reconstituted as the need to protect children from bi-directional conflict between parents with less focus on the need to protect children from unidirectional abuse. Simultaneously, abuse itself could be reconstituted as parental conflict and in this way actual or potential maltreatment could be 'disappeared'.

Across supported services many volunteers positioned the necessity for the service as a means to enable children and non-resident parents to meet in cases where conflict between the parents led the resident parent to deny contact. This was sometimes taken further, to explicitly suggest that the service was required because resident parents resented their children having contact with their ex-partners. The focus on parental conflict at times seemed to ignore the possibility that the resident parent was objecting to contact due to legitimate child protection concerns.

Ironically, despite the emphasis on neutrality in the service, some interviews with volunteers seemed to imply that the anxiety regarding judging parents was reserved only for non-resident parents; some volunteers often made judgements about the motivations of resident mothers who objected to contact arrangements, and did not seem to experience discomfort in doing so. Moreover these judgements were made in the absence of evidence to validate them. This would seem to substantiate the suggestion made above that it was the judgement involved specifically in the work of child protection which was experienced as destructive. The extracts below provide examples of this discourse:

I: Do you ever see cases where the resident parent really doesn't want contact to happen, where they are objecting to contact?

R: Oh yes.

I: And why would they be objecting to it?

R: For a number of reasons. To [pause] to keep the child on their side should I say, by letting go and letting the other parent see the child they feel they are letting go and they use the child as a pawn I suppose really.

I: And is that always the reason?

R: No no I wouldn't always say that. I think sometimes marriages break down, I think sometimes they are quite young em and the marriages break down, you know a lot of them they're not married and they are quite young. And again

you know we see them and I'd say 18, 19 year olds and mum can't cope...I don't know in that respect, I would think em yeah, no I'm not sure how to answer that one [laughs].'

[Volunteer 5, Centre 2, supported-only service]

'I: What do you see as the main aims in the work that you do?

R: I think, often when people come to the centre there's a lot of anger and bitterness and the children are used a bit by the parents as pawns and just to try and if the father...if the father pitches up every week, the mother sees he's reliable, the kids are enjoying it, eventually things improve, in ninety-five per cent of the cases.'

[Volunteer 3, Centre 1, supported-only service]

'I: Do you ever get cases in supported contact where the resident parent will make allegations against the contact parent?

R: Yeah, oh yeah...Em I would say usually it's them trying to find every single opportunity to break the relationship between the parent and the child, you know, it's to stop the contact from happening. Em that's what I said earlier about the power resident parents seem to have.'

[Volunteer 3, Centre 6, both services]

In these extracts the volunteers seem to express a construct of residents parents who object to contact which is in keeping with the notion of 'implacably hostile' mothers, identified previously in the legal arena (CASC, 2000; Fortin, 2003; Hunt & Roberts, 2004; Neale & Smart, 1997; Radford et al., 1997; Radford & Sayer, 1999; Wallbank, 1998). As discussed in Chapter 1, prior to 2000, within the family justice system, mothers who opposed contact were frequently labelled 'implacably hostile', rebuked by the courts and sometimes penalised (Fortin, 2003). The courts at this time did not focus on the quality of the relationship between the father and child and so children who objected to contact were frequently assumed to have been influenced by their mothers, and their expressed wishes dismissed (Fortin, 2003; Radford et al., 1997).

However, by the end of the 1990's this approach was being criticised particularly by those concerned about risks relating to DV (Fortin, 2003). The assumption that mothers are likely to unnecessarily obstruct contact has also been challenged by empirical research (Brown, Frederico, Hewitt, & Sheehan, 2001; Hester et al., 1994; Jaffe et al., 2003; Murphy & Caffrey, 2009; Radford et al., 1997). A decision by Justice Wall in 1999 established that mothers should not be branded 'implacably hostile' where they resist contact because they fear non-resident fathers' aggression.¹³

Aris and colleagues' research into child contact centres, collected around this time, in 2000/2001, found that mothers reported that they were constructed as unreasonably obstructive and their concerns dismissed, in keeping with the 'implacably hostile' construction (Harrison, 2008). It was also found that this perception of women presented a barrier to hearing children's voices in contact centres (Harrison, 2008). Therefore, the finding in the current research that the construct of the 'implacably hostile' mothers is still operating amongst some volunteers in supported contact services is out of kilter with broader policy and research in the area. It suggests that some volunteers in supported services have not moved on from this assumption despite evidence and policy challenging it. This presents a particular concern in terms of child protection since, as the findings below demonstrate, this construct could effectively erase child protection concerns:

'R: [The boy] has been coming, he's four now, he's been coming since he was one. Um both parents had solicitors then but once the divorce had come through they don't have solicitors anymore. The father can't afford one and I tried to tell him that he must get one because he needs to move things forward; he needs to be able to take the child out after all this time. He did behave very badly towards the mother before the child was born and she's very bitter about this and can't forget it. At one point they did speak to each other and we though...they were actually going to get together again but then she decided no she couldn't because of what had gone on before and she reckons that he hadn't really changed and said a lot about what she'd seen on the internet, which I don't know a lot about.

¹³ *Re K (Contact: Mother's Anxiety)* [1999] 2 FLR 703.

I: on the internet, what...?

R: Uh [sighs] letters he'd written...but I don't know, I think she just doesn't want to let contact move beyond the centre and she will complain about... She thinks we're on his side; we're always on the father's side and not on her side so I think she feels we're not neutral.

I: Okay. Was it him that you mentioned had a conviction or was that somebody else?

R: He did. He was on probation. He was obviously charged for domestic violence, I don't think he's been in prison but he was on probation.'

[Coordinator, Centre 5, supported-only contact]

In this extract the mother's concerns regarding her former partner's abuse are positioned as 'bitterness', despite the fact her ex-partner was convicted for DV. Indeed, the coordinator related that the father previously pushed the mother down the stairs while she was pregnant with their son, suggesting, it can be argued, a simultaneous attack on the child.

Hester (2011) has argued that the perceived implications of DV for child safeguarding are viewed so differently across DV (those working in refuges and perpetrator-oriented interventions), child protection and child contact work that they can effectively be viewed as three separate 'planets' (Hester, 2011). She suggests that the focus on the DV and child protection 'planets' is on the risk of further violence and harm to an adult (on the 'domestic violence planet') or to a child (on the 'child protection planet'). These planets are therefore concerned with past behaviour. By contrast, on the child contact 'planet', there is an assumption that all children should have two parents, even if they don't live with both. The focus is on the parent's relationship and on the future rather than the past. On this 'planet', DV in the parent's relationship can be deemed in the past and so irrelevant to child contact arrangements. This contention is supported

by research from other studies (Cobb, 1997; Furniss, 2000; Harrison, 2008; Hester et al., 1994; Trinder, Firth, et al., 2010).

In keeping with Hester's (2011) 'three planet thesis', the focus in this extract is very firmly on the present and the future rather than the past, which is deemed of no concern. The suggestion that the mother 'can't forget about it' can be said to imply that the abuse is minimised through a process of 'historicisation' (Trinder, Firth, et al., 2010, p. 13) which characterises the abuse as 'relating only to the past and with no on-going or current relevance' (Trinder, Firth, et al., 2010, p. 13). The suggestion that her concerns are a symptom of 'bitterness' would seem to further evidence a process in which abuse is 'mutualized' and reformulated as 'dispute' (Cobb, 1997, p. 416).

In keeping with research on child contact centres collected more than a decade ago (Harrison, 2008, p. 397), the findings of the current research suggest that in some cases, volunteers continued to disassociate inter-partner abuse with potential child abuse. Indeed, in the extracts above and below it is assumed that although these non-resident parents have been abusive partners, they are suitable parents. Concern for children's safety in this context was therefore not mobilised even in cases where there was clear evidence of inter-partner abuse. Due to this, resident parent's objections to contact could be viewed as misplaced. This is despite the substantial body of evidence that domestic abuse does represent a child protection concern (Buckley et al., 2007; Edleson, 1999a; Mullender et al., 2002; Ross, 1996; Strauss, 1995; Wolfe et al., 1986):

I: You were saying that sometimes the resident parent doesn't really want contact to happen; do you have a sense of why that happens? Why those parents don't really want contact to happen?

R: Well there's lots of reasons, one of which is over money, one is that they don't want the other parent to know where they live, they don't want the children talking to the other parent about their lives erm...they don't want the children perhaps to find out that on a parent to child level that that other parent isn't quite so nasty as they're being depicted at home because of course the child has a different relationship with their parent than the ex-partner might have had with that parent so it's difficult for the...particularly where

there's been violence erm, for them to say, he's been really horrible to me or she's been really horrible to me but the children get on with him or her.'

[Volunteer 2, Centre 1, supported-only service]

Previous research reported that mothers felt their experiences of DV were disbelieved by contact centre workers, but workers' perceptions were not themselves reported (Aris et al., 2002; Harrison, 2008; Humphreys & Harrison, 2003a, 2003b, 2003c; Thiara & Gill, 2012). In the current research, the construct of the 'implacably hostile' mother amongst some contact centre workers explicitly included the assumption that mothers would fabricate claims of abuse in order to obstruct contact. For example:

'I don't know the courts system that well because I'm not engaged in it but from what I understand it can...it would appear to increase the priority of a case if erm...there is you know, an allegation or certainly if there was evidence of domestic abuse or domestic violence. Yeah it's on the referral forms but the thing is once you start using that language erm...you know especially when we're talking about family breakdown and contact for children, without being disrespectful to the parents for whom this is a serious concern erm...it can be used can't it, it's something else that can be alleged erm...and parents will say to me "you don't know what he's like, he might be like this at the centre as sweet as pie but you don't know what he's done at home" and they're right I don't, who knows what he's done at home, is what she said the truth?'

[Manager, Centre 6, both services]

As the extract above suggests, this view could minimise child protection concerns. Here the accusation of abuse is reconstructed to position the potential victim as equally accused: 'who knows what he's done at home, is what she said the truth?' In the process the manager's focus is directed onto the parent's relationship rather than to protection of the child. Simultaneously, it is the parental relationship which is positioned as the problem, rather than the potential abuse of the child and in the process, the accusation appears to lose credibility.

In keeping with Aris and colleagues' research (2002), there was also evidence that the assumption that mothers' objections to contact were misplaced could silence the voices of children. Indeed, where children objected to contact they were often assumed to have been influenced by their resident parent. This is discussed further in Chapter 6.

As the cases above demonstrate, direct knowledge of abuse or potential abuse did not always lead to concern to protect the child. However, in keeping with systems approach the analysis also explored missing knowledge and misconceptions amongst workers (Dekker, 2005; Rasmussen & Svedung, 2000; Woods & Cook, 1999). This analysis demonstrated that in some cases, the absence of a child protection concern seemed to be associated with volunteers' limited knowledge about case histories and identified maltreatment risks. Indeed, in the absence of access to concrete information about families, volunteers at times made assumptions about the reasons families were using the centre. For example, in the extract below the volunteer assumes that hostility and disputes between the parents explain the necessity for their use of the centre:

'Em...I don't actually know fully what the issues have been because [manager] does tend to keep a lot to himself [laughs]. Em so em yeah I think most of the time it's just that for whatever reason they can't actually see each other without being quite hostile to one another for whatever reason. And if things are being disputed, you know it might be the money side of things or, you know various reasons I think really.'

[Volunteer 1, Centre 6, both services]

The same volunteer assumed that cases involving evidence of DV would not be accepted to the supported service; an incorrect assumption in this centre:

'I: And you mentioned that it would usually be allegations of domestic violence; do you ever have cases where there has been a conviction for domestic violence, like a non-molestation order or things like that?

R: No not to my knowledge because I don't do that side of things, [manager] does that. He does the risk assessment and as far as I am aware if there was anything like that I don't think we would allow people to come. I've got a

feeling that's one of the things on the risk assessment. If there is proven domestic violence em the perpetrator wouldn't be allowed. That would be more supervised contact I would think.'

[Volunteer 1, Centre 6, both services]

In this sense, volunteers' lack of knowledge could also colour the assumptions they made about families, with implications for the meaning they attached to their child protection practice.

4.2 The system's capacity for change and stability

The issues described above persisted across all supported contact services. However, the findings provided some evidence regarding the capacity of the system to change and stabilise in reaction to events. Two examples are discussed here.

In terms of the capacity of the system to change, Centre 1 provided an example of practice which made some volunteers uncomfortable, since it was seen to imply a judgement on parents, but which was recognised as necessary and was undertaken regardless. As discussed in Chapter 3, in this centre, volunteers, rather than parents, accompanied young children to the toilet:

'R: I don't feel comfortable going into the toilet when somebody's changing a nappy but you've got to do it.'

I: Yeah why is that; what sort of makes it uncomfortable?

R: Well basically you're saying to the person, 'you're not trusted'. We just tell them that it's for their protection and for our protection because erm...if there's an accusation at least there were two people, nobody can say to him that he [did something to] the child and if I take the child to the toilet nobody can accuse me because I wasn't in there with the child on my own.'

[Centre 1, Volunteer 3, supported-only service]

Interestingly, the practice of volunteers accompanying children to the toilet was introduced in this centre after a police investigation into possible abuse of a child by a parent in this centre in this scenario. This example would seem to emphasise the possibility for the system to change reactively when it experiences a significant disturbance. As Mitleton-Kelly explains, when the system is disturbed it:

'may reach a critical point and either degrade into disorder (loss of morale, loss of productivity, etc.) or create some new order and organisation—i.e. find new ways of working and relating—and thus create a new coherence'

(Mitleton-Kelly, 2003, p. 37).

Although volunteers continued to experience anxiety in undertaking this work, it seems, in the context of a significant external shock, the system overcame this to introduce new coherence.

By contrast, an example in Centre 2 demonstrated the capacity of the system to stabilise to maintain the status quo. The manager of the centre explained that a volunteer had left the team after a short period because she disagreed with practice at the centre:

'It's very difficult to em to explain what actually happened. I understand this volunteer had a history of working in social services and having something to do with contact centres, not as a user, but as a, in her professional life...One of the things she did want was sensitive information [information concerning previous maltreatment or risks of maltreatment] to be held at the centre on a Saturday. Em she also wasn't very happy with some of what she saw as relaxed ways of our behaviour on a Saturday. I don't quite know what she actually wanted and it was never made clear but after a short while, and it was just a few months this particular volunteer took the decision to leave the team and that was her decision. Em there was no pressure put on her, there was plenty of discussion, help, support given, all manner of argument talked out, it was her decision in the end to leave and perhaps when somebody is within a volunteer

team and they find it's not for them, well then perhaps the only and obvious solution for them is to move on from that team. The majority of people, on a positive note, who have joined the team, had been long-term volunteers and do fit in the philosophy of the way things run.'

[Manager, Centre 2, supported-only service]

In this example the challenge to the system did not lead to a change in practice. As Menzies-Lyth (1990) suggests, while individual's behaviour may be influenced by institutions, 'defences are, and can be, operated only by individuals. Their behaviour is the link between their psychic defences and the institution' (Menzies-Lyth, 1990, p. 458). For this reason, a degree of consistency between individual and social defence systems will be required. If the discrepancy is too great, 'some breakdown in the individual's relation with the institution is inevitable...commonly [it] takes the form of a temporary or permanent break in the individual's membership' (Menzies-Lyth, 1990, p. 458). Or as the manager in the extract above puts it, workers need to '*fit in the philosophy of the way things run*'. Therefore, despite the disruption caused by the volunteer, the system returned to the status quo.

4.3. Conclusions

The systems approach has attempted to capture the dynamics by which aspects of problematic child protection practice in child contact centres have become 'normal work' (Dekker, 2005). Based on the findings it was argued that at a macro-level the persistence of problematic child protection practice in child contact centres can be seen as related to a failure to address three common weaknesses in voluntary sector provision of human services, identified in Salamon's theory of 'voluntary failure' (Salamon, 1987): organisational funding, professionalization and focus. In keeping with the systems approach, these issues were explored, not just to remind the reader of the context to contact centres' work but to investigate the dynamic between them and centres' child protection practice (Dekker, 2005, p. 188).

The findings suggested that insufficient funding has been allocated to the provision of supervised services and that families can experience problems in accessing the services that do exist because of the cost of fees and the need to travel to reach services. The data suggested that this affected some referrers' local rationalities: they referred to supported services because they believed there was no other choice.

The findings further indicated that the system of child contact centres relies heavily on volunteerism and that training and qualifications across both supervised and supported services vary greatly. Even within supervised services, staff did not necessarily hold professional qualifications relevant to child protection. The findings suggested that in supported services some volunteers' attitudes presented a barrier to training as did time commitments and, in some cases, the cost of training. The absence of appropriate child protection training may influence how some workers understand issues relevant to the work of protecting children. However, it was argued that the issues surrounding resourcing, both of centres and of training, are unlikely to operate in a linear fashion. In relation to both factors, worker's attitudes seemed to mediate the effect such that neither funding for supervised services nor training for staff should necessarily be assumed to offer a panacea in itself.

It was argued that practical, resourcing measures cannot be divorced from the psychological process of protecting children. It was suggested that supported services have maintained a focus which emphasises the need to be welcoming to non-resident parents, non-judgemental and neutral. It was suggested that this focus can present a goal conflict (Woods et al., 1994) with the commitment to protect children since it can operate to exaggerate workers' anxiety about persecuting families (Menzies-Lyth, 1990), leading them to eschew the judgement and authority which are integral to the process of protecting children. Analysis of the 'Definitions of Levels of Contact' suggested that, rather than empowering workers in supported services to protect children, the emphasis in this guidance may reinforce and sustain volunteer's anxieties surrounding judgement and authority. The findings suggested that workers' focus could minimise and erase child protection concerns. Given this, systems may need to consider how they empower or disempower workers to manage the emotional component of the work of protecting children.

On this latter point, the findings substantiate previous research in the statutory child protection system which suggests that the work of protecting children involves a substantial emotional and cognitive dimension which must be recognised and addressed if workers are to be effective (Munro, 1999). Indeed, Dingwall and colleagues coined the phrase ‘rule of optimism’ (Dingwall, Eekelaar, & Murray, 1983) to refer to the phenomenon that many practitioners are reluctant to make negative professional judgements about parents.

Overall the findings presented in this chapter suggest that the work of protecting children is socially constructed in an organisational context. In other words, the meaning people attach to the work of protecting children is not fixed or inevitable. Rather the reality people experience is created through individuals’ environment, experiences and interactions (Garland, 2003; Hacking, 1999). This presents a challenge to the notion that guidance to organisations working with children can alone be an effective mechanism to implement this policy objective. In a human system, guidance is likely to combine with factors on the ground to produce unexpected and potentially undesired effects (Chapman, 2004; Munro, 2011; Vaughan, 1998). If it is to be effective, the findings suggest, guidance must address both the tangible and intangible aspects of actors’ reality: the resources available to organisation and the organisational focus. The following chapter builds on these findings to explore the influence of inter-professional working on centres’ management of their commitment to protect.

Chapter 5: The interaction of ‘coupled’ systems: the influence of inter-professional working

This chapter presents the second component of the analytic account of factors that seemed to influence child contact centres in managing their commitment to protect children from maltreatment. The analysis focuses specifically on the influence of inter-professional working on contact centres’ child protection practice. Inter-professional and inter-organisational working has, since the 1970’s, been seen as critical to the work of protecting children from maltreatment (Laming, 2003; Munro, 1999; Reder, Duncan, & Grey, 1993). In recognition of this, Working Together suggests that all organisations that work with families should have:

‘Arrangements to work effectively with other organisations to safeguard and promote the welfare of children, including arrangements for sharing information’

(HM Government, 2010, p. 43).

However, while inter-professional working is seen as a solution to child protection, it is also seen as a problem (Fish, Munro, & Bairstow, 2008) since it is known to be a challenging task where misunderstandings and omissions can easily occur (Fish et al., 2008; Munro, 1999; Reder & Duncan, 2003, 2004).

The findings presented in Chapter 3 indicate that problems in inter-professional working persist in supported child contact centres. Indeed both the current and previous research (Aris et al., 2002; Durell, 2009; Furniss, 2000; Thiara & Gill, 2012) finds that supported contact services receive and accept what have been termed, ‘inappropriate referrals’; cases which involve a level of child maltreatment risk above that which the centre is able to manage. ‘Inappropriate referrals’ can also occur in supervised services where a case is referred which would be more appropriate to no contact. As discussed in Chapter 3, of the supervised services, only Centre 5, in which practice was led by qualified social workers, had the capacity to challenge referrals. The other supervised services relied on referrers to make appropriate referrals.

Therefore the referral process for supervised contact was not without potential problems in some services.

However, in terms of inappropriate referrals, the greatest concern is for supported services which are least able to manage cases involving a risk of child maltreatment. Further to this, as discussed, unlike supervised services, supported services do not routinely make reports to referrers and so there is less feedback on cases following referral. In this sense, there may be less potential for inappropriate referrals to be rectified. For this reason and in order to provide a more-in-depth analysis of the issues, this chapter will focus exclusively on problems in inter-professional working in the referral process to supported services. It explores how these problems in inter-professional working affected supported services in managing their commitment to protect children from maltreatment. Specifically it aims to make understandable how supported child contact services routinely facilitate cases inappropriate to the service they provide.

As discussed in Chapter 1, research in the late 1990's and early 2000's found that inappropriate referrals to supported centres were the result of a lack of supervised services (Aris et al., 2002) as well as confusion surrounding the terms 'supervised' and 'supported' contact (Aris et al., 2002; Furniss, 2000). There was also confusion surrounding the amount of information referrers should share with centres and some referrers were willing to refer any cases to a child contact centre (although the research did not distinguish between services in centres) (Furniss, 2000). Furniss' (2000) research reported that solicitors may not have had the training to screen cases, while Aris and colleagues' (2002) report found that while all referrers reported that they screened cases (referrers were almost all Court Welfare Officers in this study) centres did not themselves always have screening or assessment procedures (Aris et al., 2002). In addition it was suggested that in a minority of cases solicitors may have been concealing information in the hope that the centre would accept the case (Aris et al., 2002). Fundamentally, Aris and colleagues' (2002) research suggested that the threshold amongst centres, referrers and the courts for accusations or evidence of domestic violence (DV) to be taken seriously was ambiguous and often insurmountably high. Even convictions for DV did not necessarily lead to higher levels of vigilance.

As outlined, since this research was published reforms have been introduced to improve practice in supported services. A number of the reforms discussed in Chapter 1 seem specifically to aim to improve inter-professional working. Under the National Standards, which centres must meet to become accredited and receive Cafcass funding, centres must use the Standard Referral Form to manage referrals (see Appendix 5.1). A ‘Protocol for Referrals of Families to Supported Child Contact Centres by Judges and Magistrates’ and a section in the ‘Family Law Protocol’ for referral to contact centres by solicitors (see Appendix 1.3) have been introduced. ‘Definitions of Levels of Contact’ (see Appendix 1.2) have also been introduced to clarify the services provided.

Recent research by Thiara and Gill (2012) suggested that referrers continue to issue inappropriate referrals because of the lack of supervised services and that referrals were accepted by contact centres because of a lack of awareness of DV issues and a lack of resources which led some services to ‘struggle to adopt risk assessment and screening procedures’ (Thiara & Gill, 2012, p. 129). This, it was suggested, was compounded by a, ‘lack of co-ordination, co-operation and information exchange between the various agencies’ (Thiara & Gill, 2012, p. 129). These points were not developed in any further detail and the latter point was reported as a second-hand assertion by participants, rather than a phenomenon observed by the researchers.

The current chapter aims to build on these findings. As in previous chapters, the systems approach focuses on the ‘local rationalities’ (Woods et al., 1994) of actors in the system. In the context of inter-professional working, the approach asserts the importance of the high degree of ‘coupling’ (or interconnectedness) in the system (Perrow, 1984). In such a system actors may be unaware of the potential effects of their actions on other parts of the system (Woods & Cook, 1999) and so the approach aims to investigate how misinformation or a lack of information may colour actors’ local rationalities. For this reason, the analysis also seeks to understand the feedback mechanisms available to the system to learn and address misconceptions. In addition, rather than adopting a reductionist analysis which examines the system in parts, the systems approach focuses on the ‘whole’, with particular focus on the interactions between actors (Woods & Cook, 2002). For example, it will explore whether centres viewed risk assessment as their role, and in turn how referrers constructed their own responsibility within the system; the analysis will focus on the effect of these

perceptions. Finally, unlike previous research, the current approach does not assume that the effect of tools introduced into the system is necessarily positive or neutral (Dekker, 2008; Hoffman & Woods, 2000; Hollnagel, 2003; Woods & Cook, 1999). Therefore, in this research the Standard Referral Form is positioned as a tool and is a specific focus of investigation. The analysis seeks to understand how well the Referral Form and actors interact, given their capacity and working environment.

The introduction of the mandatory use of the Standard Referral Form and development of the Protocols for Referral and Definitions of Levels of Contact as mechanisms to address the issue of inappropriate referrals can be seen as in keeping with recent trends which have seen organisations move towards ‘procolization of risk’ (Hood et al., 2001, p. 166) in which ‘visionary documents designs in the form of standards and guidelines’ (Power, 2007, p. 6) for individuals and organisations are developed. It has been suggested that this formalisation of organisational operations may serve to minimise blame and liability problems by providing a ‘due diligence’ defence when an organisation’s risk management comes to be questioned (Hood et al., 2001, p. 166): workers and organisations can say they followed guidance/standards and so are not to blame for unwanted outcomes. Additionally, ‘protocolization’ provides an audit trail for regulators to link to (Power, 1997, 2007). However, a growing body of research suggests that technical aids are of limited value in addressing issues of inter-professional working because they do not, alone, address the difficulties that actors experience in working together (Hall & Slembrouck, 2009; Horwath, 2002; Munro, 1998, 1999, 2005b; Peckover, Hall, & White, 2009; Reder & Duncan, 2003, 2004; Reder et al., 1993; White, Hall, & Peckover, 2009). The findings presented in this chapter contribute to this body of evidence.

The findings begin by sketching the landscape of inter-professional working, setting out contact centres’ referral sources and demonstrating that both supervised and supported services receive referrals from multiple sources. Both services are therefore highly ‘coupled’ (Perrow, 1984). The chapter goes on to present findings in relation to the system’s principal feedback mechanism for inter-professional working: the NACCC accreditation system. It is argued that this provides a limited and potentially problematic mechanism for learning because the use of the Standard Referral Form is in itself unlikely to provide the means to safe referral. This indicator therefore provides

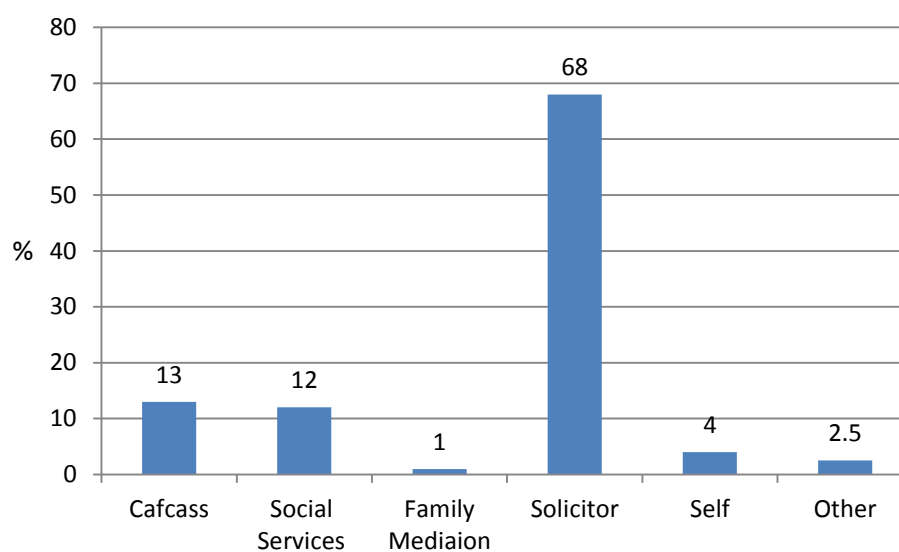
a limited and potentially misleading assessment of safe inter-professional working. In order for the Standard Referral Form to be effective, it is argued, those using it must be able to effectively *collect information, communicate information and analyse information to make decisions* concerning cases. The remainder of the chapter discusses the findings in relation to these three headings and suggests that problems persist because neither centres nor referrers necessarily have the capacity to effectively undertake these tasks. In addition, actors experience role ambiguity.

5.1 The landscape of inter-professional working: sources of referral

In keeping with previous research (Durell, 2009; Furniss, 2000; Humphreys & Harrison, 2003c, p. 420), analysis of the NACCC April 2009-2010 survey suggests that across all contact centres in England, most referrals were made by solicitors. As discussed in Chapter 2, within this figure it is unfortunately impossible to discriminate from the data between referrals involving a court order and those negotiated through solicitors. Neither can we distinguish between cases in which Cafcass or social services have been involved, although they do not make the referral. This is despite the fact that the qualitative data suggest that this was a frequent occurrence in the case study centres. In addition, the survey data do not stipulate whether cases referred by social services are public or private law cases.

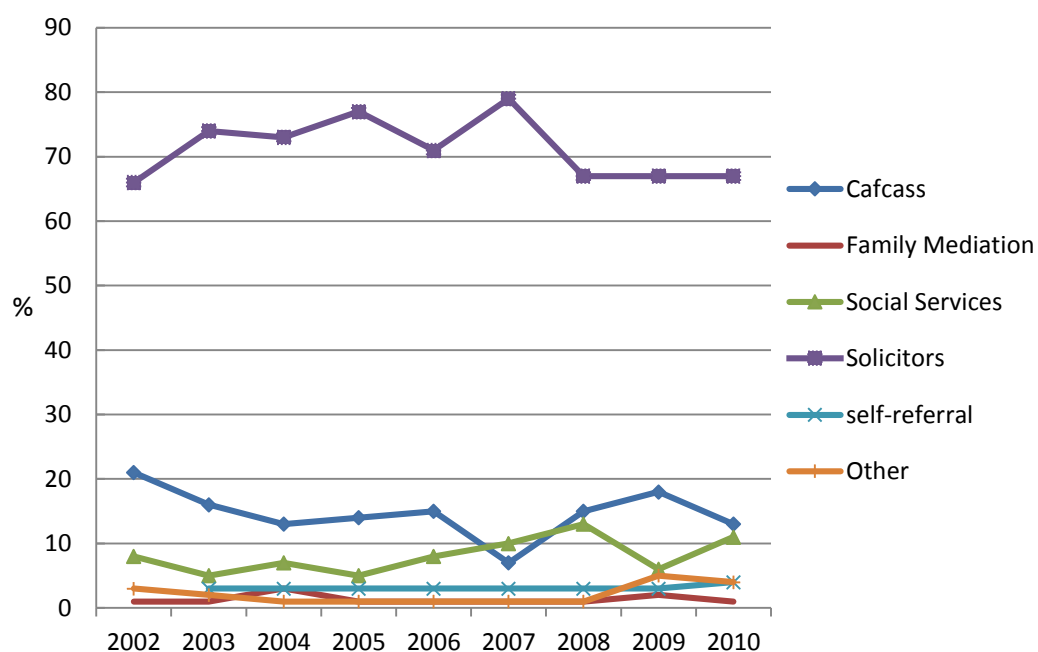
Nonetheless, as Figure 6 below demonstrates, the data do suggest that after solicitors, who referred 68% of cases, Cafcass is the next most frequent referrer across all centres; directly referring 13% of cases. They also suggest that social services refer directly to contact centres. Indeed in 2009/10 12% of all cases were referred directly by social services. Family Mediation meanwhile accounted for less than 1% of referrals while self-referral represented 4%. Referral from other sources was at 2.5%.

Figure 7: Percentage of Referrals by Referral Source: April 2009-10



As Figure 7 below suggests, the general pattern of referral did not vary dramatically over the course of the previous decade.

Figure 8: Percentage of Referrals by Referral Source: 2002-2010¹⁴

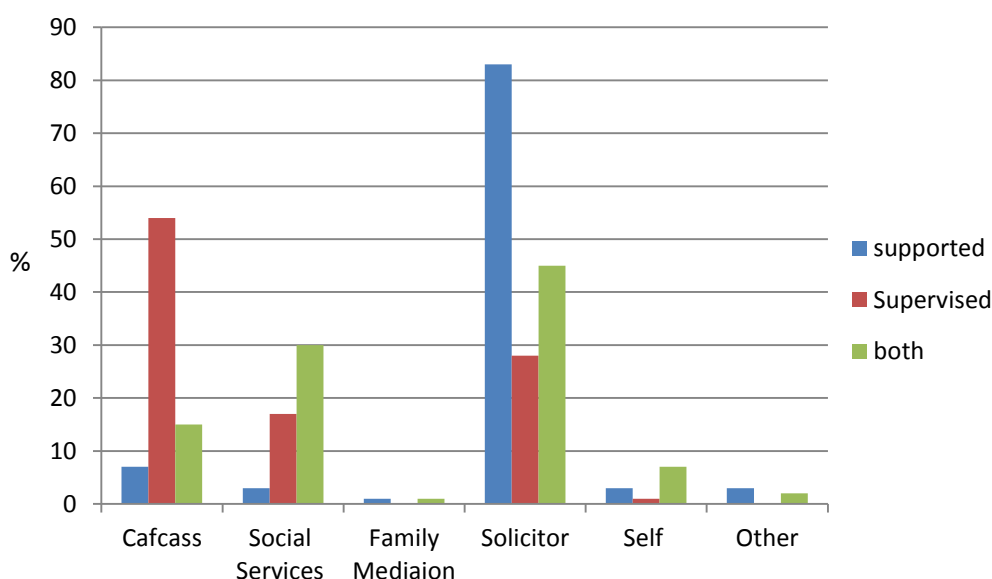


¹⁴ This question was not asked prior to 2002

As might be expected, the data suggest that centres differ starkly in their referral patterns depending on the type of service they provide. As can be seen from Figure 8 below, in the year 2009/10 amongst the supported-only members, the vast majority of referrals were made by solicitors (83%). As discussed above, this figure is not sufficiently discriminative between cases. However, the data do indicate that Cafcass and social services make direct referrals to supported-only services: 7% and 3% respectively. Indeed, the data suggest that while supported-only services, on average, received few cases via these routes (the mean number of cases from April 2009-April 2010 referred via both routes was two per centre), a large percentage of supported-only services had received at least one referral via these routes: 56% of supported-only services reported that they received at least one referral from Cafcass and 38% reported receiving at least one referral from social services. In addition the data suggest that 'self-referrals' and referrals by family mediation currently comprise a small percentage of referrals to supported-only services: 3% and 1% respectively. Self-referrals made up only 3% of cases.

By contrast, the data suggest that supervised-only centres received more than half of their referrals directly from Cafcass (54%), while 17% came from social services. Only 28% of referrals came from solicitors and no referrals came from family mediation. Centres offering both services sit somewhere between these two extremes. These centres received most referrals from solicitors (45%) but also a significant number from social services (30%) and Cafcass (15%). Only 1% of referrals came from family mediation services, while 7% of cases were 'self-referred' and 2% came from other sources.

Figure 9: Referrals by service type April 2009-April 2010



Overall therefore the data suggest that all contact centre services deal with multiple professions in the process of receiving referrals. In the language of systems approach, the system is highly ‘coupled’ or interconnected (Perrow, 1984).

5.2 Feedback for learning

As discussed in Chapter 1, the systems approach asserts the importance of mechanisms for system feedback and learning to identify and address latent issues as they emerge (Dekker, 2007a; Reason, 1997; Woods & Cook, 2002). In Chapter 3 it was suggested that the NACCC accreditation system, which relies on the National Standards, is the principal mechanism for feedback in the system of child contact centres. However, it was found that the system uses indicators rather than direct observation to assess practice in centres and the indicators used do not necessarily capture the quality of practice in centres.

In relation to system feedback on the referral process, the findings suggest that the NACCC accreditation system places heavy focus on centres’ and referrers’ use of the Standard Referral Form. In order to achieve accreditation, centres,

‘must use the contents of the standard NACCC referral form’ (p. 4. S.4.1) [and] must be in possession of a properly completed referral form giving full details

of both parties and any other people involved in the contact before a family is accepted' (S. 4.2).

This chapter argues that while use of the Standard Referral Form is a potential ingredient to effective inter-professional working, its use does not address the complexity of the process. Indeed, the findings presented below suggest that the Form leaves a large gap between procedural process and effective practice which actors on the ground must fill. Therefore the use of a completed referral form is in itself unlikely to ensure that only appropriate cases are facilitated at supported services. For this reason, the accreditation system in this respect does not provide a particularly meaningful mechanism for feedback on how the referral process is working.

In keeping with research in the statutory child protection sector, the findings suggest that the technical transfer of information is only one aspect of inter-professional communication (Fish et al., 2008; Gillingham & Humphreys, 2010; Hall & Slembrouck, 2009; Munro, 2005b; Peckover et al., 2009; Reder & Duncan, 2003). The more challenging aspects, which this referral form does not address, relate to how the tool is used. The findings suggest that in order to communicate successfully professionals require the means to effectively collect information and communicate it to other professionals as well as the means to analyse the information collected and to make decisions based on it (Munro, 2005b; Reder & Duncan, 2003). Throughout, the system requires role clarity to ensure that actors understand their role within the wider system of inter-professional working (Bliss, 2000; Blyth & Milner, 1990; Caldwell & Atwal, 2003; Glisson & Hemmelgarn, 1998; Harker, Dobel-Ober, Berridge, & Sinclair, 2004; Menzies-Lyth, 1990; Munro, 2005b; Rawson, 1994; Reder & Duncan, 2003). The findings in relation to these issues are discussed below in detail.

5.3 Collecting information

Research suggests that in order to effectively collect information regarding child protection concerns, expert skill is required (Munro, 2008; Robinson & Moloney, 2010; Stanley, Miller, & Richardson Foster, 2012). The question of 'what is or has been happening?' is deceptively simple. It is also 'most important' because 'the best

guide to future behaviour is past behaviour' (Munro, 2008, p. 77) and because assessments and decisions concerning the case will rely fundamentally on the quality of the information collected (Munro, 2008, p. 77; Robinson & Moloney, 2010).

Research suggests that although child protection concerns are common in the cohort of litigating families (Cassidy & Davey, 2011b; Hunt & MacLeod, 2008), identifying them is challenging (Aris & Harrison, 2007; Aris et al., 2002; Barnett, 1999; Hester, 2006; Jaffe et al., 2003; Kelly & Radford, 1996; Robinson & Moloney, 2010; Stanley et al., 2012; Trinder et al., 2011), even for highly qualified staff, working with multi-dimensional tools, undertaking a holistic, on-going assessment (Robinson & Moloney, 2010). Research suggests that identification may be particularly difficult where screening is brief and involves only a single method, rather than adopting an ongoing and holistic approach (Aris & Harrison, 2007; Jaffe et al., 2003; Munro, 2008; Robinson & Moloney, 2010; Trinder et al., 2011).

Analysis of the National Standards and the Protocols for Referral suggests that it is unclear from these *who* in the system should collect information about families. Referrers are clearly responsible for transferring information to centres via the referral form, which may imply that they should also collect information but this is not explicitly stated. At the same time, the Protocol for Judges would seem to suggest that centres may also collect information about families:

'It is a requirement that the parents and children attend a pre-contact meeting or equivalent (for example a telephone discussion). Parents are seen or spoken to separately so that the Centres can follow their own risk assessment procedure' (p. 2)

The ambiguity is compounded by the fact that a statement to this effect is not reproduced in the Protocol for Solicitors. The National Standards for supported services suggest that:

'Wherever possible, families must be offered the chance to visit a Child Contact Centre in advance of contact starting' (S. 4.5).

However, the purpose of the visit is not stipulated, making it unclear whether the purpose is to collect information. Therefore, in order to explore system role clarity and actors' capacity to collect information, this section begins by discussing findings in relation to the role of centres. It is followed by findings relating to the role of referrers

5.3.1 Centres' role

The findings suggest that the practice of information collection varied dramatically between centres. All of the case study supported centres expected that referrers would provide them with information regarding the case. Therefore where centres collected information at pre-visits, this was seen as an additional check on the work of referrers, rather than as the primary method of information collection.

With the exception of Centre 4, all of the supported services reported that they tried to meet families before contact. The purpose of this was not only to collect information, rather centres sought to provide families with an opportunity to see the centre in order to reduce anxieties and to answer any questions the families had. Centre 4 (which offered both services) did not meet families before contact but relied entirely on referrers to provide information.

The findings suggest that in practice, pre-visits could present logistical problems which, despite the efforts of coordinators, could make interviews difficult or impossible for some centres. Firstly, a separate room was required in order to conduct the interview; in winter time an additional heated room was required. This was available in some but not all centres. Centre 1 dealt with the problem by holding interviews in the contact room while other families were having contact. However, given the public nature of the interview, this may have made some parents less likely to disclose important information. Pre-visit interviews also required that the centre coordinator was away from the contact session. In Centre 3 it was felt that this was not always possible as an appropriate person was not always available to lead the volunteers in the coordinator's absence. Observations of practice indicated that at times the pre-visit simply involved families visiting the centre during the contact session to see what the centre was like and speaking briefly with the coordinator while she managed the session; again a private room was not available.

In addition to the availability of these logistics, the literature suggest that professional judgement needs to be part of the process of collecting information about families (Kropp, 2008; Munro, 2005b; Stanley et al., 2012). Indeed if workers do not have and use theories, research knowledge and conceptual frameworks in the process of collecting information, they leave themselves vulnerable to dealing only with issues brought to their attention by families (Munro, 1998, p. 90). As the findings in Chapter 4 illustrated, while all of the managers of supported services had received some training, none were professionally qualified in child protection work and there was evidence that some lacked an in-depth understanding of issues surrounding child protection.

The data suggest that where the managers of services undertook some collection of information, they improvised the process rather than relying on an evidence-based approach: Centre 1 asked parents the questions on the referral form. Centres 2 and 3 reported that they provided an opportunity for parents to air their concerns while the manager of Centre 6 reported that he asked the general questions: ‘do you have any concerns?’ and ‘How do you think your child will react to contact?’ Interviews also suggested that some coordinators may be unclear about what information they should collect. In particular some coordinators suggested that the cause of parent’s separation was not the concern of the centre. For example:

‘R: Some of the things you don’t really want to know, do you?’

I: Like what?’

R: (Pause) like, I mean is it your business to know what actually caused the break up? We’re only concerned with the children really.’

[Coordinator, Centre 1, supported-only service]

This disassociation of the causes of parental separation on the one hand and safety and child protection concerns on the other would seem to imply a lack of knowledge surrounding the links between partner abuse and child abuse. In addition, it would

seem to ignore the potential relevance of issues surrounding parental drug or alcohol addiction and mental health concerns.

Centres reported that if older children happened to arrive to the pre-visit with their resident parent they were sometimes asked in the company of their resident parent how they felt about contact. This suggests that some information was sometimes collected about children's wishes and feelings. However, as will be discussed further in Chapter 6, none of the supported services engaged systematically with children prior to accepting the case.

Overall, the findings suggest that supported services may be limited in their capacity to collect information. The supported services all positioned referrers as responsible for providing information through the referral form, before the case could be accepted. However, centres constructed the extent of their responsibility in the process in different ways leading to variations in practice. While some centres explicitly undertook interviews to collect information, others informally asked if parents had concerns while showing them the centre. One centre did not collect any information, but left this task entirely to referrers. As discussed in Chapter 4, coordinators of the supported services had not received professional child protection training and so where they did collect information, the findings suggest that they improvised the process rather than relying on evidence based practice. Older children were sometimes asked how they felt about contact but only if they happened to be present. Children and babies were not systematically engaged with prior to contact. Importantly, centres are also systematically limited in the information they can collect since they cannot directly access police and social services checks. Given this, the findings suggest that in practice, the system relies heavily on referrers to effectively collect information and to communicate this information to centres on referral. The following sections therefore examine referrers' role in collecting information and transferring that information to centres.

5.3.2 Referrers' role: private law cases referred via the courts

Only cases referred to contact centres via the courts are subject to official police and social services checks. Since April 2010 Cafcass has been required to undertake

safeguarding checks in all private law contact cases prior to the First Hearing Dispute Resolution Appointment (FHDRA).¹⁵ Practice Direction 12b, *The Revised Private Law Programme*¹⁶ states this should include checks with local authorities and police and individual risk identification interviews by telephone with each of the parties [par. 3.9]. The outcome of the checks should be reported to the court in a ‘Schedule 2’ letter. The court should also receive a C100 application, completed by parties with their solicitors (if they have one) and a C1A application if any party has welfare concerns [par. 4.2]; these forms seek to identify any safety concerns held by parents. If the case reaches a First Hearing, a Cafcass Officer who is a registered and qualified social worker should attend. The Cafcass Officer ‘shall, where practicable, speak separately to each party at court and before the hearing’ (par. 4.5).

While the Cafcass safeguarding checks provide some level of screening for all cases referred through the courts, they are not a comprehensive risk assessment. Notably, children are not engaged with. The use of phone calls may also present challenges to disclosure of safeguarding information since parents may not feel safe revealing confidential information via the phone and there is little opportunity to build a trusting relationship. Moreover, although Cafcass shall ‘where practicable’ speak with parents before the first hearing, this may not happen.

While police and social services checks are important, research suggests a large discrepancy between reported rates of child maltreatment and actual rates (Gilbert, Kemp, et al., 2009). Similarly, DV remains an under-reported crime (Felson & Paré, 2005; K. Smith et al., 2010; Tarling & Morris, 2010). Indeed data from the British Crime Survey Self-Completion Module (2010-11) suggests that only around 23% of victims of partner abuse reported the abuse to the police in that year (K. R. Smith & Britain, 2012, p. 97). The literature suggests therefore that agency checks will not identify many cases of child abuse or DV.

For this reason, speaking with parents is an important additional component to the checks. However, research by Trinder and colleagues (2011) found that whilst the

¹⁵ The safeguarding checks were to be fully implemented by 4th October 2010 (Trinder et al., 2011).

¹⁶ Available at:

http://www.justice.gov.uk/courts/procedure/family/practice_directions/pd_part_12b#IDAKUXXC

checks with police and social services *mostly* occurred, the pre-court telephone calls to each of the parties were not taking place systematically. In some places the phone calls were not happening at all, in others they were happening in at most 50% of cases. In addition, phone calls were most likely to occur with applicants (the party who takes the case) since their contact details were more readily available. However, respondents (the party required to respond in a legal dispute) are more likely to raise safeguarding concerns (Trinder et al., 2011). This research reported that where Cafcass could not undertake pre-court phone calls, Officers asked parties to disclose safeguarding concerns ‘in the more pressurised and less private court environment’ (Trinder et al., 2011, p. 27). The research found that even then, some Cafcass Officers reported that some judges discouraged them from eliciting safeguarding information from parents as they wanted them instead to focus on brokering agreements (Trinder et al., 2011). In keeping with these findings, some solicitors in the current research reported that Cafcass does not always have time to speak with clients.

If cases are not settled at this point and instead progress through the courts there are further opportunities for data collection. In particular, where there are allegations of DV, the court may, undertake a fact-finding hearing.¹⁷ However, in recent research the majority of respondent judges, barristers, solicitors and Cafcass Officers suggested that these hearings take place in fewer than 25% of cases where DV is raised as an issue, while 42% of respondents estimated that they take place in fewer than 10% of such cases. In addition, fewer than half of respondents (47%) reported that expert risk assessment occurred quite often or very often following admissions or findings of fact of DV (Hunter & Barnett, 2013, p. 432).

Progression through the courts also presents the opportunity to address the lack of independent assessment of children’s wishes and welfare. The court can do so by ordering Cafcass to undertake a Section 7 ‘Welfare’ report or by appointing a Cafcass Children’s Guardian to represent the child. In 2011 Bailey and colleagues provide some indication of the number of cases that receive a Welfare Report, reporting that Cafcass screen around 40,000 private law court applications and provide welfare

¹⁷ Under *Practice Direction: Residence and Contact Orders: Domestic Violence and Harm* [2008] 2 FLR 103

reports on around 22,000 of them (55%). Separate representation of children by a Cafcass Children's Guardian was far rarer: it was reported that in 2009/10 Guardians represented around 1200 children (3% of cases) (Bailey, Thoburn, & Timms, 2011, p. 125).

Solicitors in the current study reported that Cafcass reports are not routinely ordered for cases referred to a contact centre. Indeed some solicitors perceived that, due to funding shortages, Cafcass is not always appointed where the solicitor feels their expertise is required. For example:

'I would say recently, because of difficulties Cafcass are having with the level of funding and also because the majority of child, children cases are now going to magistrate's courts rather than the judge's courts there's an awful lot of cases where there should be reports but they're trying to... oh let's just see if we can deal with this without the need for one. I mean I had one that was in court for two years and I think after six months I requested a proper report because it was the only way that we were going to get any independent evidence that my client was okay to see this child and I think it was 18 months in, that eventually the court went "oh we'd better get a Cafcass report".'

[Solicitor C]

In addition, all three judges interviewed reported that when they ordered Cafcass Welfare reports, they were experiencing delays in receiving them of between six weeks and five months. They reported that as a result, they had not necessarily received the report by the time that contact was ordered at a contact centre:

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

[Judge B]

Overall therefore, cases referred via the courts all receive a Safeguarding check with police and social services. This provides an important component in the screening process, which is not available through any other referral route. There are, however, limitations to the process. Where cases only receive Cafcass Safeguarding checks, children will not be engaged with, and engagement with parents may be limited. Where cases are subject to a Section 7 Cafcass Welfare Report, children will be engaged with. However, the research suggests that cases referred to child contact centres via the courts do not routinely receive a Cafcass Welfare Report and some solicitors feel that reports are not being undertaken in cases where they are required. In addition, the research suggests that judges are experiencing delays in receiving Welfare Reports and may therefore not have received them at the time the referral is made to the contact centre. In this scenario, although the judge believes that independent assessment of the child's wishes and feelings is required, the case will, for a time, be facilitated at a contact centre in the absence of that assessment. Therefore, although referral through the courts provides the opportunity for a more comprehensive collection of information, it by no means guarantees it. In practice the information collected may be limited.

5.3.3 Referrers' role: cases referred via solicitors

All solicitors interviewed articulated that they had a role in providing centres with information concerning the case. In this respect, centres' and solicitors' role perceptions matched. In keeping with the National Standards, all centres required solicitors to use the Standard Referral Form in their communication with the centre. However, the process of communicating information requires that professionals can effectively collect information (Munro, 2005b; Reder & Duncan, 2003). Solicitors articulated that where they were acting in a case which had come via the courts, they were responsible for providing centres with the court order and any other relevant information from the court case, requested on the referral form. Therefore in cases coming through the courts, solicitors' role was to communicate information already collected, while playing a minor role in its collection. However, where the case was negotiated through solicitors, without the involvement of the courts, solicitors articulated that they were required to speak with parents in order to complete the

referral form. The findings suggest a number of limitations in terms of the capacity of solicitors to effectively collect and communicate information to centres.

Firstly, in keeping with previous research (Furniss, 2000; Hester et al., 1994), the findings suggest that private law solicitors do not usually meet children or speak with them about the case. Indeed some solicitors in this sample explained that they actively avoided meeting children:

I: Do you ever meet the child when you take on a case?

R: Urm I try very hard not to. I know that sounds horrible. You do occasionally, certainly with the young children, the ones who are under the age of three you'll meet because often mum can't get childcare and she comes in with the child and... anything sort of over that age it's just not comfortable having discussions about you know allegations about the child's mother or father in front of the child.'

[Solicitor C]

Therefore the information collected about families, excluded any assessment of children's perspectives or directly related experiences. Secondly, echoing Furniss' (2000) findings a decade ago, some solicitors seemed unaware of the challenges of identifying child protection concerns and eliciting disclosure. Indeed it was sometimes assumed that parent's concerns would automatically and certainly emerge in the course of the discussion. For example:

I: In terms of the risks that might be presented in the case, how do you find out the information on that, about the family? Sorry, if the courts aren't involved.

R: Em, because we'd already be acting for the client the client would have already told us everything to do with the matter, and even if there's a father who had contact stopped, he would have told us the reasons why his, for example, his partner stopped the contact. Likewise, if it's the mother who stopped contact, she would again tell us the history.'

[Solicitor H]

Given that this assumption is contrary to the evidence cited above, which suggests that eliciting disclosure is challenging, this would seem to imply a lack of knowledge on the subject area.

Further misconceptions were evident amongst some solicitors. For example:

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

[Solicitor E]

In this extract, the solicitor asserts that cases involving potential risk of harm, particularly violent cases are 'fairly few and far between'. He assumes that cases where there is a 'true risk of violence' will be referred to supervised contact 'or really' will involve social services. Yet research suggests that safeguarding concerns are by no means unusual in private family law cases. Indeed there is evidence that more than 50% of cases present with safeguarding concerns (Cassidy & Davey, 2011b; Hunt & MacLeod, 2008). Despite this, as discussed in Chapter 4, it is very unusual for social services to provide supervised contact in private law cases.

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

'I think you're very dependent on what someone will reveal and it's not completely unusual for, for you not to get told the whole truth, or for someone to minimise certain behaviour on their part, or for that matter on the other parent's part. Urm so that if you do then subsequently end up at court and

Cafcass have done their checks and social services and the police, you can then see information come out which, which you kind of think to yourself, well I wish they'd told me that in the first place.'

[Solicitor I]

The problematic nature of screening by solicitors is also substantiated by other research. Aris and Harrison (2007) examined the use of the C100 Form, which is filled in by clients with the aid of their solicitors prior to application to court. This study found that in 29.3% (n=41) of 140 applications where applicants answered 'no' to the trigger question (Q7), *'Do you believe that the child(ren) named above have suffered or are at risk of suffering any harm from any of the following: any form of domestic abuse; violence within the household; child abduction; other conduct or behaviour by any person who is or has been involved in caring for the child(ren) or lives with, or has contact with, the child(ren)?'*, a high level of violence was found in police reports, non-molestation orders or convictions for violence and reports from health and social services. Indeed, the research found that on these forms 'there were many omissions and anomalies, particularly in relation to the subheadings on the C1A [completed where clients answer 'yes' to the trigger question], which were rarely completed in full' (Aris and Harrison, 2007, p. ii). The authors concluded that the quality of the information on the C1A form was related to the experience and skill of the solicitors.

Overall, the findings above should perhaps be unsurprising. Solicitors are not trained to engage with vulnerable children for the purpose of collecting child protection information. Neither are they trained in risk assessment or in the specific task of collecting information for that purpose (Furniss, 2000). Solicitors' general lack of knowledge on child welfare should hardly come as a surprise given that this is not an element of their training. Indeed, in recent research, solicitors reported that they had learnt about DV 'on the job', or from their own research and/or from involvement with local DV services (Hunter & Barnett, 2013, p. 5).

5.4 Communicating information

Information that has been collected must also be communicated from referrers to centres. However, the process of inter-professional communication is also an area where problems frequently occur. Indeed, research in the statutory child protection sector has demonstrated that information which has been collected is not always passed on (Reder and Duncan, 2003; Munro, 1999).

In keeping with research more than a decade ago (Aris et al., 2002; Furniss, 2000), all of the case study supported services reported that solicitors often did not communicate important information to them at the point of referral. Coordinators reported that they sometimes had to follow up referrals by contacting solicitors, Cafcass or social services. For example:

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

[Coordinator, Centre 1, supported-only service]

'There are occasions where the form is done very quickly, it's not complete and it also clashes with what the other side have said.'

[Manager, Centre 6, both services]

Examples of this were also observed during observations. For example a coordinator of a supported-only service explained during a pre-contact session meeting:

'We should have had a new family but [pause] I think the solicitor was a bit sparing with the truth on his form. He has been [pause as she reads the referral

form] “ABH” [Assault Occasioning Actual Bodily Harm] he does say, but he was supposed to start today and he phoned up and said well he couldn’t start today [laughs a little] because he’s excluded from the [place name] area.’

[Coordinator, Centre 5, supported-only service]

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

The findings do not provide strong conclusions as to why solicitors did not initially provide all of the information at their disposal to centres. The solicitors interviewed articulated that they did provide all of the information they were expected to provide. It is possible that, as some coordinators suggested, solicitors excluded information with a view to engineering a favourable result for their client who wished to use the cost-free service. One coordinator also suggested that perhaps solicitors sometimes simply filled out the forms too quickly and so omitted details. The findings can neither substantiate nor reject these assertions, since although solicitors themselves did not admit to this; they would perhaps be unlikely to do so.

The findings do however provide some tentative evidence that some solicitors may provide the minimum amount of information since they are aware that centres will return to them if they require more. For example:

‘Yes, so you provide [information] and, if, the centre, there’s always that option to ask for more information if they need that, em...but yes, the referral form will require details of the concerns, involvement of social services, any existing court proceedings, any safeguarding issues, any, you know, child abduction concerns that you put that information in.’

[Solicitor D]

Indeed, this extract would seem to suggest that the practice of centres returning to referrers to seek additional information where forms are incomplete may encourage some referrers to believe that they can provide a minimum amount of detail. The assertion that centres '*can ask for more information if they need that*' would seem to imply that this solicitor assumes that all of the information at his disposal is not required.

There was also some tentative evidence of confusion surrounding the information which referrers must provide. For example, in the exchange below the coordinator of Centre 2 suggests that referrers are not required to provide information relating to concerns of emotional abuse. The exchange follows her stipulation that the centre will not accept cases where a parent has been convicted of the sexual abuse of a child:

I: okay, and is that for all forms of abuse, so say if it were emotional abuse or physical abuse, is it only sexual abuse?

R: Usually just [convictions for] sexual abuse [that the centre does not accept], yes. And the other kinds of abuse haven't actually been mentioned on our referral in my experience, like I haven't actually hosted a referral where say emotional abuse has been even mentioned. And in the main solicitors wouldn't probably share that information with us eh but they are obliged to if it is a sexual offence.'

[Coordinator, Centre 2, supported-only service]

A solicitor who had referred to this centre reported that she had referred a case where the child had a child protection plan due to emotional abuse from the contact parent, suggesting that such a case had certainly been facilitated at the centre although the details were not listed on the referral form.

Although it is not possible to establish a causal link from these data, it can be speculated that this may be in part an unintended effect of the referral form which is arguably unclear in terms of the child protection information it requires. The form asks if there have been any 'sexual/child abuse allegations', 'risks of abduction' or

‘allegations, undertakings, injunctions or convictions relating to violence involving either party, their respective families or the children.’ The list does not explicitly require details of any allegations or evidence of emotional abuse. The question on abduction may also exclude some cases where parents have concerns. In contrast to the other questions in this section, which refer to evidence and allegations, the question on abduction asks referrers whether there ‘is or is likely to be a risk of abduction’; it therefore requires an analysis from referrers. This may result in a subjective portrayal which may exclude parents’ unsubstantiated concerns. The final section of the form requests ‘additional background information’, however, this requires solicitors to make a subjective assessment about what information is required.

Overall, these findings are in keeping with other research which has found that actors do not respond to forms in a standardised way. Rather people are informed by their local context and may make moral and strategic decisions about what to include and how to present it (White et al., 2009). These decisions may be informed by factors including actors’ knowledge and perspective on the issues at hand. As Horwath (2002, p. 209) points out, frameworks, such as this referral form, ‘are really only aide-memoires, or organising principles for effective practice.’ (p. 209). Completing it effectively with a view to ensuring referrals are appropriate requires interviewing skills (Munro, 2005b) as well as knowledge to underpin the ‘organising principles’ on which the form is based (Horwath, 2002). Where skills and knowledge are not provided for, it might be expected that the quality of information collected and transferred will not be sufficient to achieve the desired purpose. Having discussed the collection and communication of information, the following section presents findings in relation to the analysis of that information and decision making.

5.5 Analysing information and making decisions

This section argues that while collecting information and recording it on the Referral Form is important in terms of ensuring appropriate referrals to supported services, this process will not in itself ensure that referrals to supported services are appropriate. Transferring information has no effect unless those communicating are able to attribute meaning to the information conveyed (Reder & Duncan, 2003). In other words, ‘facts

on their own are silent' (Munro, 1998, p. 92). This implies that in order to ensure that referrals are appropriate, an analysis must be made of the information on the form and a decision must be made as to whether and how the case can be safely facilitated. Research in the statutory child protection sector suggests that this is a highly skilled activity requiring knowledge of relevant theories and research to interpret the facts and formulate assessments of risk (Munro, 1998; Reder & Duncan, 2003, p. 95). Therefore if the system expects appropriate referrals, it will require the capacity to undertake this work.

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

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

However, it also seems to imply some role for judges in referring appropriate cases when it suggests that they should consider visiting a local contact centre as such visits,

'will help you to understand the facilities available locally and thus the type of case that is most suited to contact at the Supported Child Contact Centre'
[p.4].

The Protocol for solicitors also seems to suggest that Centres are responsible for analysing the information and deciding whether the case is appropriate:

'Contact Centres are not equipped to deal with abusers who pose a serious threat to their families and it is vital that the Centre Co-ordinator is given the full background (orally, if necessary) in order to decide whether the Centre can accommodate the family' [p.1]

In particular the reference to ‘serious threat’ followed by the assertion that centres will decide based on the information provided would seem to imply that centres will evaluate what constitutes a serious threat. The Protocol for Solicitors also seems to make an ambiguous reference which potentially implies a dual role for solicitors in the decision-making process:

‘Where violence is an issue, careful thought should be given to the use of Child Contact Centres. In cases of domestic violence (especially where there have been criminal proceedings or injunctive relief) supervised contact will generally be necessary, at least initially’ [p.1].

It is therefore unclear from the guidance provided who in the system is responsible for analysing the information collected and making a decision regarding the case. This is important because problems can arise when there is ambiguity about professionals’ role (Blyth & Milner, 1990; Caldwell & Atwal, 2003; Glisson & Hemmelgarn, 1998; Harker et al., 2004; Munro, 2005b; Rawson, 1994; Reder & Duncan, 2003; Reder et al., 1993). Indeed, as Reder et al. (1993) point out, in transferring information actors also manoeuvre to define their relationship and so the transfer of information requires that actors define their meta-communications (Reder et al., 1993, p. 64). In this sense, the transfer of information is not simply a technical process, but a psychological, social and interactional one (Hall & Slembrouck, 2009; Munro, 2005b; Reder & Duncan, 2003). Where meta-communications remain ill-defined it may be unclear what should be done with the information and who should do it. In light of this, this section presents findings relating to centres’ and referrers’ understanding of their respective roles in this process. In addition, it explores how the information collected on referral forms was used by each of the groups of actors.

5.5.1 The role of centres

The findings suggest that centres focused on receiving and sometimes collecting information about families. However, the case study centres were not conducting an in-depth evidence-based analysis of the information to come to conclusions about it. Interviews with centre coordinators suggested that the information was principally

used to weed out two types of cases: cases where supervised contact had been recommended by another professional and cases where an individual having contact had been convicted of the sexual abuse of a child. The National Standards for supported services expressly state that supported services should not accept a referral where somebody involved has been convicted of an offence relating to the physical or sexual abuse of any child, unless there are exceptional circumstances and they have sought appropriate professional advice (p.5). This may explain why cases involving a conviction for sexual child abuse were routinely rejected by supported services but does not explain why cases involving a conviction for physical abuse were not routinely excluded by all centres.

The exclusion of cases where another professional has recommended supervised contact relies on the analysis of another professional. Meanwhile the exclusion of cases involving the sexual or physical abuse of a child excludes one risk factor but does not address the multitude of others which may present. Where information was collected on other risk factors including accusations or evidence of DV, emotional abuse, mental health issues or drug/alcohol misuse, this information was not routinely analysed to inform a decision about whether the case should be accepted. For example, in the extract below the coordinator of Centre 2 discusses how she uses the information collected about families:

T: And how does that information help you?

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

[Coordinator, Centre 2, supported-only service]

The extract suggests that the information is used to inform the centre about the family; this coordinator suggests that it helps her to understand parent's reactions and

disposition. However, the information collected is not used to analyse whether or not the case can be safely managed at the centre, the assumption is that ‘the parent and the child...are coming in to have this time together.’ Similarly the coordinator of Centre 3 suggests that the pre-visit is an opportunity for the centre to set their expectations for the first visit:

‘But it’s good to have the resident parents and the child who can then see what the centre is like and they can tell us the problems about what...I mean some of them are really scared of coming they don’t want to meet the other parent and I think it reassures them if they come, how we work and listen to them and that’s all....And I can explain how they don’t have to leave the centre if they don’t want to they can stay in the parents’ room and we can establish if the child is going to [pause] if they think the child would be not willing to see the other parent whether they would be willing to stay in the room until the child gets used to its other parent or not. And if not [laughs a little] we know what we are going to deal with at the first visit.’

[Coordinator, Centre 3, supported-only service]

As this extract suggests, while information was sometimes collected from parents and children’s wishes were sometimes sought, this information was not routinely used to provide an analysis or to inform a decision about whether the case should be accepted.

The findings suggest therefore that the role of attributing meaning to the information collected and coming to a decision about it was not a part of the work of supported services. In refusing referrals, supported services relied heavily on other professionals to categorise the cases as only suitable for supervised contact. Outside of this, the centres would only usually exclude cases involving a conviction for the sexual abuse of a child. Indeed the manager of Centre 6, which offered both services, observed that cases in supported and supervised contact had similar characteristics. The difference, he observed, was that in supervised contact, a referring professional had decided that the case should be closely observed and the analysis fed back:

‘I: The issues that you mentioned of domestic violence, drug alcohol abuse,

abduction concerns those things, do they go to both services...?

R: I think they can be...I think they get mentioned across both erm because you know if you're asked to fill in a form and indicate what your concerns are then parental disagreement, alcohol abuse, violent behaviour, aggressive you know towards partner those sort of things are going to come up with families irrespective of the contact it seems to me. I think the only differential is that somebody else has decided that supervised contact needs to be supervised as opposed to monitored and supported... and you know that's the difference here anyway... because there needs to be close observation of how this parent is so some information can be fed back.'

[Manager, Centre 6, both services]

This observation would seem to fit with the findings across all of the supported contact services. Cases characterised as suitable only for 'supervised contact' were designated as such, not based on analysis of the case, but based on whether or not a professional outside of contact centres had designated it as such.

Centres' lack of capacity to analyse the information they received was particularly evident in relation to their concerns about 'self-referrals'. In the extract below the coordinator of Centre 3 explicitly expresses concern that in 'self-referred' cases, centres are expected to collect and analyse the information and make a decision about the appropriateness of the case:

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

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

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

[Coordinator, Centre 3, supported-only service]

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

The experience of Centre 1 suggested that where centres do not have support to undertake this analysis and make decisions about cases, they may resort to accepting cases and rejecting them if an incident occurs:

T: How do you feel about doing the risk assessment [participant's wording] for the self-referrals?

R: Well I'm not particularly, I kind of feel we didn't have to know but I kind of feel you know you talk to both, you lay down the rules, and again you're working on your sort of gut reaction almost, if...I mean the one I told you about that I was concerned about did take up other...but it wasn't...I didn't get much help so I think you just have to try it and if you actually are concerned put a limit on it, say "you know well we'll reassess this and see how it goes".'

[Coordinator, Centre 1, supported-only service]

However, such an approach surely misses the point in terms of protecting children since cases will be excluded only when harm is observed to have occurred.

5.5.2 The role of referrers

As the section above demonstrates, supported services did not have the capacity to provide a risk assessment of cases referred to them; they were not equipped to attribute evidence-informed meaning to the information they received and to use that analysis to inform an acceptance or rejection of cases. From the perspective of supported services therefore, there was a reliance on referrers to do this work. However, the findings presented in this section firstly provide evidence of role confusion: some referrers assumed that centres did indeed have the capacity to undertake such an analysis and relied on them to do so. Secondly, it suggests that while other referrers believed that it was their role to decide whether the case was appropriate for the service, some of these referrers were ill-equipped to make this decision. Based on these findings it is argued that the system for referral lacks capacity to attribute meaning to information and to make informed decisions based on this. It suggests that inappropriate cases are often being facilitated at supported services because no one in the system is making the decision that they should be rejected.

7.5.2.1 Role clarity

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

[Centres should be given sufficient information] to enable them to make a decision as to whether they can properly offer the facility. So if they are told that father for instance has a long history of drug taking, alcohol abuse and serious unpredictable aggression and violence, then they need to know that in order to enable them to ensure that they can properly provide the facility and indeed make sure their own staff are properly looked after...and if they say “we can’t cope with that”, that’s fine....common sense would dictate to me that they will assess their own facilities, they will assess the prospects of a child being injured in some way, and address those issues. They would also

obviously carry out an assessment, for instance if there is going to be a disruptive parent or child coming, not only what service they can offer to that disruptive individual but what the impact of having that individual there would be on the other families and indeed their own staff.'

[Judge A, referred to Centre 2, supported-only service]

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

'I: Have you ordered contact at a supervised contact centre?

R: Urm, I am going to say probably. In the vast majority of cases, well in fact, in all cases, I do not play an active role in selecting the contact centre. This is done either by the parents or legal representatives, urm who are familiar with the whole, you know, of those available and in a position, are well placed to assess which ones can provide the appropriate service. Or I am guided by Cafcass or the local authority or some other agency who will look at the suitability of the location in question having regard to what's available in the first place.

I: Okay and so would the order specifically say whether it was for supervised of supported contact or would it simply say that contact will happen in a contact centre?

R: It generally just says that it will happen in a contact centre. My philosophy, and I think it's shared by most of my colleagues, is that it is not for us to dictate down to the last detail how that contact will be affected on the ground...we normally take comfort from the fact that because it is in a contact centre, clearly it isn't sort of just one-to-one in private and that of itself is all that is needed to ensure that some contact can take place, all be it artificial, without the child being put in danger.'

[Judge A, ordered contact at Centre 2, supported-only service]

Given that centres relied on referrers to classify cases which were inappropriate to supported contact as suitable only for supervised contact, the practice of not classifying cases is potentially problematic. It implies role ambiguity since neither Centre 2 nor this judge believed that they were responsible for classifying the case. As will be discussed, the judge's reliance on solicitors may be misplaced. The judge's suggestion that 'because it is in a contact centre...that of itself is all that is needed to ensure that some contact can take place...without the child being put in danger' seems to further suggest a misperception that both supported and supervised services can address child safety and welfare concerns.

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

'It's obviously, it's up to the centre it's the centre's own admission policy. They screen and decide which cases they're prepared to take...we can't force them to take any cases. Obviously in order to try to avoid delay, we would try to make sure that we are only referring cases that are appropriate for whichever place it is that we are sending them to...these supported centres are not appropriate for dealing with cases that involve serious risk or serious violence.'

[Judge B, ordered contact at Centre 3, supported-only service]

In this extract there is more of a focus on referring suitable cases but the judge does not construct this as the referrer's responsibility per se. Rather it is still assumed that centres undertake this work and the rationale for referring appropriate cases is merely to save time.

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

I: Do the families that you refer to [Centre 3] ever need to be screened for risk before they go to the centre?

R: Well the centre always undertakes that em, that role. All that I'm aware of. You know it's not just about making a referral and being accepted; the referral is made, the coordinator will undertake a risk assessment and then on that basis get back to you as to whether or not the family can be accepted.

I: Okay. And does that happen during the pre-visit is it?

R: No that happens on receipt of a referral form.

I: Ah I see, so through the information that you provide.

R: Yes...I'm not sure how, what...how they undertake the risk assessment but I certainly understand that they do.

[Solicitor D]

By contrast all of the social workers interviewed took responsibility for collecting information about families and, on the basis of this, undertook a risk assessment. No social worker interviewed relied on contact centres to collect information, analyse it or to make a decision about the level of vigilance required for the case. The role of social workers therefore seemed clear compared to other referrers.

Given the level of ambiguity within the National Standards and Protocols for Referral it is interesting that actors asserted their role and that of others with such confidence. These findings indicate that, as other authors have suggested, actors in the system confidently constructed the boundaries of their responsibility (Rawson, 1994; Reder & Duncan, 2003). Many of these actors did so in ways which assumed that the difficult task of coming to conclusions about cases was not theirs.

7.5.2.2 Referrer's capacity

Some solicitors believed that it was their role to decide which cases were appropriate to the centre. Some reported that they would not refer cases involving a 'serious' risk to the child. However, cases involving DV, alcohol/drug addiction etc. were still routinely considered appropriate, suggesting perhaps that solicitors are ill-equipped to assess whether a risk is serious or not. Indeed, this might be expected given that solicitors do not receive training in the area of risk assessment or child welfare.

As discussed in Chapter 4, barriers in accessing supervised services were at times a key factor influencing the local rationalities of solicitors in making referrals. In some cases it seemed that the referral decision was based, not on any analysis of the case history or risk factors, but on practical logistics. For example:

'I: If the courts aren't involved, if it's negotiated through solicitors, how is a decision made there?

R: I think it's more the solicitors using their own initiative, if they think that it's a matter where children are at risk and they need to be watched, you know, they need to be watched at all times then we would go to supervised but I mean, in this firm especially, we don't, there's not that many supervised contact centres in use, and they'd be maybe more for like the care files maybe, but for sort of the private law children matters more supported centres....Generally [the courts] refer to supported to be honest. Only when there's a very serious case... they are more concerned about finding a centre with availability and finding one with a suitable location.'

[Solicitor H]

Similarly, in the extract below, the issue of risk to the child does not seem to be taken account of in any sense. For example:

'I: How do you decide whether the case is appropriate for the centre or not when it's just agreed between solicitors, when the courts aren't involved?

R: Urm basically it comes down to geography. Is it the, is it the closest contact centre? Urm whether anything better, if you like, is on offer. i.e. if the parent with care is saying well the only contact I'm offering is at a contact centre, then you haven't got much option. Urm, so those are the two main factors.'

[Solicitor I]

Social workers reported quite different referral practices compared to solicitors. All social workers interviewed reported that they undertook a risk assessment prior to referral. Social workers therefore seemed to construct the responsibility for making decisions about the case as their own, regardless of the practice of contact centres, which was sometimes unclear to them.

Overall the findings suggest that the Referral Form may be used in such a way as to focus attention on collecting information without any move to use it for the purpose of analysis or to come to a decision about the case. This would seem to be an example of a process becoming 'form-led' (Horwath, 2002, p. 204). As Horwath (2002) points out, where actors do not have the capacity to make sense of the information, important tasks may be interpreted as merely another procedure to follow. In this context, the focus becomes information collection and forms can become 'the security blankets of procedurally driven practice' (Horwath, 2002, p. 205). The findings emphasise the importance of clarifying the purpose of collecting information. Indeed as Duncan and Reder (2003: 88) point out, a message given without purpose is likely to become 'lost' in transmission. The findings further suggest the need to ensure that the system has capacity to use that information and that it is clear who is responsible for this task. In keeping with research in other contexts the findings suggest that diffusion of responsibility throughout a system can have the effect that 'responsibility [is] not generally experienced specifically or seriously'. This can become a 'policy for inactivity' (Menzies-Lyth, 1990, p. 449).

5.5.3 Misconceptions about the service provided

In terms of actors' analysis and decision making on cases, it is important to also consider whether local rationalities are influenced by gaps in knowledge or

misunderstandings about the service provided. Indeed, previous research suggested that inappropriate referrals were in part due to a lack of clarity about what constituted supported and supervised contact (Aris et al., 2002; Furniss, 2000). In part this was because centres varied substantially in the services they provided and so the labels ‘supervised’ and ‘supported’ did not always hold clear meaning (Aris et al., 2002). As previously outlined, since this research, NACCC has developed definitions of services in order to provide clarification. Centres provided referrers with the NACCC Definitions of Levels of Contact in an effort to ensure they were clear about the services provided. The evidence in relation to misperceptions of services is explored below firstly in relation to solicitors, then judges and finally, social workers.

5.5.3.1 Solicitors

Most solicitors in this sample understood the basic distinction between supported and supervised contact. They expected that in supported contact conversations would not be closely monitored and that contact would not be supervised by an individual worker, rather multiple families would have contact in a room together. They understood that the centre would not provide detailed reports or analysis of contact. However, understanding was not universal and there was evidence of misconceptions which suggested that some cases may be referred to supported services in part because solicitors, while differentiating between supported and supervised contact, overestimate the capacity of supported services. For example:

I: Would you expect workers to listen in on families conversations at all times?

R: Em, maybe not all the time, because obviously I mean like this one is a voluntary centre isn't it, so I wouldn't sort of expect someone to always be there to listen in and what not. But I do know that contact centres have to make contact notes so they would need to engage in and listen in on some aspects to provide the contact notes which sometimes have to be used in court proceedings. Like I know one of the directions [in a recent case referred to Centre 1]... is for the contact centre to make the contact notes, if they have any available.

I: And what would be included in those notes?

R: It's just sort of things like how they think the contact is getting on or is the child, you know, difficulty around the father, or you know, if there's any cause for concern about what the father is doing, if he's, you know, if he, whether he tries to antagonise or aggravate the mother at all, that's what you'd sort of expect to see.....

I: Would you expect workers to accompany children to the toilet?

R: Ahm...I'd say perhaps yes. If it's supervised and supported yeah. Especially if there's been any sort of, history of any sexual or physical abuse, then perhaps it's best that bringing the child to the toilet is done by one of the workers rather than the parent.

I: Okay. What level of sort of physical security would you expect to see in the centre?

S: Ahm, to be honest, I'd expect it to be at a fairly high level, if there's a risk of the child being abducted...

I: And what kind of things would that include do you imagine?

R: Ahm, I guess sort of, CCTV, you know just workers around on site, I wouldn't, I'd say security guards, but I think to be honest I think that's a little bit steep for, you know, a voluntary contact centre.'

[Solicitor H, referred to Centre 1, supported-only service]

In this extract the solicitor articulates a number of misperceptions: that Centre 1 will observe contact and provide feedback to the referrer, including an analysis of the contact; that the centre has a 'fairly high' level of physical security including CCTV and sufficient mechanisms to prevent abduction. The extract also indicates that the solicitor believes cases involving a history of sexual or physical abuse of the child are suitable for this supported service. He is correct in suggesting that in this centre, workers rather than parents bring children to the toilet, but the findings suggest that this was unusual amongst supported services.

Across other centres, one solicitor believed that workers rather than parents would take young children to the toilet and another did not know what the practice was; in both centres parents took children to the toilet. One solicitor believed that all workers in the centre would be aware of the background to the case and another solicitor assumed that most workers were paid staff in a centre in which only the coordinator was paid. Three solicitors articulated that they did not know what training volunteers had. One solicitor was unaware of any facilities to provide supervised contact aside from those provided by social services:

I: Have you referred any families to supervised contact?

R: Well what do you define as supervised?

I: That's a good question actually, how do you define it?

R: [Pause] well supervised is any contact that takes place in front of an independent third party. Now that could be a grandparent, it could be an aunt; it could be you know a facility where social services provide supervision so yeah it could be any of those things.

I: And have you come across any contact centres in the voluntary sector that provide supervised contact, or privately owned companies that are providing contact?

H: Not that I can remember.'

[Solicitor G, referred to Centre 1, supported-only service]

The findings suggest therefore that misperceptions concerning the service provided may still affect solicitor referrals. Some of these misperceptions concerned issues not referred to in the Definitions of Contact developed by NACCC, perhaps because practice on these issues varies between centres. This may suggest a need for a more in-depth standardisation of supported services in order to improve clarity.

5.5.3.2 Judges

There was no evidence that the judges who were interviewed had misperceptions in relation to practice in centres. However, one judge who was interviewed did not feel that it was the judiciary's role to know the details of the service provided; rather, he felt, that this was irrelevant since, as he understood it, the contact centre was responsible for deciding which cases were appropriate to their service. There were therefore gaps in his knowledge concerning the service:

I: Ok and would you expect all staff in the centre to be given that information or just the manager of the centre?

R: That's a matter for them. It's not a matter for me as a judge.

I: Okay I see. And what training or qualifications would you expect the workers in the centre to have, in supported and supervised contact?

R: Again, that's not a matter for me.

I: Okay and what level of physical security would you expect at the centre?

R: Again, I don't think that's a matter for the judiciary.

I: Okay, I see. So you see that as something that the centre should decide themselves?

R: Yes, yes because they are providing the service. They have very clear rules which are set out by the National Association of Contact Centres and I know that [Centre 6] complies with all that. I think that's a matter for them and I don't think it's appropriate for the judiciary to interfere in any way.'

[Judge C, ordered Contact at Centre 6]

The suggestion in this extract that the centre is accredited and that there is therefore no need to understand the exact service provided would seem to imply that the accreditation process itself can provide a false sense of security.

5.5.3.3 Social workers

The findings suggest that social workers may be vulnerable to misunderstanding the nature of supported services. The social workers interviewed reported that they rarely referred to supported services; supervised services were usually used. Four of the eight social workers interviewed had referred one or more cases to supported contact. Three of these workers were aware that supported contact was unsuitable for cases involving a risk to the child and had therefore only referred cases where their assessment suggested that there were no risks. However, the experience of the fourth social worker suggests that misperceptions may persist amongst social workers if they assume that all contact centres provide a similar service to in-house local authority contact services. In the case referred to below the court sought to increase the mother's contact with her children who were in foster care. Since the local authority (LA) service does not operate at the weekend it directed that the family use a voluntary sector supported contact service to supplement the LA service:

I: What would you expect the ratio of workers to families to be at the [named] centre?

R: Well, urm I would expect it to be urr really urm you need it to be one-to-one. I mean you need the supervisor to be there for the full two hours, in the room ideally...But it didn't appear that this was happening, it seemed that they were more arm's length supervision i.e. they were in the building, and they would help and sort things out if things, you know got a bit chaotic or went wrong I think they would then be involved but otherwise I think they were fairly arms off. So there was a bit of difficulty there because obviously if the mum had turned up drunk or smelling of alcohol then I wasn't quite sure whether [centre name] would've... how aware they would be of that....

I: Would you expect them to be listening into conversation at all?

R: Urm I yes I would

...

Urm I don't know what skills or qualifications are available obviously to be a social worker, I've got a degree and I wouldn't expect that level. I'd expect urr... NVQs. I don't know if they do NVQs or equivalent qualifications but I would, I think you need something. ...Rather than absolutely nothing. Experience of looking after children is, is really useful I don't think it's enough...[they need] the ability to urm to monitor a situation and know when, when to step in. So they really need to have seen the risk assessment that's produce by the, sent by the social worker or the referral and then know what the risks are with this particular family and also urm when they need to, to step in.'

[Social worker D]

As this extract suggests social workers may at times be unclear about the service provided. Local authority in-house services only provide supervised contact and the assumption of this worker is that a similar service will be provided by the supported service he referred to. He therefore held a number of misconceptions. He expected one-on-one supervision where the worker would listen into conversations and expected staff to be trained. He was unsure about the level of staff training but expected a qualification, perhaps to NVQ Level 2. He also seemed unaware that the centre was staffed by volunteers.

In keeping with this, the findings suggest that some social workers may refer inappropriate cases as they misunderstand the service provided. Indeed, the coordinator of Centre 1 suggested that in her experience, social workers '*don't have a clue what child contact centres are about*' she also reported that the cases referred by social workers were '*particularly difficult*'.

5.6 Conclusions

The findings presented in this chapter addressed the second component of the second research question: *‘what factors seem to help or hinder centres in managing their commitment to protect children?’* This chapter focused on the contribution of inter-professional working to centres’ child protection practice. Specifically it aimed to explain the dynamics underpinning the routine facilitation of cases inappropriate to supported contact at supported services. The findings suggest that the facilitation of inappropriate cases does not represent random mistakes or ‘slips’ in centres’ practice. Rather this practice is the outcome of problematic but ‘normal’ (Dekker, 2005) inter-professional working in this context. The chapter demonstrated how an exploration of actors’ working environment can explain how this practice has endured despite the introduction of reforms.

In keeping with research in other contexts, the findings presented in this chapter illustrate the potential for problems to occur in the process of inter-professional working (Fish et al., 2008; Munro, 1999; Reder & Duncan, 2003, 2004). The findings suggest that reforms have not addressed the issue of ‘inappropriate referrals’ to supported services because they do not themselves address the difficulties which actors face in this context. In line with findings in other contexts (Hall & Slembrouck, 2009; Horwath, 2002; Munro, 1998, 1999, 2005b; Peckover et al., 2009; Reder & Duncan, 2003, 2004; Reder et al., 1993; White et al., 2009), the research suggests that the technical transfer of information is only one aspect of effective inter-professional working. In order to manage the safe referral of cases, actors also need to be able to a) effectively collect relevant information about families b) communicate that information to other actors and c) analyse that information to make decisions about referral of the case (Munro, 2005b; Reder & Duncan, 2003).

The findings suggest that supported services lack the capacity to effectively undertake these tasks. However, neither is the capacity necessarily available to referrers. As discussed in Chapter 4, solicitors are by far the most frequent referrers to supported services (in 2009/10 they were responsible for 83% of referrals to supported-only services), yet the findings suggest that solicitors are not equipped to undertake any

aspect of this work. Cases coming through the courts may involve a more in-depth process of information collection but there are also limits to the information collected by the courts. Moreover, where this information is transferred by solicitors and where solicitors are left to make decisions regarding the case, problems are still likely to occur. By contrast, social workers who referred to contact centres have been enabled to undertake this work. However, the findings suggest that inappropriate cases may still be referred because some social workers may overestimate the capacity of supported services. While the broad distinction between supported and supervised services was understood by referrers, misperceptions and a lack of information concerning important details of supported services may also contribute to inappropriate referrals by judges, solicitors and social workers.

The findings also suggest that role ambiguity amongst actors may contribute to problems in the referral process. Analysis of the Protocols for Referral suggested that the actors' roles are ambiguous in a number of respects. Despite this and the lack of capacity in the system to undertake work in the three key areas, referrers and centres confidently constructed the boundaries of their responsibility and that of others in the system in light of their capacity (Rawson, 1994; Reder & Duncan, 2003). Many actors did so in ways which assumed that the difficult task of coming to conclusions about cases was not theirs.

Given these findings it can be suggested that the facilitation of cases involving a child protection concern can be considered a product of a system which does not enable actors to effectively work together to safely manage referrals. This chapter has drawn attention to the limits of tools and protocols to improve inter-professional practice. In keeping with research in other contexts, the findings emphasise the importance of the local context into which such mechanisms are introduced (Hall & Slembrouck, 2009; Horwath, 2002; Munro, 1998, 1999, 2005b; Peckover et al., 2009; Reder & Duncan, 2003, 2004; Reder et al., 1993; White et al., 2009). A high level of professional training as well as experience is required to undertake each stage of this work. Tools cannot be used to replace expertise (Gillingham & Humphreys, 2010; Horwath, 2002; Munro, 2005b).

It can be argued that problems in the process of referral have also persisted because the system lacks an effective feedback mechanism for learning. The findings suggest that in relation to the referral process, the focus of NACCC accreditation for supported services is principally on whether centres use the Standard Referral Form. The accreditation system does not directly assess whether centres' and referrers' practice is more broadly appropriate to the protection of children. This is in keeping with recent trends in risk management which have seen organisations manage risk by providing workers with more and more procedures to follow (Hood et al., 2001; Power, 2004, 2007). At the same time the procedures tend to say little about the most challenging aspects of the work; the approach may be more concerned with telling workers what to do than it is with providing the means to do it (Munro, 2005a, 2005b).

The findings suggest that because the accreditation system does not provide an accurate appraisal of how well the system is working, it can create a false sense of security (Stevens & Cox, 2008). Referrers may assume that because centres request information about families using the referral form, they have the capacity to analyse it and act on it to ensure that inappropriate cases will be rejected. In this sense, the use of the referral form in the absence of appropriate professional capacity may have the unintended effect of making practice less, rather than more, safe. For this reason, the emphasis on its use may be in danger of becoming another example of a tool, developed in an attempt to improve performance 'interacting in such a way that the cumulative effect is negative' (Munro, 2010a, p. 1136 see also, Hoffman & Woods, 2000; Hollnagel, 2003; Woods & Hollnagel, 2006).

Based on these findings it can be argued that the system requires an alternative system of feedback for learning. Specifically, the findings suggest that instead of telling actors what to do, the 'top' requires a means to identify any barriers to doing so as well as a mechanism to understand any unexpected impact of reforms introduced. More generally, actors in this highly 'coupled' (Perrow, 1984) system require feedback to enable them to understand the impact their actions (or inactions) have on other parts of the system. As Woods (2002) suggests, such feedback is critical in order to avert the basic pattern in human systems, of 'drift towards failure as planned defences erode in the face of production pressures and change' (Woods & Cook, 2002, p. 143).

Chapter 6: Hearing the ‘voice of the child’?

This chapter contributes to both research questions but focuses on the analysis of them in relation to centres’ engagement with children. It therefore aims to provide an understanding of a) how well child contact centres engaged with children, in the context of their commitment to protect them from maltreatment and b) what factors seemed to influence centres in their engagement with children.

Research suggests that hearing and taking account of children’s wishes and feelings is central to protecting children from abuse and neglect since children are the most direct source of authority on whether they are being or are at risk of being maltreated (Horwath, 2002; Munro, 2011, p. 39; Willow, 2002). Hearing children directly is also important for ensuring that children feel empowered to disclose maltreatment and that they are taken seriously when they do so (Horwath, 2002; Munro, 2011, p. 39; Willow, 2002). Indeed, Serious Case Reviews (SCRs) have highlighted the importance of listening to children (Ofsted, 2011). In a review of 65 SCRs Ofsted reported that:

‘too often the focus on the child was lost; adequate steps were not taken to establish the wishes and feelings of children and young people; and their voice was not heard sufficiently’

(Ofsted, 2011, p. 5).

This report also emphasised the importance of observing children and babies who are non-verbal (Ofsted, 2011, p. 6). In the specific context of child contact, it has been argued that there is particular impetus to hear children since a child refusing to meet a parent may be distressed by contact and total ongoing disregard for his/her distress may be damaging to the child (Johnston, 2005).

In keeping with this research, the ‘Working Together’ (2010) guidance suggests that in order for organisations that work with children to fulfil their safeguarding ‘commitment’ they should have:

‘A culture of listening to and engaging in dialogue with children – seeking their views in ways appropriate to their age and understanding, and taking account of those both in individual decisions and the establishment or development and improvement of services.’

(HM Government, 2010, p. 42).

The sentiment of this statement is reproduced in the 2013 guidance (HM Government, 2013, p. 48). In addition the updated guidance states:

‘Anyone working with children should see and speak to the child; listen to what they say; take their views seriously; and work with them collaboratively when deciding how to support their needs.’

(HM Government, 2010, p. 9).

The importance of engaging with children is also enshrined in Article 12 of the UN Convention on the Rights of the Child (1989), which was ratified by the UK in 1991. It states:

1. *‘States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.’*
2. *‘For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with procedural rules and national law.’*

(The United Nations, 1989, Article 12)

In terms of English law, section 1(3) of the Children Act (1989) provides that in both public and private law proceedings concerning contact, the court shall, among other considerations listed, have regard to:

'The ascertainable wishes and feelings of the child concerned (considered in light of his age and understanding).'

It is important to note that under neither the UNCRC nor English law¹⁸ does listening to and taking account of children's wishes and feelings entail an expectation that children will make decisions about their lives. Rather the emphasis is on the importance of *adults* listening to children and taking their wishes and feelings into account (in accordance with the child's age and maturity) when *adults* make decisions that affect children's lives. This may involve a decision which is contrary to the child's wishes but thought to be in his/her best-interest. The legal framework is therefore not 'based on any concept or recognition of children's *rights*, but rather on the duty and responsibilities of parents and the court to protect and further children's *interest*' (Potter, 2008, p. xx). This, it would seem, is also the sentiment reflected in the UNCRC (1989) and 'Working together' (2010; 2013), which are not legally binding.

It can be argued therefore that there is a consensus at a policy level about the importance of hearing 'the voice of the child' and taking account of what children say. The importance of doing so, in this context, is emphasised as a child safety and welfare issue. However, research in other organisational contexts has suggested that the rhetoric of engaging with children may not necessarily imply corresponding practice (Franklin & Sloper, 2005; Holt, 2011b; A. James, 2007). Moreover, the articulation of the need to listen to children does not consider the potential barriers to doing so.

Little is known about engagement with children in child contact centres. The National Standards for supervised contact services suggest that:

'when and where it is appropriate [children] should be asked their wishes and feelings concerning contact' and they should 'not be forced to have contact or take part in a programme of work against their will' (p.11).

¹⁸ Outside the field of consent by a mature child to medical treatment, see *Gillick v West Norfolk and Wisbech Area Health Authority and Another* [1986] AC 112, [1986] 1 FLR 224.

However, neither the National Standards for supported services, nor the NACCC (2010) Guidelines for Safeguarding and Child Protection, make any reference to engagement with children. As discussed in Chapter 1, research on child contact centres more than a decade ago found that some children, ‘who were clearly expressing their views and showing their distress were placed under pressure to have contact apparently against their wishes’ (Harrison, 2008, p. 399). The research indicated that this may have occurred due to volunteer’s ‘pro-contact’ stance. As a result of this, children could be believed when they wanted contact but disbelieved when they did not (Harrison, 2008, p. 399). In addition, the labelling of mothers as obstructive meant that children’s reluctance to have contact was often interpreted as being due to manipulation by the resident parent rather than as a response to past experience of abuse (Humphreys & Harrison, 2003b, p. 255). The issue of centres’ engagement with children was not discussed in the most recent research on contact centres (Thiara & Gill, 2012). This chapter therefore aims to build on the findings of Aris and colleagues’ work (2002) to provide an up-to-date and more in-depth understanding of the issue.

As in previous chapters, the analysis focuses on understanding ‘normal work’ and ‘local rationalities’ in the system. The system as a whole is also investigated with a focus on the interactions between parts, rather than on the parts alone. The first part of the chapter presents a typology of engagement with children which was developed from the data. This is comprised of three categories; ‘coercive engagement’, ‘limited engagement’ and ‘meaningful engagement’. It suggests that engagement with children in child contact centres is diverse and emphasises the importance of local context in informing practice. The second part of the chapter presents an explanatory account of the factors which seemed to influence engagement with children in this context. It suggests that issues affecting engagement with children in child contact centres are located not only in contact centres themselves, but in the wider family justice system.

6.1 Engagement with children: notes from the literature

The broader literature on child engagement suggests that, with the right support from adults, children of any age can be listened to and engaged with. While children do not

necessarily have the same competence in communicating as adults, this does not mean that information from children is invalid. Rather it emphasises the need to find methods which maximise children's ability to communicate in a manner which is most comfortable to them (Hart, 1992). This includes young children and babies who are often assumed to be incapable of participation. Research suggests that an indication of their individual wishes and feelings can be observed through non-verbal behaviour (Alderson, 2008; Horwath, 2002; Kaltenborn, 2001; Ofsted, 2011; A. B. Smith, Taylor, & Tapp, 2003; Willow, 2002).

Research has also undermined the developmental model of childhood, which suggests that children's views should be taken into account in accordance with their age. It is increasingly suggested that this is inappropriate since children will develop different competencies based on their individual characteristic and experiences, rather than their age (Cafcass, 2010c; Kaltenborn, 2001; Smart, Wade, & Neale, 1999). Overall, research has found that children are far more competent at expressing their wishes and feelings than adults generally believe (Butler, Scanlan, Robinson, Douglas, & Murch, 2002; Gollop, Smith, & Taylor, 2000; Hart, 1992; Smart, 2002; Willow, 2002).

Research on children's perspectives on participation has found that that most children understand the difficulties in making choices and do not want to be forced to make choices. However, they do want to have a voice and to understand what is happening (Bretherton, 2002; Butler et al., 2002; Campbell, 2008; Cashmore, 2011; Cashmore & Parkinson, 2008; Gollop et al., 2000; Graham-Bermann & Levendosky, 2011; Graham & Fitzgerald, 2006; Holt, 2011b; Neale, 2002; Smart, 2002; Smart et al., 1999). This of course includes the right to voice a wish not to take part in decision making (Cashmore, 2011; Neale, 2002; Smart, 2002).

While research has increasingly demonstrated children's competence and desire to communicate, the sociology of childhood literature (Allison James, Jenks, & Prout, 1998; A. James & Prout, 1990; Jenks, 2005; Prout & Hallet, 2003; Smart, Neale, & Wade, 2001) has emphasised that adults construct children's capacity to do so, with implications for child engagement. Indeed, James and Prout (1990) have asserted that while 'the immaturity of children is a biological fact of life...the ways in which this

immaturity is understood and made meaningful is a fact of culture' (A. James & Prout, 1990, p. 7).

Research has found that adults may assume that children (and in particular young children) lack the competence to participate in their safety and welfare and that their views would simply reflect those of adults (Gollop et al., 2000; Holt, 2011b; Mantle et al., 2007; Smart, 2004 ; Taylor, 2006). Some adults may also avoid engaging with children because they feel that asking children about their wishes and feelings will over-burden them with responsibility or deny them their 'childhood' (Hart, 1992; Holt, 2011b; Neale, 2002; Willow, 2002). It has been argued that the perceived threat to children's welfare is particularly salient in the context of parental separation where it is often thought that children must be protected by keeping them as uninvolved as possible (Neale, 2002). Research examining perceptions of childhood has further suggested that some adults may assume a universal construct of what is 'good' and 'bad' for children. This may create the false perception that engagement with children is not required since a universal model of what is 'good' for children is sufficient to inform adults of a particular child's welfare (Holt, 2011b; Neale, 2002). As previously discussed, there is some evidence that the family justice system has tended towards an assumption that contact is in the best interests of all children (Aris & Harrison, 2007; Collier, 2006; Hester et al., 1994; Hunt & MacLeod, 2008; Kaganas & Day Sclater, 2004; Lewis, 2002; Perry & Rainey, 2007; Radford & Sayer, 1999; Smart, 1991; Smart et al., 2005; Trinder, Firth, et al., 2010). Research by Timms and colleagues suggested that there may be a sizeable minority of children who feel 'pestered' by the courts or feel they have been pushed into having contact against their wishes (Timms, Bailey, & Thoburn, 2007).

While adult's constructions of childhood can form a barrier to engagement, the research suggests that other issues can also have an effect. The literature suggests that adults require support and training to develop skills which will enable them to effectively and confidently engage with children (Cashmore, 2011; Gollop et al., 2000; C. Wilson & Powell, 2001). Indeed, research has found that practitioners may feel particularly intimidated when placed in situations requiring the use of non-verbal communication skills, for example when working with very young children. In this respect they require training to build confidence and skill (Horwath, 2002, p. 208).

Additionally, the literature suggests that in order for engagement to be effective, adults must have the time to build trusting relationships with children (Gollop et al., 2000; Willow, 2002; C. Wilson & Powell, 2001). Since adult discretion will determine the extent to which children's views should be taken into account in each case (Neale, 2002), adults may further require training in order to analyse and make sense of the information they receive (Horwath, 2002; Johnston, 2005). If support is not in place professionals may perpetuate the powerlessness of children. This may be because they are uncertain how or even whether to engage children (Taylor, 2006) rather than simply because they are opposed to the idea.

6.2 Hearing the 'voice of the child': a typology of child engagement

A typology of child engagement was developed from the data, which suggests that engagement with children across contact centres is diverse. In keeping with typologies of child engagement which have been developed in other contexts, the typology developed here suggests that categories of engagement can be understood to sit along a spectrum (Butler & Williamson, 1996; Hart, 1992; Shier, 2001) and that both meaningful and pseudo forms of engagement can be identified (Hart, 1992). A more in-depth overview of the typologies listed above is provided in Appendix 6.1.

The categories of engagement in the typology developed in this thesis are different from those in previous typologies. The typology developed from the present data suggests that engagement can be conceptualised as ranging from 'coercive' to 'limited' to 'meaningful'. The typology is rooted within the normative perspective outlined above which asserts the importance of listening to children and taking their wishes and feelings into account, a stance which is supported by policy and research.

The categories do not refer necessarily to the engagement of entire centres; multiple forms of engagement could be seen in some centres. Rather the categories refer to the ways in which individual workers in centres engaged with children at particular moments in time. It is also important to note that the analysis does not make any claims concerning quantification; it is not possible to tell how frequently the categories

of engagement identified in the typology occur across centres. However, the evidence presented here does suggest that these forms of engagement exist and it is argued that the typology offers a useful mechanism for understanding engagement with children.

6.2.1 Coercive engagement

The category of coercion is conceptually distinct from categories of ‘manipulation’ previously developed by, for example, Hart (1992) and Butler and Williamson (1995). In the ‘manipulation’ category, as these authors conceptualise it, children may be part of the process and may feel positive about what they are doing but the process does not necessarily take into account their wishes and feelings. In these scenarios the child’s wishes and feelings may not be known or sought. By contrast, in the category of ‘coercive engagement’ developed here, children’s wishes are known, but are disregarded.

In the fields of mental health and political science ‘coercion’ is generally understood as a threat which seeks to override the will of another (McCloskey, 1980; Nozick, 1972; O'Brien & Golding, 2003) . There are four key tenets which distinguish the category of ‘coercive engagement’ developed here:

- (1) The decision about what is best for the child is made in the absence of taking the child’s wishes and feelings into account.
- (2) Children’s expressed wishes and feelings have no power to change the decision or to influence workers’ evaluation of what is best for them.
- (3) A threat is leveraged in an attempt to ensure that children do something which is against their expressed wishes
- (4) Children may only have power in so far as they can physically obstruct the process.

In order to ground the discussion, two examples of what has been termed ‘coercive engagement’ are presented below.

Figure 10: Field notes: visit to Centre 3, supported-only contact service

A 7-year-old boy refused to meet his father. The court order in this case is for the centre to facilitate the 'handover' of the child so that the parents do not see each other. Contact between the child and his father should then take place outside the centre, unsupervised for 4 hours every 2 weeks. A Cafcass Officer has not been appointed to the case.

In a meeting before the contact session the volunteers noted that the child had been going out with his father but has recently refused to have contact and that it was likely that he would do so again today. A volunteer was nominated to 'deal with' the child. There was no discussion of the possible reasons for the child's objection or of any context to the case. The centre coordinator reported in interview that the mother has said that in the past her son witnessed his father abuse her.

On entering the centre the child immediately stated that he did not want to see his father and refused to go into the contact room. The mother and two volunteers repeatedly suggested that he go into the contact room to see his father. No one asked the child why he was refusing. When he continued to refuse, the centre coordinator brought the father from the contact room to the hallway where the child was. The child initially continued to refuse, but after further suggestions that he should see his father he went into the contact room.

I stood beside the only volunteer in the contact room and over the noise of other families playing it was not possible to hear the conversation between this boy and his father, particularly because the father spoke quietly.

The child played with his father for approximately 20 minutes and then started physically pushing his father away saying 'leave me alone, I'll beat you up' and repeating 'leave me alone'. The child ran out of the room, put on his coat and said he wanted to go home. He became withdrawn and hung his head. He appeared upset but did not cry.

The volunteer who had been assigned to ‘deal with’ the child followed him out of the contact room and spent around 10 minutes trying to convince him to go back into the room. She did so with statements that included ‘your dad has come a long way to see you’ and ‘just go in for ten minutes more’. The father came out of the contact room and stood by as this happened. The volunteer repeatedly tried to get the child to promise that next time he would go with his father. She eventually stated, ‘okay [not this time] but next time you come and daddy wants to take you out, you will let him okay?’ The child nodded. The father then said to the child in an angry tone ‘fine you don’t have to, you can go; you are free’. The mother and child left the centre.

In this example the child’s wishes and feelings appear to have no power to influence workers’ perception that he should have contact with his father. Indeed the reasons for the child’s refusal are not explored when he objects to contact on entering the centre; nor when he shouts at his father to ‘leave me alone’ or he will ‘beat you up’. The second interaction is particularly surprising given that none of the workers could have known what the father said to the child.

This thesis suggests that the mode of engagement in this interaction is coercive because a threat is used in an attempt to pressure the child into an action which is against his expressed wishes. It could be argued that the language used here is not overly threatening. The worker does not suggest to the child that he will experience negative consequences due to his refusal. However, threats can be more subtle than this. Whether something is coercive or not depends on its meaning to the coerced (Carroll, 1991). According to Wertheimer (1993) it also depends on the threat’s ‘framing in a social context’. It can be argued that telling a child to do something without presenting a choice is threatening due to the broader cultural context which children experience. Socially, children and adults are unequal. Children are often told to do something by an adult and are not given choices. Where children do not do as adults specify, there commonly are negative consequences for the child; in school (s)he may be set additional homework, at home (s)he may be put on the ‘naughty step’. It is suggested therefore, that to tell a child to do something without presenting him/her

with a choice is inherently threatening because of this broader cultural context. In this instance, a further threat is evident when the worker refers to negative consequences for the child's father who she asserts 'has come a long way to see [him]', implying a threat that his father's effort will be wasted if the child does not comply.

Another example, from the observations of practice, is presented below in Figure 10. It suggests that threats were sometimes less subtle.

Figure 11: Field notes: visit to Centre 1, supported-only contact service

A family arrived at the centre for a pre-visit. At this centre, the pre-visit involves a discussion between the coordinator of the centre and each of the parents, who are seen separately. The father is requesting contact with his son (who appeared around 8 years old) and daughter (aged 12). There is no court order in this case and solicitors are not involved. This is a 'self-referral'.

The father was interviewed before the mother and children arrived. During the interview the father informed the coordinator that the reason he had not seen his children was because he 'had been drinking'. However, he also seemed to imply that his ex-partner was obstructing contact, opening the conversation saying that his son told him, 'mummy doesn't want me to speak to you'.

The father mentioned that he also has a six year old son from a more recent relationship which has recently ended. He said he is also hoping to see this son at the centre. At the end of the interview he related (unprompted) that social services are involved in that relationship as his ex-partner has alleged domestic violence (DV). The police have advised that he stay away from the house and this is the reason he has not seen this son for some time. The family visiting are unaware of this situation and do not know that the relationship with his recent partner has ended. The coordinator agreed not to inform them of the situation.

When the mother and children arrived, the coordinator suggested that the children spend time with the father while she spoke to their mother. The daughter said she did not want to see her father but the son was keen to. The coordinator therefore spoke to the mother and daughter in a separate room while the son spent time with his father in the 'contact room'.

The discussion began with the daughter articulating that she was 'not ready' to see her father 'yet'. The coordinator told the girl that she could decide for herself whether or not she wanted contact. The coordinator then told the girl that there would be 'no reason to feel nervous' if she decided to see her father as the volunteers would be nearby. She claimed that it was 'important' for the girl to see her father and that she had 'a right' to do so. At this point the daughter agreed to spend a short amount of time with her father today, on the condition that her mother would stay in the building.

The interview continued through the Standard Referral Form questions. Towards the end of the conversation the coordinator pointed out that at the moment there is no court order in this case. But, she said, she had 'seen cases where there is a court order' and suggested to the girl that though the centre cannot force her to have contact, where there is a court order her mother 'would be in contempt of court and would have to go to prison if she did not have contact'. The coordinator said she hoped this would be the start of the girl 'building a relationship' with her father to 'a point where you can trust him'. Following the interview the girl spent time with her father and returned to the centre again the next week.

Again, in this interaction, the young person has limited opportunity to inform the coordinator's understanding of her best interest. When the girl asserts her objection to seeing her father at this time, her concerns are dismissed without investigation through the coordinator's assertions that she 'should not be nervous' and that contact is 'important'. The options available to the young person are manipulated through the use of a threat. The threat is not focused directly at the young person, but on the negative impact the choice not to have contact would have on her mother, who it is suggested, could be imprisoned. Protection in this context is something which is done 'to' rather

than ‘with’ the young person. As in the previous example it can be observed that coercion can operate via what is objectively not a serious threat (since the coordinator misrepresents the legal position)¹⁹, but which nonetheless may be perceived as serious to the threatened person. Children and young people may be particularly vulnerable to such threats due to their relative reliance on adults for objective and accurate information.

Workers in the case-study centres articulated that they would not physically force a child to have contact and no instances of physical force were observed. However, one volunteer suggested (unprompted) that there are centres which do this. This seemed to be corroborated by a mother in the same centre who approached me and spoke informally to me when I was observing contact at the centre. She related that she previously used another centre which has since closed down. The mother described this centre as ‘awful’. She claimed the volunteers would ‘grab’ her 4-year-old daughter when she was crying and bring her to her father, insisting that the mother leave. She felt she and her daughter were traumatised by the experience. She stated that she prefers the centre they are currently at because ‘they take more time with the child’ and the mothers can stay at the centre in another room. Therefore, while physically coerced contact was not observed in this research, such engagement may have taken place in other centres.

The incidents of ‘coercive’ engagement referred to above occurred in two supported-only contact centres. However, it is important to note that although all the case study centres reported that they experienced children who objected to contact, I only witnessed children objecting in the centres referred to above. Therefore I only had the opportunity to observe centres’ reactions in these centres. The data for the other case-study centres rely on workers’ own descriptions of events, collected through interview

¹⁹ The courts can impose a custodial sentence for any breach of a contact order (House of Common's Library, 2011) The court's general contempt of court powers are governed by the Magistrates' Court Act 1980, s 63). However, in *Re M (Contact Order: Committal)* [1999] 1 FLR 810, the Court of Appeal stated that, a commitment to prison should be ‘a last resort in an urgent and exceptional case.’ This power would however seem irrelevant in this case since the mother is not obstructing contact, indeed she has voluntarily brought her children to the contact centre. Moreover, the coordinator does not take account of the obligation on the court to take into account the wishes and feelings of the child. In *Re B (Minors) (Change of Surname)* [1996] 1 FLR 791, [1996] 2 FCR 304 it was held that it would be exceptional for a court to make orders contrary to the wishes of a teenager. Since this girl is twelve years old, it is likely that her wishes would carry significant weight.

data. These data may be less reliable and so it is possible that ‘coercive engagement’ was more widespread amongst the sample than these findings indicate. Nonetheless, as discussed above, the quantification of types of engagement is not the concern of this analysis.

6.2.2 *Limited engagement*

The second category in the engagement typology is labelled ‘limited engagement’. The key tenets are as follows:

- (1) The decision about what is in the ‘best interest’ of the child is *not* pre-determined.
- (2) The child’s wishes and feelings *can* influence workers’ decisions about contact.
- (3) Engagement is not sufficient to achieve a wider understanding of the child’s position or to support the child by addressing his or her issues or those of the parent(s).
- (4) No scaffolding is provided so children are limited in their ability to communicate and be heard.

In ‘limited engagement’ workers are concerned to monitor whether contact is in the interest of the particular child they are engaging with. For example, the coordinator of Centre 2 articulated:

‘The interest of the child is absolutely paramount. Yes, you want the absent parent to see that child and to have a really good visit and re-establish a relationship, which may have broken down, but you have to look at the needs of the child all the time and whether the child is benefitting from this event, being happy about it, thriving as a result of it and it’s the child who will drive everything. If that child is over-anxious, intimidated, not very happy, not thriving as a result of re-establishing this relationship with the absent parent then it needs looking at and it needs questioning.’

[Coordinator, Centre 2, supported-only service]

In this extract children are situated as social agents whose reactions are a meaningful and valuable indicator of their well-being. Children are therefore co-producers of their own protection; adults work ‘with’ rather than ‘on’ them to achieve this.

In ‘limited engagement’ children may still be ‘encouraged’ to have contact. However, according to workers’ accounts, this did not reach the threshold of coercion.

R: [If the child doesn’t] want to go in contact room, in this case we can’t force and the parents they can’t force ... we say okay this is your ... first and last warning you can give, you can’t take pressure, you can’t force him or force her to go in contact room. Because this is in contact centre and the child is first priority.

I: Okay and if the child says “I don’t want to go in”, what happens?

R: Then we try, we try a couple of times and we try like we offer the toys we, we try to busy [the child] ... So we try but if they don’t want to go then we’ll, we’ll cancel it.’

[Supervisor 2, Centre 4, both services]

In this account the staff member views it as his role to protect children from ‘pressure’ which may emanate from parents. However, the form of engagement does not involve engaging with the child’s concerns; rather the focus is on distracting the child with toys. In this sense engagement with the child is limited.

‘Limited engagement’ is therefore substantively different to ‘coercive engagement’. Nonetheless it does not go as far as it could to enable the child as a co-producer of his/her own protection. While there is a focus on reacting to children’s distress, in order to be heard, children needed to take the initiative. They were required to spontaneously articulate verbally that they did not want to have contact or to become

visibly distressed. This is limiting in two ways. First, workers in some supported centres were not always observing children; in some centres children could be left alone with parents in some of the multiple contact rooms for periods of time. Even when workers were in the same room as families, in keeping with the set-up of a supported centre, they were not observing families closely. Therefore children's more subtle forms of communicating distress could easily be missed.

Secondly, in both supervised and supported services where 'limited engagement' was recalled, there were no mechanisms for systematically and proactively assessing each child's wishes and feelings about contact *before* they arrived at the centre to have contact. In this sense a subtle form of pressure may be placed on children to have contact through the default assumption that this is what should happen; and there is an onus on children to disrupt the 'normal' course of events in order to be heard. Fundamentally, it can also be argued that the tendency to begin by encouraging objecting children to have contact in the absence of fully exploring the child's concerns is dismissive of the child as a source of information on his or her own safety and well-being.

This limited form of engagement may enable children who are particularly articulate and assertive (whether verbally or behaviourally) to communicate their concerns and have them acted upon. However, the voices of children who lack this assertiveness may not be enabled in this context. In particular, children who do not want to have contact may be more easily heard than children who feel concerned about contact. Yet in a child protection context, a feeling of concern must logically be equal in importance to a decisive wish not to have contact since it may be equally indicative of a threat to the child's safety or well-being. Finally, 'limited engagement' simply facilitates contact; it does not provide services to deal with child or parental issues which may prevent contact from happening safely.

6.2.3 Meaningful engagement

The final category in the engagement typology is 'meaningful engagement'. The key tenets of 'meaningful engagement' are:

- (1) The decision about what is best for the child is not pre-determined
- (2) The child's wishes and feelings can influence workers' decisions about contact.
- (3) Engagement with the child is based on the aim of deeply understanding the child's position and taking his/her individual needs into account.
- (4) Scaffolding is provided in order to enable the child's communication.
- (5) Support is provided to address child and parental issues affecting contact.

Only one of the case-study centres had systematically implemented 'meaningful engagement' across the organisation. This was a supervised-only contact service which is situated within a broader organisation that provides support for families who have experienced DV.

In this centre, engagement with children was pro-active rather than reactive. Children who were verbal were met alone from their parents in order to hear their wishes and feelings about contact before the case was accepted at the centre. Younger children and babies who were non-verbal were observed before contact in order to understand what behaviour was 'normal' for them. This was compared with the child's reaction to his or her non-resident parent in a contact session. In this way the centre sought to elicit the wishes and feelings of all children and babies. A supervisor explained:

'With the pre-contact sessions it's trying to figure out what's normal for that child because it could be that that child is just very shy all the time or very loud and boisterous all the time. So it's about getting a gauge for what's normal and then seeing in the session how that might change or get exaggerated.'

[Staff member A, Centre 5, supervised-only service]

Where children objected to contact and the centre had assessed contact as safe, workers could provide up to two 'reluctant child sessions'. The manager of the centre explained what was involved in this:

'We prepare children who are reluctant for contact, we do...the workers will do a bit of life story with them, bit of identity work with them, bit of wishing and feelings work, just to ascertain where they're at and also just to do some reassuring around what the child's anxiety has been. For instance, they might be anxious that they've got to go and live with that parent, so we can do some reassuring around, this is what we're going to do, the aim is not to live with that parent. It might be that they've built a picture of what this parent looks like or what this parent doesn't look like or the child might not be told that this parent is their parent. So within our reluctant child sessions, which should only be one or two sessions maximum, we can address some of those issues and actually work with the resident parent around how we can support them and their child in this process.'

[Manager, Centre 5, supervised-only service]

Here the purpose of interaction with the child is to understand the child's position rather than to move the child to a position favoured by the worker. The information provided to children is not used to manipulate or coerce them, but to inform them. In this way the worker supports the child to enable him/her to develop informed wishes and feelings concerning contact.

Where contact was considered safe but the child nervous, the child was encouraged to set the boundaries of his or her engagement with the parent. A worker described one such session. It started off with the child and non-resident parent in separate rooms. The child and parent were encouraged to draw pictures or write notes to each other from this distance. The child eventually asked to meet the parent. In this form of engagement the child is in control of the process and the child meets the parent only when s/he feels ready.

In 'meaningful engagement' the worker's role is also highly analytical. As described above, prior to contact, the worker tries to discover and understand the child's position and takes this into account in making a decision about what is best for that child. During contact the assessment of the case continues. The child is seen as a key source of information and is observed closely for obvious and subtle forms of communication:

'The initial sessions are very intense and you want to be sure that you are gauging the right ... well that you are not missing anything. And these things can be very subtle and so just making sure that that child appears comfortable really ... I'm looking out for eye contact, not just between the parents, also ... their involvement with the other person that's in the room ... depending on the history, how are they responding to the physical affection? Is that what I would consider normal or ... cause it's something they are used to, is it cultural? Is it a cultural thing that maybe I'm not used to? So it's about having that kind of open mind about it but really, but still ... it's like well ... it doesn't really matter if it's cultural or not, is that child safe? Or is that child relaxed and happy with that kind of affection?'

[Staff member A, Centre 5, supervised-only service]

In 'meaningful engagement' therefore, children are understood to be communicating important messages beyond crying and directly stating that they do not want contact. This was also the case in 'limited engagement'. The difference here is that, unlike in supported services, in this supervised service, workers are constantly, closely looking out for signs of communication and they are trained to do so.

Where the child is still objecting after the 'reluctant child sessions' contact may not go ahead, at least until further work is completed with the child and/or parent. In addition to contact supervision, as discussed in Chapter 3, Centre 5 could also provide child and parent counselling, a Parenting Information Programme (PIP) and a Domestic Violence Intervention Programme (DVIP). In this sense, 'meaningful engagement' takes on a distinctly supportive role; it seeks to understand children and also to enable them by opening up options to them.

6.3 An explanatory account: factors influencing engagement

The second part of this chapter presents an explanatory account of factors which

seemed to influence the type of engagement with children in this context. It is argued that engagement with children in contact centres is not simply influenced by factors within contact centres. Rather, an examination of the system of contact centres as a ‘whole’ (Dekker, 2005; Hoffman & Woods, 2000; Woods & Cook, 2002, p. 140) demonstrates the contribution of factors related to interactions between contact centres and the wider system. Moreover, the examination of local rationalities demonstrates the importance of local context and actors’ perceptions in informing engagement with children.

6.3.1 Perceptions of children’s best-interest

The findings indicated that the managers of the two centres where ‘coercive engagement’ was observed seemed to construct the ‘best interests’ of the child in a way which assumed that contact is in the best interests of all children:

‘Well there is all this research that people do; a child that knows both parents is far happier and is going to do far better and be far more balanced if it actually knows both parents, even you know, though one might have done something quite horrible. So it is good that they should know both parents.’

[Coordinator, Centre 3, supported-only service]

Similarly, the manager of Centre 1 explained the benefits of contact to a mother as follows. Due to DV, this mother’s two-year-old daughter had a child protection plan while the mother was in a relationship with the father. The manager explained:

‘We are here so [the child] can build a relationship with her dad and everyone says that’s what’s best for children, even if [the parent is] not good.’

[Coordinator, Centre 1, supported-only service]

These managers seemed to perceive contact always to be in the best interests of the

child. As per the extracts above, this included where the parent is '*not good*' or where he/she has done something '*quite horrible*'. A misunderstanding of the evidence seems evident here. As discussed in Chapter 1, research suggests that contact is not itself good for children; rather it is the opportunity which contact presents for *quality* parenting that matters to child outcomes (Amato & Gilbreth, 1999; Dunn, 2004; Marsiglio et al., 2000). Where there is no pre-existing relationship or where the relationship is of poor quality, the benefits of contact can be negated (Hunt & Roberts, 2004). Where contact places the child at risk of maltreatment, the potential benefits of contact can be outweighed by the risks (Ellis, 2000; Lamb, 2007). Although both of these individuals had received training as coordinators of contact centres, this message seemed to have been either misunderstood or not articulated.

The data indicate therefore that the idea of 'protecting' children may be variously constructed by individuals working with children. While guidance such as 'Working Together' (2010; 2013) is concerned that workers protect children from maltreatment, those working on the ground may focus on other risks: in this context some workers were concerned to protect children from a perceived risk of losing contact with a non-resident parent. From the perspective of these workers therefore, when they attempted to coerce children into contact, it seems that they perceived themselves to be acting protectively.

6.3.2 *Perceptions of children's capacity*

The findings suggest that workers constructed children's capacity to express 'valid' wishes and feelings in different ways, with significant impact on the way they listened. The findings substantiate previous research which suggests that children may be listened to where their wishes and feelings coincide with adults but dis-believed when they do not (Aris et al., 2002; Munro, 1999; Smart et al., 2005). Children's capacity could be constructed within the assumption that contact is always in the interests of children such that where children did not wish to have contact it was sometimes assumed that their expressed wishes and feelings were not their own and should therefore not necessarily be taken into account. Often, the child's resident parent rather than the child him/herself was seen as 'responsible' for the child's objections. Workers articulating this assumption did so without speaking with the child about his/her

reasons for objecting and, in some centres, without access to the background of the case. Conversely, when children were happy to see their parent despite a history of, for example, DV, workers did not articulate a concern that they may have been influenced by one of their parents. For example:

'[Resident parents] feel that if they help the child to work through this then they are actually encouraging contact to happen when in fact most of the resident parents really don't want contact to happen. And then they actually say, when the child looks visibly distressed at going through to see the non-resident parent, the resident parent will then blame the contact centre and the courts saying "oh this is so cruel putting these children through it! How could they do this? This is so cruel!" and they don't actually appreciate that it's because they haven't encouraged it themselves ... And so you have got this poor child and you can see the anguish and the agony on their face thinking, what on earth do I do? ... So they are thinking if I do what I want to do, which is to go and see the father, that would be really lovely to see him but I know mum will be cross and a bit tetchy with me for the rest of the week and so it's a real yeah, horrible.'

[Volunteer 1, Centre 6, both services]

In this extract the volunteer makes this assumption about the child's feelings in the absence of speaking directly with the child and without access to the case history. The child's articulated wishes and feelings are dismissed by positioning the resident parent as obstructive. The volunteer does not differentiate between parents' objections on the basis of child welfare or safety concerns and so all objections seem to be classified as illegitimate. Since the child is assumed to be influenced by the resident parent, the child's wishes and feelings are positioned as illegitimate by extension. In this way the child's visible distress at contact is positioned as irrelevant to the child's 'real' feelings, which are entirely subjectively constructed by the volunteer.

While children's capacity to articulate 'real' wishes and feelings was more often questioned due to the perceived influence of resident parents, the manager of one centre seemed to question whether children generally had capacity to know what they

want:

I: And how much say do you think children should be allowed to have in whether they have contact?

R: How much say? I think the more important question is who's going to find that out? Who's going to ask that question? And what is the question?

I: And how does that work? How do you find out what children want, or is that possible to do?

R: I think it's pretty impossible because I think confusion for the child is separating being at the contact centre or erm being with dad ... Finding out what children want until they're old enough, at least to think they know what they want when they say, "I don't want to see him" or "I ain't going to that place" ... Well I don't think... that's a relevant question I threw it out myself hypothetically, I don't think you can. So finding out what children want about contact is too big a question, it's like somebody says to me repeatedly you know, or I can get asked "what do you want for dinner?" yea? And the answer is I don't know, I don't mind, whatever. What do you want to do this weekend? I don't know. Do you want to go and see your dad? I don't know really, which dad... I don't know yea. So I'd like to know far more from someone like you having done all this research, how everybody does it and it might be that at the end of the day, and I'm aware of this, that it can be done here, it's just that I'm the blockage, it's just not me, maybe [deputy coordinator] will have to do it.'

[Manager, Centre 6, both services]

In this extract the manager repeatedly suggests that children 'don't know' what they want. He suggests that they will 'confuse' multiple other issues with whether they want to see their non-resident parent and so it may be 'impossible' to find out what children want. In this case, the limited level of engagement with children seems to be linked to a construction of children's capacity. However, he also concedes the possibility that 'it can be done here, it's just that I'm the blockage' and suggests that

‘it’s just not me, maybe [deputy coordinator] will have to do it’. This seems to suggest that regardless of children’s capacity, he is not interested in getting involved in supporting the articulation of their wishes and feelings.

6.3.3 Contact centre workers’ sense of empowerment

The differentiated ways in which contact centre workers engaged with children seemed to be explained further by workers’ sense of empowerment within the wider system. In particular, workers’ perceptions of the relative authority of contact centres and the family law courts seemed influential. Contrasting perceptions of contact centre’s role were identified from the data. Centres were variously believed to principally have, what this thesis has labelled as, a ‘compliance-focused’ role or a ‘child-focused’ role. Some workers believed that it was the role of contact centres to encourage contact. For example:

‘What we’ve got to do is we try our best to get the child to come see the father because obviously that’s our job.’

[Staff member 1, Centre 4, both services]

Other workers felt that their role was to provide a space where contact could happen, but they felt no obligation to ‘encourage’ contact to happen. At the same time, they did not feel particularly empowered to challenge contact orders where children objected. For some, the authority of the court was such that even where children who were known to have been exposed to DV or direct abuse were distressed by contact, it was assumed that the centre had to continue to facilitate contact at least until it was clear that contact was practically impossible:

‘In cases where you can see that it’s the children that’s afraid of stepping forward and making that em, you know, an approach to leave the mother to go to the father, it’s usually because the child’s actually experienced domestic violence or has experienced some sort of abuse ... There has been one incident,

or one that I remember, that was quite vivid where the child really didn't want to go, did not want to leave the mum go and see dad and the emotion was, your heart just went out to this child who just really didn't want to go, crying, screaming, panicking ... and end of the day you can't force the child to go but the courts say that the father has to have contact, so the mother is forced to bring the child to the contact centre to see the father there, knowing that the child really doesn't want to go because of what the child's experienced, so it can be a bit difficult that way because it doesn't seem as if there's anything set out to give the children any support psychologically to deal with what they've experienced.'

[Volunteer 1, Centre 5, supported-only service]

Despite the reference to the child 'crying, screaming, panicking' the volunteer does not question the role of the centre in facilitating contact. She suggests that children at the centre require additional support but in the absence of this she still assumes that the court order should be implemented.

The priority here is on compliance with the court order. The perceived authority of the court seemed to disempower some contact centre workers. It has implications for how they understand their responsibility to protect children from potentially traumatic contact and whether they hear and take into account children's wishes and feelings. Indeed, the focus on compliance presents a paradox for contact centre workers in which the perceived need to comply conflicts directly with the notion of hearing and taking into account children's wishes and feelings. In this sense it seems to represent another goal conflict (Woods & Cook, 2002) within the system. Where compliance takes precedence, the focus by default is not on the child.

By contrast, some workers seemed to articulate that their primary role was to ensure the safety and welfare of children. In this conceptualisation, centre workers felt empowered to challenge the court's or parent's decisions about contact where they felt that that decision was not in the best interest of the child.

As indicated in the discussion of 'limited engagement', some workers in supported-

only services on occasion felt empowered to challenge contact orders where children were displaying distress during contact. However, staff in Centre 5, the supervised-only centre, felt distinctly empowered to assess contact continuously, to refuse cases and to stop contact if necessary:

'A case can be stopped at any point if you feel the risk is too great. For instance...we might meet a child that's changed, there's quite a gap from when Cafcass saw them and when we've seen them and it might be that this present moment in time, having met with that child, contact can't continue and the workers are qualified enough to say "look this is what happened during our pre-contact meeting, we're concerned about this, this and this" and sometimes they might say that perhaps they might need a bit of therapy before contact is re-visited because they came in and they're absolutely traumatized by being here; they're crying, they're shaking, you can see and then at that point we might say "no, we can't do, at this point this child's not ready".'

[Manager, Centre 5, supervised-only service]

This finding builds on those presented in Chapter 4 which suggested that the focus of supported child contact services as a 'welcoming', 'non-judgemental' and 'neutral' can disempower workers sense of authority and judgement, which are necessary to the work of child protection. The findings presented here suggest that the organisational focus may also, in part, be influenced by workers' perceptions of the role of the service within the wider system.

The role of training

The level of training volunteers and staff in contact centres had received seemed to influence their sense of empowerment to engage meaningfully with children and to challenge decisions about contact. As discussed in Chapter 4, unlike in the other case-study contact centres, work at Centre 5 is led by qualified social workers and all workers are qualified to at least NVQ level 4 in social care and child development. They also receive additional in-house training from qualified staff.

With the exception of Centre 5, the case-study contact centres did not feel that it was their role to assess systematically the wishes and feelings of all children who were referred to the centre. This role, it was felt, should be undertaken by professionals. For example, referring to a specific case, a volunteer commented:

'I don't feel it's my place or, or my role to get alongside some twelve-year-old girl and try to find out why she doesn't want to come see her dad. I would try to encourage her to come in [pause] but I wouldn't feel it is part of my job to find out why, what's the problem. Because I don't feel as a volunteer with no particular expertise in child psychology or anything like that, that I should start to try and talk to teenage girls in that sort of close way you know, because there may be all sorts of things that they wouldn't want to say. So I am not a social worker, I am just somebody who is giving up a Saturday afternoon to help out. And I think you go on very dodgy ground if you start getting involved too closely on that.'

[Volunteer 2, Centre 1, supported-only service]

As this extract suggests, speaking with young people in this context was considered to require professional training in child psychology or social work. The volunteer's sense of unease at the idea of speaking with a young person about contact seems evident, particularly in his suggestion that to do so would place him on 'dodgy ground'. This finding is in keeping with the research cited above, which suggests that adults require support and training to develop skills which will enable them to effectively and confidently engage with children (Cashmore, 2011; Franklin & Sloper, 2005; Gollop et al., 2000; C. Wilson & Powell, 2001). Sufficient time and an appropriate place are also required to engage with children before contact; this was not available to the coordinators of all supported centres.

6.3.4 System-wide divergent discourse and role ambiguity

The findings presented below suggest that the contrasting perceptions concerning children's capacity and the role of contact centres do not exist in isolation; rather they

are part of system-wide ambiguity. Contrasting perceptions were identified amongst social worker and solicitor referrers as well as judges who had ordered contact at a contact centre.

Social worker referrers

Amongst social workers, a liberal ‘social actor’ perception of children’s capacity was largely evident. The social workers interviewed generally articulated the belief that children and babies of all ages were capable of having wishes and feelings about contact and that these should be taken into account. Only one social worker mentioned age as a barrier to involvement in decisions about contact:

I: In your opinion, should children be involved in decisions about contact?

R: Urm certainly if they’re old enough.

I: Mm. And what sort of age are you thinking?

R: Mm I would say urm eight or nine. They begin to get a urm... better knowledge about things. Maybe older, nine or 10 urm... if it’s going to be about their views on the contact and how they would like it changed in any way and how we can accommodate that, I suppose that could happen at a younger age. But I haven’t really done it with any children under seven, under eight.’

[Social Worker D]

All other social workers interviewed felt that children could and should be involved from any age. Indeed, age was not seen as a barrier to understanding children’s wishes and feelings. Rather the child’s age or development was positioned as a factor which may determine the way in which the child would communicate. For example:

I: In your opinion, to what extent should children be involved in decisions about contact with their parents?

R: Absolutely! Absolutely they should...and I think particularly as children get

older and they're able to talk about their own feelings and wishes...And we we've recently had quite a lot of training about looking at, even babies, and how babies behave and how babies respond...and what even very small children are saying about contact just by you know non-verbal children just by the way they're behaving and responding. Absolutely children have to have a voice in terms of contact.'

[Social Worker C]

This understanding of children's capacity to communicate important information appeared to underpin social workers' expectations of how contact centres should engage with children. First a social worker should assess the child's wishes and feelings prior to a decision about contact being made. If a child were then to object to contact at the centre this would need to be addressed by speaking with the child in order to understand why the child was objecting. This would help the worker to assess the seriousness of the issue and inform their decision about whether contact should continue. For example:

'I: And what would you expect to happen in a centre if the child got to the centre and said that they didn't want to have contact with their parent?

R: Well usually the child, I would expect the child to have said that before they even got there. But basically I would expect them to be, not to be taken into a separate room but away from the person they were going to see, for whoever is you know for the contact supervisor to say well you know, "why don't you want to see them?" ... and if they really don't want to see them then the contact should be cancelled.'

[Social Worker F]

Solicitor referrers

As a group, the solicitors interviewed seemed to articulate a qualitatively different perspective. All but one solicitor felt that it was either the parent's or the centre's role to persuade the child to have contact. This often seemed to be related to a perception

that the wishes and feelings, particularly of younger children, were unimportant. For example:

'My opinion is, children of a certain age, their sort of wishes or feelings carry more weight ... I suppose any child over about eleven, if they have strong views on not wanting to see the parent then that has to be taken on board, I think younger ones, if they sort of kick up a stink then they still need to go because I think they are not old enough for sort of their wishes and feeling to carry a lot of weight.'

[Solicitor H]

One solicitor felt that, from a child protection perspective, contact centres should not have any role in 'persuading' children to have contact:

'I: And what would you expect to be the practice in a centre if a child didn't want to have contact?

R: Well I think their role is just to note the arrival time and departure times and any significant incidents that take place that they might be able to report on but I don't think they can have any role in trying to persuade contact to go ahead because ultimately contact might have been ordered or agreed to take place in a contact centre but if there is a real problem...that only comes to light afterwards, for example a kind of suppressed sexual abuse allegation that hasn't come up in the proceedings, it wouldn't be for the contact centre to persuade the child or be seen to persuade the child to have contact if really the child's wishes are based on a genuine concern.'

[Solicitor E]

The perception that it is the resident parent's role to encourage the child to have contact was articulated not just by some solicitors but also by contact centre workers. It was also evident from the observations of practice that many resident parents perceived that they were expected to encourage contact, regardless of their concerns. Yet the positioning of parents in this role would seem to conflict with the idea, simultaneously articulated by some solicitors and judges, that it was resident parents'

responsibility to advocate for the child by stopping contact and bringing the case (back) to court if they were concerned about the child's safety or well being. In this sense the role of resident parents within the system also seems conflicted and ambiguous. Indeed, a further goal conflict (Woods & Cook, 2002) seemed evident in this regard. It seemed that the authority of the court, felt either directly through a court order or through the 'the shadow of the law' (Mnookin & Kornhauser, 1979) could create the impression that resident parents have a 'compliance' rather than a 'child-focused' role. Where contact centres also believed that they principally had a 'compliance-focused' role, this could leave children with no advocate to support the on-going articulation of their wishes and feelings and ensure that they were protected from potentially harmful contact.

Judges

The three judges differed in how they understood the role of contact centres. One judge described a child objecting to contact as a 'concern' and expected that the issue would be drawn to the court's attention:

'I would certainly expect that if there's something that the contact centre are worried about, that they notify either the court or Cafcass about that ... A child specifically saying they do not want to be in the room. I would expect that to be drawn to the court's attention.'

[Judge B]

This judge seems to suggest that contact centres have a 'child-focused' role, in which they do not simply comply with a court order, but act to protect the child from contact which may be harmful by alerting the court.

The role of contact centres was understood differently by the two other judges. In these accounts, contact centres were, to some extent, seen to have a 'child-focused' role but at the same time it was suggested that they had a 'compliance-focused' role. The contradictions in these co-existing roles were reconciled through the notion of contact centres' discretion:

T: What would you expect to be the practice in the centre if a child didn't want to have contact?

R: That's a very difficult question because the contact centre knows that the judge has made an order and therefore would have to encourage it. Again it would be a matter for the staff to decide whether, if the child was visibly distressed, whether they should intervene and bring the contact session to an end. I am aware that has happened. I think the staff would have to use their discretion.'

[Judge A]

T: Ok and what would you expect to be the practice in the centre if a child said that they didn't want to have contact with their parent?

R: I don't see centre staff necessarily as interfering with that, at the end of the day that is a matter between the parents...Urm I would expect primarily the centre staff to be neutral on that and to enable the parents to try and get the child to see the father or find out why, a sort of good reason why the child shouldn't. I wouldn't expect the centre staff to start getting involved in that discussion.'

[Judge C]

In both accounts there seems an expectation that centres will go beyond a facilitation role to implement contact; centres would 'have to encourage' contact and are expected to 'enable the parents to try and get the child to see the father'. The authority of the court is evident in both accounts but is particularly strong in that of Judge A, who suggests that 'the contact centre knows that the judge has made an order and therefore would *have to* encourage it'. The lack of agency is echoed in Judge C's assertion that he would not expect centres to 'interfere' with contact.

Yet the ascription of this compliance role is constructed alongside something of a 'child-focused' role. Both judges suggest that there are instances where the centre may

consider stopping contact; in Judge A's account this may happen where a child is visibly distressed to the extent that the centre is concerned, or, in Judge C's account, where the centre finds 'a sort of good reason' why the child should not see his/her non-resident parent. Notably, in contrast to Judge B's stance, the child's objection is not in itself a reason. In these accounts a goal conflict (Woods & Cook, 2002) would seem to persist between centres' prescribed compliance role and their child-focused role. These tensions seemed to create ambiguity which was resolved by contact centres in varying ways. While in some instances centres focused primarily on compliance, in other centres the focus was on the child. The ambiguity therefore would seem to be located not simply in centres themselves, but in the wider system.

6.4 The capacity of the wider system

The perception amongst some contact centre workers and referrers that contact centres have a compliance-focused role may assume that the work of hearing and taking into account children's wishes and feelings is undertaken before children arrive at contact centres. By this logic, referrers would ensure that contact was in the best-interest of the child and contact centres could then follow this decision.

However, the proposition is problematic for a number of reasons. Firstly, children's wishes and feelings may change over time. Moreover, risk factors for maltreatment may not be disclosed at the time of referral or be known to resident parents; evidence of them may emerge only over time. Where the referral has been negotiated by solicitors or is a 'self-referral' by the family, it will likely be made in the absence of any independent assessment of the child's wishes and feeling or their safety. It may be suggested that resident parents will advocate for objecting children by refusing contact but, as discussed, parents' role is also conflicted and ambiguous. For this reason it cannot be assumed that resident parents will adopt a 'child-focused' role.

Even where the case comes through the courts, the capacity of the courts to take the wishes and feelings of the child into account prior to making a referral for contact at a centre is limited. In private law it is very unusual for children to be made party to

proceedings (Potter, 2008). Indeed in 2009/10, a Guardian was appointed in only 3% of cases (Bailey et al., 2011, p. 125). Rather children are usually heard indirectly by the court. Children's wishes and feelings are routinely represented by their parents, allowing for the possibility that the child will be misrepresented (Baroness Hale, 2011; Lowe & Murch, 2001). Where the court considers that the child's views and feelings may not be adequately represented by the parties, the judge can order a Welfare Report from a Cafcass Officer. However, even in cases where a Welfare Report is ordered, there are questions over the variable quality of practice amongst Cafcass Officers and concern that this indirect representation of children's wishes and feeling can lead to misrepresentation (Butler et al., 2002; Mantle et al., 2007; Ofsted, 2008; Thiara & Gill, 2012). There is also concern that the time Officers are able to spend with the child may be insufficient to build a trusting relationship to foster disclosure (Mantle et al., 2007; Potter, 2008; Thiara & Gill, 2012). Finally, the weight judges give to children's wishes and feelings may vary based on assumptions about what is good for children (Dingwall & Eekelaar, 1986). Indeed, various authors have questioned whether the system adequately provides for the representation of children's wishes and feelings in decisions that affect them (Baroness Hale, 2011; Bischoff, 1990; Bretherton, 2002; Butler et al., 2002; Cafcass, 2010c; Crichton, 2008; Day Sclater & Piper, 2001; Family Justice Council Voice of the Child Sub-Group, 2008; Neale, 2002; Potter, 2008; Smart, 2004; Smart et al., 1999; Timms et al., 2007; Trinder, Jenks, & Firth, 2010). Further to these concerns, as reported in Chapter 5, the findings of this research suggest that where judges do order Cafcass Welfare Reports they are experiencing severe delays in receiving them. In some cases where the judge believes that a Cafcass Welfare Report is necessary to ascertain the wishes and feelings of the child, the judge may not have received the report at the time that contact is ordered at a contact centre.

For these reasons, it cannot be assumed that because a case has been referred to a contact centre from the courts that the child's wishes and feelings will have been taken into account and that this process will have been undertaken in a way which is guaranteed to ensure the child's best interest. For these reasons, when the system is examined as a 'whole' it becomes apparent that, from a child protection perspective, a 'compliance-focused' role for contact centres is questionable.

6.5 Conclusions

At a policy level, a consensus seems to have been reached concerning the importance of hearing the ‘voice of the child’ and taking that voice into account. Yet the findings presented here suggest that practice in contact centres does not uniformly match the rhetoric of national policy. A typology of child engagement was developed which suggested that ‘coercive’, ‘limited’ and ‘meaningful’ forms of engagement can be identified in contact centres. The explanatory account presented asserts that these forms of engagement are influenced by the ‘local rationalities’ of contact centre workers.

Since factors at the individual and organisational levels vary greatly between centres these ‘local rationalities’ produce varying and unexpected effects. Contact centres inevitably develop ‘emergent properties’ (Dekker, 2007a). It was argued that the ways in which workers in contact centres engage with children is influenced by factors within centres, including the level of staff training. However, the findings suggest that practice is also influenced by interactions at the level of the wider system. Contact centre workers as well as referrer judges, solicitors and social workers demonstrated divergent understandings of children’s capacity to have ‘valid’ wishes and feeling. Contrasting perceptions of contact centre’s role were also identified; centres were believed variously to have a ‘compliance-focused’ or a ‘child-focused’ role. Similarly, there was evidence that the role and responsibility of resident parents in the system is ambiguous. It was suggested that these ambiguities created ‘goal conflicts’ for actors, which were resolved in varying ways.

Based on these findings it seems there is a pressing need to emphasise the capacity of children and babies of all ages to have and articulate (behaviourally and verbally) wishes and feelings, which are important in terms of their safety and well-being. The findings also suggest that the role of contact centres in the wider system needs to be clarified and subject to critical evaluation from a child protection perspective. A ‘compliance-focused’ role for contact centres is incompatible with the aim of protecting this vulnerable cohort of children from abuse and neglect. Since the wider system has limited capacity to listen to children, centres cannot be assured that

referrals for contact will always be in the child's best-interest. More fundamentally, a focus on compliance conflicts with the notion of continuously listening to children and taking their wishes and feelings into account. Rather, contact centres must be enabled to adopt a 'child-focused' role. For this to happen, workers in contact centres need to be empowered both within the organisational context of contact centres *and* within the wider family justice system to engage meaningfully with children.

Chapter 7: Conclusions

This research sought to understand how well child contact centres in England, as organisations that work with children, manage their commitment to protect children from maltreatment and what factors influence them in this task. The research questions were situated within the context of the state's articulation that all organisations that work with children have a commitment to protect them, as outlined in 'Working Together to Safeguard Children' (2010; 2013). From the outset, the research problematized this commitment by reference to the human safety literature which has shown the limits of top-down guidance in achieving desired levels of practice. This literature was also used to problematize the top-down reforms introduced to contact centres by NACCC since Aris and colleagues' (2002) research. This included the introduction of National Standards for contact services and the associated accreditation system, Protocols for Referral, a Standard Referral Form and Definitions of Levels of Contact. The human safety literature provided a systems framework for studying how this guidance was being implemented on the ground, including how it was interpreted by different actors in the system and how they interacted to produce the observed level of practice.

This chapter summarises the main findings of the research and discusses their contribution to the literature. The limitations of the study are noted and the implications of the findings for policy and research are explored.

7.1 Summary of empirical findings

7.1.1 Contribution in relation to the first research question

This study sought to contribute original knowledge by using a systems approach to build on previous research on contact centres (Aris et al., 2002; Furniss, 2000; Thiara & Gill, 2012). The first research question asked, 'how well do child contact centres, as organisations that work with children, manage their commitment to protect children from maltreatment?' In addressing this question, the systems approach focused on contributing a more in-depth, up-to-date understanding of 'normal work' (Dekker,

2005; Rasmussen & Svedung, 2000) in contact centres than was available from previous research (Aris et al., 2002; Furniss, 2000; Thiara & Gill, 2012). These findings (presented in Chapter 3) suggest diversity in terms of how well child contact centres manage their commitment to protect.

Before this study there was no up-to-date research directly examining current practice in supervised services. Based on the findings, it can be argued that the case study supervised services managed the commitment well. The findings indicated that across supervised services, cases involving a child protection concern were monitored closely through one-on-one supervision in which the supervisor listened to all conversations and observed all behaviour. In addition handovers were strictly managed so that it would be unlikely for parents to meet or be followed. Where the case study supervised services encountered signs of maltreatment including emotional, physical or sexual abuse, normal practice was to intervene immediately to protect the child. Signs of maltreatment were routinely communicated to referrers through reports. However, outside of these issues, the findings suggest some variation within supervised services' practice.

Levels of physical security varied somewhat between the case study supervised services: only one centre had panic alarms and in practice, not all centres had a staff member available on reception at all times to assist supervisors when needed and to let families in and out of the centre. Only one supervised service (Centre 5) sought a full case history and provided a continuous risk assessment. The other supervised services did not receive a full case history and relied instead on referrers to provide the conclusions to risk assessment: to tell them what the risks in the case were and how to manage them. Supervised services also varied in terms of the services available in the centre to build safety and move families on. Only Centre 5 worked in conjunction with referrers to move families on by assessing cases and addressing safety issues through an in-house counselling service, a Domestic Violence Intervention Programme (DVIP) and parenting information programme. Moving on was managed entirely by referrers in the other services, which did not assess cases or provide any services to build safety. This variation suggests that although all supervised services managed the maltreatment risks in their case load well, some supervised services may be better able to manage the commitment to protect than others.

The findings suggested that supported services were less able to manage their commitment to protect and that problematic child protection practice persists in some centres despite the reforms introduced since Aris and colleagues' (2002) research. The findings build on Thiara and Gill's (2012) evidence that supported services continue to facilitate cases involving domestic violence (DV). The findings of the current research suggested that all of the supported contact services in this study routinely facilitated cases involving various child protection concerns, despite their not being designed for this purpose.

The findings suggested that supported services could manage cases involving drug or alcohol addiction well in terms of checking that parents were not under the influence and denying contact where parents were found to be. However, it was found that this policy was not always strictly implemented in supported centres and so children could be placed at risk of harm where contact was allowed with parents who were under the influence of drugs/alcohol.

Similarly, the evidence suggested that some supported services could manage handovers strictly so that parents were unlikely to meet or be followed. However, other centres did not manage handovers strictly and so could place children at risk of harm in cases where there was a risk that children could witness domestic abuse or be maltreated by their non-resident parent. Supported services also differed in the physical security they provided. While some were secure, others were not, leaving a risk that children could be abducted. Practice was similarly diverse in relation to monitoring contact. While some supported centres maintained staff in all of the contact rooms, in others parents were allowed to spend short amounts of time alone with children in some rooms which were not constantly monitored, providing an opportunity for abuse to occur. In addition, while some services did not place any pressure on families to move on from the service, others placed huge pressure on families to do so, despite the lack of assessment to ensure that moving on from the centre was safe and the lack of available services within supported services to build safety.

Routine practice in supported services seemed consistently inappropriate to deal with other child maltreatment risks identified on referral. In particular, despite taking on

cases which involved a risk of emotional abuse or disclosure of information which could compromise children's physical safety, supported services did not monitor conversations. Where there was evidence of 'inappropriate' conversation occurring, supported services did not necessarily stop contact or report the incident to the referrer, nor did this result in close monitoring of conversations. It can be argued that practice across supported services was also inappropriate in terms of inter-centre communication. Case histories and concerns known to coordinators were not routinely passed on to volunteers in any case study supported service. Therefore, volunteers were not routinely aware of the specific risks in cases and practice was not adapted to manage the specific risks in each case. Therefore, given the cases facilitated by the cases study supported services, it was argued that while some services managed their commitment to protect better than others, none managed it well. Across supported services 'normal work' provided opportunities for abuse to occur in cases in which there were known risk factors for child maltreatment.

The research also contributed an in-depth, up-to-date investigation of how well workers in child contact centres engage with children as part of their commitment to protect. Based on the findings a typology of child engagement was developed which suggested that engagement with children in contact centres could be conceptualised along a spectrum from 'coercive' to 'limited' to 'meaningful'. The finding of, what has been termed, 'coercive' and 'limited' engagement suggests that some individuals working in contact centres are not managing their commitment to listen to children well. Indeed, the child's voice, as a key source of information regarding their safety and well-being, could be ignored or not heard effectively. 'Meaningful' engagement with children in contact centres is likely to be rare given that a minority of centres offer supervised contact and not all of these are staffed by qualified staff with the skills to scaffold children's communication.

Overall, in relation to the first research question, the findings indicate that the suggestion in 'Working Together to Safeguard Children' (2010) that organisations that work with children have a 'commitment' to protect, did not necessarily, in the context of child contact centres, lead to effective management of this commitment. Moreover, problematic practice has persisted despite the reforms introduced by NACCC since Aris and colleagues' (2002) research.

7.1.2 Contribution in relation to the second research question

The second research question asked, ‘What factors seem to influence centres in managing their commitment to protect children from maltreatment?’ The findings suggested that contact centres’ child protection practice was influenced by a myriad of factors. Indeed, ‘Working Together to Safeguard Children’ (2010) was implemented in child contact centres in rich local contexts. The multiple factors in these contexts inevitably combined with the guidance to produce diverse and at times unexpected practice on the ground.

Within the empirical chapters the findings on this question were explored by examining, firstly, the influence on practice of factors within centres, secondly, the influence of inter-professional working on referrals to supported services and thirdly influences relating to engagement with children. As discussed in the Introduction Chapter, the analysis within each chapter focused on exploring the influence of interactions between the multiple interacting layers of the system. This allowed for a non-linear examination of the multiple interacting levels.

In respect of the second research question, the findings as a whole suggest that that key differences in the characteristics of supported and supervised services may influence their respective capacities to protect. These are listed below in Table 7.

Table 7: Supervised and Supported Services: key differences

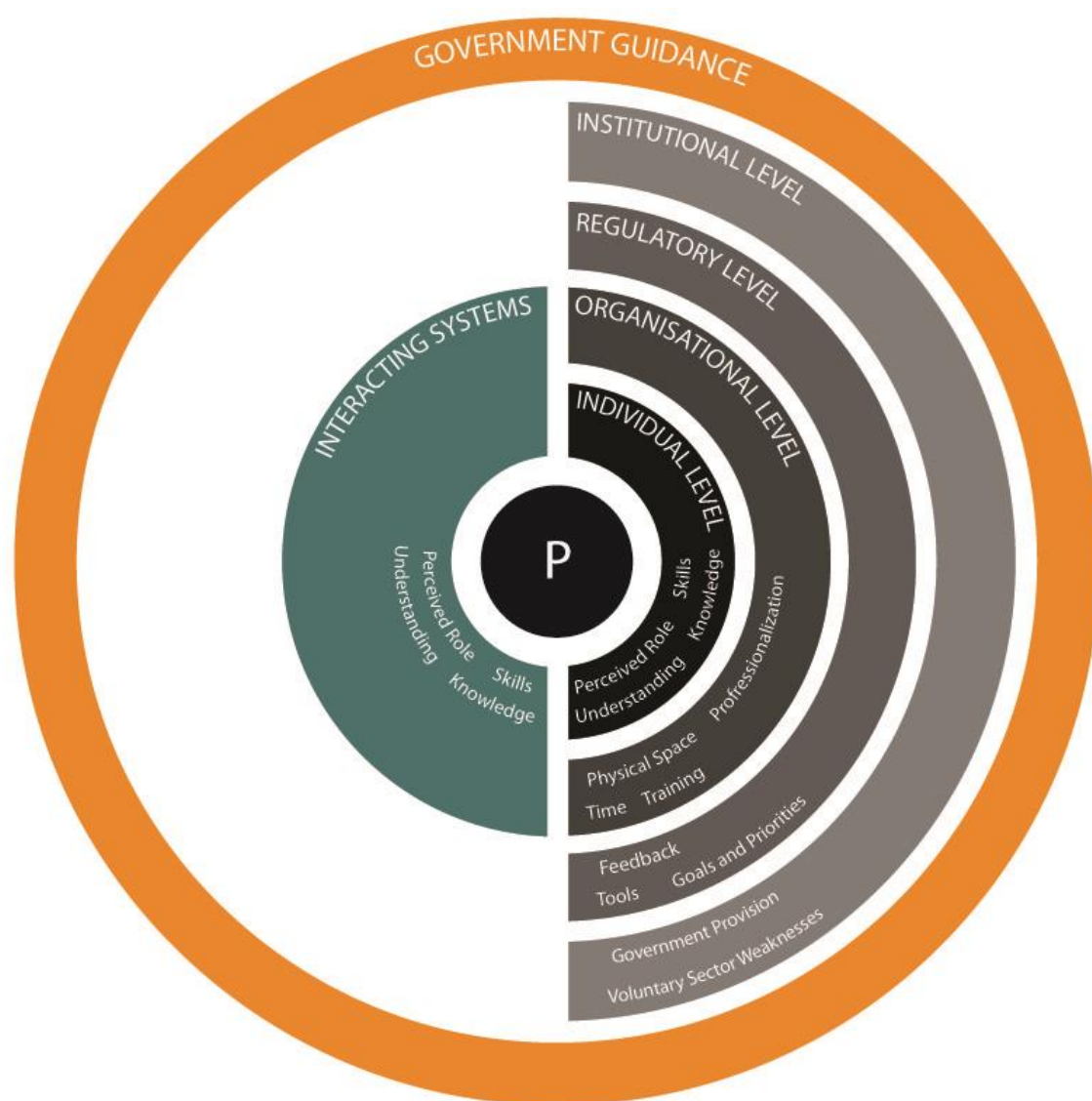
	Supervised services	Supported services
Primary focus	Protecting children from maltreatment	Providing a ‘welcoming’, ‘non-judgemental’, ‘neutral’ contact service
Primary staffing	Paid staff	Volunteers
Annual funding	46% of centres above £10,000, 32% above £50,000	75% below £5000
Reports to referrers	Yes	No (unless there is a significant risk to a child)

As Table 7 suggests, the primary focus of the respective services seemed to influence aspects of practice. The focus influenced whether workers observed families closely, listened into conversation or were routinely informed of the case history. Staffing also seemed an important factor. In supported services, some volunteers were resistant to training given their perception of their role and did not necessarily wish to donate extra time for it. Coordinators who were donating their time also felt burdened by the necessity to follow up referrals and find time to interview families outside of the contact session. Since workers in supervised services were paid, training and specific elements of the work could be implemented without the reliance on voluntary donation of time. The findings further suggested that, on average, supported services existed on lower levels of funding compared to supervised services. Higher levels of funding enabled supervised services to employ paid staff and, in some cases, to provide professional services to build safety. Finally, the provision of reports to referrers in supervised services provided an important means of communication throughout the time cases were facilitated. This ensured an on-going stream of information about the case which could be used by referrers to end contact at any time if concerns emerged. Since this facility did not exist in supported services, there was a reliance on centre coordinators and volunteers to highlight concerns which they subjectively deemed significant.

Table 7 may be helpful from a policy perspective in terms of identifying some key issues which may improve practice in supported services. However, the table does not demonstrate the influence of the interaction of factors within the system which seemed to combine to produce practice. In keeping with the systems approach, the findings from across the empirical chapters are brought together in Figure 11 below to provide a summary in terms of identified influences at various levels within the system. As discussed in the Introduction Chapter, in this graphic, the system itself is surrounded by the government guidance, 'Working Together to Safeguard Children' (2010). In this way the graphic attempts to convey the idea that the various interacting layers of the system mediate between guidance at the top and 'P', practice, on the ground. As also noted in Chapter 1, the systems approach suggests that these factors cannot be understood through a process of reduction; it is their combined, interacting effect which produces practice (Dekker, 2008; Hoffman & Woods, 2000; Reason, 1997). For this reason the analysis does not result in the isolation of a single factor which can be

considered most important from a policy perspective. The findings suggest that interactions at the following levels influence practice in contact centres: the institutional level, the regulatory level, the organisational level, the individual level and the level of interacting (referring) systems. The identified factors and their interactions are summarised within each level of the system.

Figure 12: Factors Influencing Contact Centres' Management of the Commitment to Protect



Starting from the inside of the circle, the graphic illustrates the finding that practice ('P') in contact centres is influenced by factors at the **'individual level'**; the level of

individual workers. This includes workers' skills, knowledge and understanding on issues relevant to child welfare. It was suggested that this influenced workers' capacity to attach evidence-informed meaning to information they encountered in their work. In contrast to previous recent research (Thiara & Gill, 2012), workers' 'local rationalities' were explored directly and in-depth. The findings identified that some contact centre workers held misconceptions surrounding the relative importance of contact, the relevance of past histories of abuse and the capacity of children and babies to have wishes and feelings which are an important source of information for their protection. In addition, it was found that some volunteers felt unable to systematically speak with all children about their wishes and feelings and to take these into account because they did not have the skills, experience or knowledge to do so.

Levels of knowledge, skill and understanding also influenced the capacity of supported services to effectively undertake certain tasks and to engage effectively with the Standard Referral Form. On referral, coordinators of supported services had a limited capacity to effectively collect child protection relevant information from families. Similarly, when coordinators received information about families they had a limited capacity to analyse it and to make evidence-informed decisions as to whether the case could be safely managed by their service and how it should be managed. In addition, the skill level available to the service as a whole constrained the services which could be provided to build safety, including the provision of child and parent counselling, parenting information programmes and DV intervention programmes.

In Chapter 4 it was argued that supported contact service workers' perceptions of their role influenced the meaning they attached to their actions. This issue had not been highlighted in any previous research on contact centres. Thiara and Gill's recent research suggested that volunteers in supported services were 'struggling to properly monitor all the families' (Thiara & Gill, 2012, p. 127) and that 'due to time pressure there was an observable lack of, or limited, information exchange between co-ordinators and volunteers in many centres' (Thiara & Gill, 2012, p. 128). Similarly, the earlier research suggested that information was sometimes 'lost', especially in centres with a high turnover of volunteers (Humphreys & Harrison, 2003b, p. 244). By contrast, examination of workers' local rationalities in the current research suggested that in the case study services, the lax monitoring of families and limited intra-centre

communication as well as the reluctance to judge resident parents, was not a slip or a mistake but was instead intentional and routine.

Based on the findings, it was argued that such practice was based on supported workers' perceived need to be 'welcoming' 'neutral' and 'non-judgemental'. The findings suggested that workers' focus on these aspects of their role could present a 'goal conflict' (Dekker, 2002; Woods et al., 1994) with the work of protecting children since it could lead workers to experience the judgement and authority inherent in the work of child protection as negative or even destructive.

The findings also suggested that across supervised and supported services, contact centre workers had divergent understandings of their role in the system. While some workers believed they had an 'implementation' role others believed they had a 'child-centred' role. This influenced how they listened to children and took their wishes and feelings into account. It was suggested that the perception of a 'implementation' role could present another 'goal conflict' (Dekker, 2002; Woods et al., 1994) for workers since the perceived need to implement a court order conflicts directly with the notion of continuously listening to children and taking account of their wishes and feelings.

However, as the next layer in the circle, the '**organisational level**', illustrates, these individual-level factors did not operate in a vacuum; rather, the findings suggest, factors at the level of the individual worker were influenced by factors at the organisation level. It was argued that workers' skills, knowledge and understanding were likely influenced by the training they had received and the levels of professionalization in centres. Previous research suggested that training amongst volunteers was 'uneven and that there was a strong reliance on shadowing more experienced workers and volunteers rather than attending short courses' (Aris et al., 2002, p. 55). Thiara and Gill's (2012) recent research suggested that DV training remained 'patchy...with many having received little or no training on domestic violence' (Thiara & Gill, 2012, p. 127).

The findings of the current research provided up-to-date, detailed information on broader levels of training and qualifications across supervised and supported services. It was shown that training across the case study centres varied dramatically. In

supported services some workers had received externally provided (by NACCC or other organisations) modules of safeguarding training while others had simply read booklets in their own time and shadowed colleagues; others had just shadowed colleagues. Neither volunteers nor coordinators necessarily had qualifications relevant to child welfare. Even in supervised services, it was found that not all services required workers to have qualifications relevant to child welfare. Prior to supervising a case, some workers had received only a few hours of training provided by a colleague. At the other end of the spectrum, work in Centre 5 was led by qualified social workers and other supervisors were qualified to at least NVQ Level 4 in social care and child development.

In addition to influencing the meaning workers attached to information, the level of training workers had received also seemed to influence role perceptions at the ‘individual level’. Some volunteers did not feel they could speak systematically with children about their wishes and feelings and take these into account in making decisions about the case, because they were not qualified to do so.

However, the findings also emphasise the interaction between the layers of the circle as individual attitudes were also shown to affect whether workers took up training. In addition, some coordinators experienced barriers to training where it was offered in a location a great distance away or at an inconvenient time or where the cost was perceived as problematic. In this sense, the availability of training alone did not determine the level of training workers had received. This may explain why the provision of NACCC training has not led to the universal attainment of that training.

At the organisational level, other factors also influenced the capacity of centres to undertake certain tasks. The findings suggest that in some centres the time allocated to the role of coordinator was not sufficient to account for the time required to undertake pre-visit interviews with families, which often needed to be done outside of the time the centre was open for contact sessions. The significant time required to chase referrers for information relevant to safe referral also placed a strain on coordinators, particularly those working on a voluntary basis. Similarly, at the organisational level, physical space was not always available to undertake certain tasks. Some supported services did not have a suitable, available space to undertake pre-visit interviews. It

must be noted, however, that issues of time and physical space are not absolute but are determined by the goals at an organisational level.

Moving to the third circle from the inside, the **‘regulatory level’**, the findings suggested that the regulatory system exerts an influence on the organisational level and thus on the individual and their practice. The influence of this level in the system had not previously been explored by research on contact centres. It was suggested that the uniform focus across all of the case study supported services on providing a ‘welcoming’ ‘neutral’ and ‘non-judgemental’ service may emanate from the original purpose of child contact centres when they were set up but it is enshrined in the definition of supported services in the NACCC ‘Definitions of Levels of Contact’. It was suggested therefore that this guidance itself may sustain the goal conflict for supported services; certainly it has not challenged it. In so doing, this NACCC guidance may undermine the capacity of workers to embrace the authority and judgement which is necessary to the work of child protection.

The National Standards and associated accreditation system also determined some of the tools used by contact centres. These were developed by NACCC with Cafcass (NACCC, 2011, p. 7). The influence of these tools, introduced since Aris and colleagues’ (2002) research was not explored in Thiara and Gill’s (2012) recent study. In keeping with the systems approach’s conceptualisation of tools, the current research placed particular focus on supported services’ use of the Standard Referral Form, which is required as a criterion of accreditation. In addition, it drew attention to the influence of the Protocols for Referral which have been developed at the regulatory level by NACCC with the Office of the President of the Family Division and the Law Society. The findings, presented in Chapter 5, suggest that actors in the system have not been enabled to undertake the work required to use the Standard Referral Form effectively and roles in the system are ambiguous. For this reason the Form does not in itself enable actors to make safe referrals. Moreover the Form can make practice more dangerous by providing a false sense of security. Some referrers falsely believed that because centres were collecting information about families through the use of this form, they were using that information to make decisions about contact. It was argued that this is in part a fault of the feedback system which has been adopted at the regulatory level. As demonstrated in the first empirical chapter, the indicators used in

the National Standards are not sufficiently sensitive to pick up on problems occurring in the system and so the system has no means to routinely identify problematic practice and adapt accordingly.

The outermost circle in the graphic, the '**institutional level**', represents the framework of the argument presented in Chapter 4. Here it was suggested that some problems experienced in child contact centres can be positioned as relating to the dynamic between government provision for contact centres and voluntary sector weaknesses. It was argued that problematic practice can be positioned, to some extent, as a product of three common weaknesses in voluntary sector provision: insufficient funding, insufficient professionalization and narrow organisational focus (Salamon, 1987). Although the state has sought to address these weaknesses by entering into a relationship with contact centres in which it provides an important level of funding, it was suggested that it has not fully addressed these voluntary weaknesses and as a result, problems persist.

The findings suggested that the funding available is insufficient to ensure that families requiring supervised contact can access the service. The data demonstrated large geographical gaps in the provision of supervised services and that families must often pay fees to access a supervised service. The latter issue has not been previously identified in research. Interviews with referrers demonstrated that both of these factors acted as an access barrier to supervised services. The findings suggest that these funding related issues affect some referrers' local rationalities, influencing them to refer cases involving child protection concerns to supported services, which are easier to access, but cannot safely manage child protection issues.

Relatedly, it was suggested that the levels of professionalization, identified at the organisational level, are at least in part, constrained by the funding available to the service. The service as a whole operates on a very low level of funding which relies on volunteerism. Finally, in keeping with Aris and colleagues (2002) argument, it was argued that the goals and priorities identified at the organisational level are influenced by the voluntary sector origins of the service, which began by narrowly focusing on providing a service for families who were not experiencing child protection issues. It was suggested that although the state has entered into a 'third party government'

(Salamon, 1987) relationship with centres, the focus of the service has not expanded sufficiently to address the high level of child protection concerns in the service-user population.

Finally, the smaller circle on the left of the graphic represents the influence of **‘interacting systems’** on child contact centres’ management of their commitment to protect children. It was suggested that child contact centres are a highly ‘coupled’ (Perrow, 1984) system and so practice in them is influenced by interactions with actors in systems which refer to them. In keeping with research in other organisational contexts, the findings illustrate the potential for problems to occur in the process of inter-professional working (Fish et al., 2008; Munro, 1999; Reder & Duncan, 2003, 2004).

In Chapter 6, the findings demonstrated that ambiguity surrounding children’s best interest and children’s capacity to have ‘valid’ wishes and feelings was not only located in contact centres. Rather the ambiguity could be identified amongst referring judges, solicitors and social workers. This suggests that these issues are unclear at a system level. Similarly, divergent understandings of the role of contact centres, as either ‘implementation-focused’ or ‘child-focused’, were not confined to contact centres; referrers exhibited similarly disparate understandings, suggesting that the role of contact centres in the system is also unclear.

The research further explored how issues of inter-professional working affect the work of child contact centres by focusing on the use of the Standard Referral Form in supported services. The findings suggested that cases inappropriate to supported services continue to be facilitated at these services due to problems in inter-professional working, which relate not just to contact centres, but to the interaction between contact centres and other professionals. It was argued that the form is not user-centred (Norman, 1993) since it does not take account of the context in which it is being used. It was found that while (as discussed above) contact centres do not have the skills, understanding or knowledge of child welfare to undertake the work of collecting information, analysing it and making evidence-based decisions about it, neither do some referrers. Referrers and centres experienced ambiguity surrounding their roles, suggesting that these roles are also unclear in the wider system. In addition,

it was found that while the definitions of supported and supervised contact seem clearer since Aris and colleagues' (2002) research, misunderstandings concerning the work of contact centres remain amongst some referrers and could lead some to refer to services inappropriate to their case.

7.2 Limitations of the research

The limitations of the research were discussed in detail in the Methodology section (Chapter 2, section 2.4). They remain important in considering both the findings, discussed above, and the implications of the study, discussed below. In particular, it is important to note that further issues may be identified by additional research, particularly research which would expand the scope of this study. It should also be noted that much of this research relies on qualitative data. These data generalise to theory rather than to populations and so should not be considered statistically representative. Exact quantification of some issues is not possible through the methodology adopted. Nonetheless, the linking of various issues (for example, levels of volunteerism, funding and service charges) to quantitative data has provided some indication of potential frequency of some issues.

7.3 Implications of the findings

7.3.1 Policy implications

7.3.1.1 The limits of top-down guidance

The findings presented above suggest that in the empirical context of child contact centres, the 'Working Together' (2010) guidance to organisations working with children does not itself produce predictable effects which will fulfil the guidance aims. Nor does the additional guidance provided to contact centres by NACCC in the form of the National Standards, Definitions of Contact and Protocols for Referral. Overall, these findings suggest that the work of protecting children is socially constructed. In other words, the meaning people attach to the work of protecting children is not fixed or inevitable. Rather the reality people experience is created through individuals'

environment, experiences and interactions (Garland, 2003; Hacking, 1999). For this reason, when guidance combines with local factors it produces unexpected effects. In other words, guidance is mediated by the context into which it is implemented. In this sense, the findings contribute to the body of systems literature which suggests the limits of top-down guidance in achieving the desired level of practice (Chapman, 2004; Dekker, 2007a; Helmreich, 2000; Munro, 2005a, 2011; Reason, 1997; Vaughan, 1998; Wallace & Ross, 2006). It can be argued that the implication of this is that policy makers need to focus, not simply on telling organisations what to do, but also on enabling them to do it (Cook et al., 1998; Dekker, 2005; Dekker, 2008; Fish et al., 2009; Helmreich, 2000; Hoffman & Woods, 2000; Rasmussen, 2003; Reason, 1990, 1997, 2000; Woods & Cook, 2002; Woods & Hollnagel, 2006). In conjunction with evidence from other organisational contexts, the findings provide some more specific tentative policy implications. These are discussed below.

7.3.1.2 The need to recognise the cognitive and emotional dimensions of the work

The findings contribute to the body of literature which suggests that the work of protecting children from maltreatment is not simply a mechanical or a procedural task, but an emotional and cognitive one (Cooper, 1992; Dingwall et al., 1983; Munro, 1999, 2011; Reder & Duncan, 2003). People therefore need to be enabled to deal with the emotional and cognitive aspects of the work.

In terms of the cognitive aspect, certain elements of the work of child contact centres would seem to require a degree of knowledge, skill and experience in the area of child welfare which is in keeping with the attainment of a social work or equivalent qualification. As demonstrated, contact centres cannot rely on referrers to effectively undertake the work required to manage referrals safely. It was suggested that that work involves effectively collecting information, analysing that information and making an evidence-informed decision about it. Therefore, centres require an appropriately skilled, knowledgeable and experienced individual who can collect information about families (including systematically assessing the wishes and feelings of each child), analyse that information and come to evidence-informed decisions about whether the particular service offered by that contact centre can manage the case and how the centre should do so. It could also be argued that since all risk assessments are fallible

and should be on-going (Munro, 2008, p. 94), centres require appropriately knowledgeable, experienced and skilled practitioners who will continuously assess cases which are referred to centres.

At the most basic level, the findings suggest that the current level of understanding of child welfare amongst some volunteers in supported services is inadequate. It would seem that further training is required to address the misconceptions identified amongst some volunteers in supported services. This includes misconceptions surrounding the relevance of accusations or evidence of previous histories of intimate partner abuse, the relevance of children's wishes and feelings and the relative importance of contact. However, the findings also imply the limitations of simply making training available to volunteers. It was found that some volunteers were resistant to training as they viewed it as unnecessary given their perception of their role and that some volunteers may not wish to spend extra time attending training. In addition, the data indicated that some coordinators experienced practical barriers to accessing training. These findings suggest that policy makers cannot assume that the availability of training will necessarily ensure uptake and the attainment of the appropriate level of understanding/knowledge. Indeed, the level of commitment and time required to attain an appropriate level of training may be above that which some volunteers are willing to donate. In this sense, increased training may require the remuneration of staff. In addition, given that coordinators of some supported services were struggling to find the time to undertake pre-visits and to chase referrers, the level of time required for coordinators/managers of contact centres to effectively undertake the work involved in referrals may be beyond that which volunteers are able or willing to donate.

Overall, the findings suggest that at the regulatory level, thought needs to be given to the level of training required to do this work, in both supervised and supported services. While the National Standards suggest that workers should be trained, there is no specification of the level of training that is required. In the absence of any regulation in this regard, levels of training amongst workers in both supervised and supported services are likely to continue to vary, based on factors at the level of individual centres.

The findings also contribute to the body of research which suggests that there is a need for policy makers to recognise the emotional aspect of the work of protecting children (Cooper, 1992; Dingwall et al., 1983; Munro, 1999): the work of protecting children can generate anxiety, which may influence the meaning workers attach to their actions. Indeed, the anxiety workers in supported services articulated concerning actions which might jeopardise the ‘welcoming’, ‘neutral’ and ‘non-judgemental’ environment they sought to create, suggests the need to empower those working with children to deal with the inherent judgment and authority involved in the process of protecting children. In addition the findings of this research suggest policy makers also need to consider how other (perceived) goals may present a conflict with the work of protecting children. Since these conflicting goals can be socially constructed, policy makers need to begin by seeking to understand how workers perceive and negotiate their role within the organisational and system-wide context.

7.3.1.3 Conceptualisations of children

The findings imply a need for policy makers to clarify some specific ambiguities and misunderstanding, which seem to permeate the work of some contact centre workers and some referrers. It seems there is a pressing need to emphasise the capacity of children and babies of all ages to have and articulate (behaviourally and verbally) wishes and feelings, which are important in terms of their safety and well-being. A large body of research supports this position (Alderson, 2008; Gollop et al., 2000; Hart, 1992; Kaltenborn, 2001; Smart, 2002; Willow, 2002). It also seems necessary to ensure that all contact centre workers and referrers are aware of the evidence which strongly suggests that it cannot be assumed that contact with a non-resident parent is in the best interest of all children (Amato & Gilbreth, 1999; Dunn, 2004; Hunt & Roberts, 2004; Lamb, 2007). In addition, there is a need to emphasise the difficulties in identifying abuse and child protection concerns and the challenges of eliciting disclosure (Aris et al., 2002; Gilbert, Kemp, et al., 2009; Kelly & Radford, 1996; Robinson & Moloney, 2010; Stanley et al., 2012). This underlies the need for all professionals to remain vigilant to evidence of abuse and to take signs of maltreatment seriously when they encounter them.

7.3.1.4 Tools

In keeping with the findings of research in other contexts, the research findings presented in this thesis imply that policy makers must take account of the local context into which tools are introduced (Hall & Slembrouck, 2009; Horwath, 2002; Munro, 1998, 1999, 2005b; Peckover et al., 2009; Reder & Duncan, 2003, 2004; Reder et al., 1993; White et al., 2009). Tools are not a panacea. In the context of child contact centres, a high level of professional training as well as experience is required to effectively undertake each stage of the referral process; tools cannot be used to replace expertise (Gillingham & Humphreys, 2010; Horwath, 2002; Munro, 2005b). Indeed, the findings suggest the need for policy makers to study the effects of any tools introduced, since tools have the potential to make practice less (as well as more) safe; in the case of contact centres by creating a false sense of security.

7.3.1.5 Empowerment at the system level

In a number of respects, this research suggests that problematic management of the commitment to protect cannot be addressed through measures in contact centres alone. The misunderstandings and ambiguities surrounding child welfare, identified amongst some contact centre workers, were mirrored amongst some referrers. In addition, the findings suggested that the role of contact centres is ambiguous not just amongst contact centre workers, but in the wider system. By implication it would seem that these issues need to be clarified not just in contact centres but within the wider system.

More specifically, there is a need for policy makers to critically evaluate the role of contact centres within the wider system, from a child protection perspective. In addition, the role of resident parents needs to be clarified and subject to critique. As discussed in Chapter 6, the notion of an ‘implementation role’ for contact centres is problematic from a child protection perspective. On a fundamental level, given the fallibility of assessment and the need to continuously listen to children, any assessment of cases should be on-going rather than a one off (Munro, 2008, p. 94). This research has argued that contact centres need to be enabled to adopt a ‘child-focused’ role. The case study of Centre 5, the supervised-only service would seem to provide a helpful example of a ‘child-centred’ service which could be used as a model.

Overall, based on these findings, it can be argued that the system as a whole takes insufficient account of safety in child contact cases. This is reflected in the failure to locate clear responsibility within the system for key safeguarding processes. This includes failure to ensure clear responsibility within the referral process for the collection of safeguarding information, analysis of that information and decision making on how the case should be managed. There is also systematic failure to locate responsibility for meaningful engagement with children, in order to ensure that their wishes and feelings are heard. The persistent conceptualisation of mothers who object to contact as ‘implacably hostile’, regardless of their reasons for objecting, is symptomatic of on-going disregard amongst some centre workers for the strong body of evidence which emphasises the link between child abuse and inter-partner abuse. In addition, the finding that some referrers and contact centre workers question the need to engage meaningfully with children underlies a worrying devaluation of children’s voices, which are a valuable source of evidence on children’s safety and well-being. It is also a violation of children’s rights under Article 12 of the UNCRC (1989). Finally, the finding that in supported services, lax monitoring of families, limited intra-centre communication of safeguarding issues and reluctance to judge non-resident parents was not a slip or mistake, but was instead intended practice, emphasises that safety is not a priority in supported services. It can be argued, that this systematic under-valuing of safety in the system of child contact centres serves a functional purpose: it maintains the status quo, in which the service as a whole remains a low-cost, volunteer-led service, which does not demand significant public funds. The cost, it would seem, is instead placed on non-resident parents and children using the service, who are routinely placed at risk of harm in some services.

7.3.1.5 Feedback for learning

The findings also imply that child contact centres suffer from an inadequate system of feedback for learning. Since the NACCC accreditation system, based on the National Standards, is not sufficiently sensitive to pick up on problematic practice or its causes, there is no means by which the system can identify problems with a view to adapting to address the inevitable ‘drift towards failure’ (Dekker, 2008; Woods & Cook, 2002). Indeed, there is no means for actors in the system to learn about the implications of their actions (or inactions) for other parts of the system. This inadequate feedback

sustained the role ambiguities for both centres and referrers. It also contributed to gaps in the child protection net, where important aspects of practice, unbeknown to parts of the system relying on them, were omitted or inadequately undertaken.

The human safety literature suggests that an alternative system of feedback for learning is required which continues to observe, reflect, create and act to maintain safety (Reason, 1997). Such a system would monitor the effects of any changes introduced to the system, rather than assuming that the response to them will be positive or neutral.

7.3.1.6 The institutional position of child contact centres

Ultimately, implementation of the policy implications outlined above cannot be undertaken by contact centres alone. At a fundamental level, the findings suggest that increased access to supervised services is required, if cases are to be appropriately facilitated. Given the stark difference in funding required for supervised compared to supported services, this would require a substantial increase in funding to establish these services. The findings also seem to imply that the current policy of part funding supervised services through fees at the point of delivery is incompatible with the aim of protecting children since the evidence suggests that these fees present a significant barrier to the ability of families to access the service. In this sense, it can be argued that increased state funding is required to ensure that families can access supervised services on the basis of need rather than on the basis of affordability to individual families.

Given the problems in levying fees it is also difficult to see how the voluntary or private sectors could establish the increase in funding required to ensure that services are staffed by appropriately trained and qualified staff and that these staff are available for sufficient time to undertake all aspects of the work required. Similarly funding would be required to establish more services in contact centres to build safety and to introduce changes to the accreditation system to enable a meaningful system of feedback for learning. Without such funding, it seems unlikely that any changes in the regulations surrounding required training for contact centre staff could be implemented.

7.3.1.7 Implications for recent policy developments

Since the fieldwork for this research was undertaken, NACCC has been piloting a new referral system for self-referred cases. The focus on self-referred cases has been adopted against the backdrop of recent changes to Free Legal Aid (FLA).²⁰ NACCC believes that these changes will increase the number of self-referrals to contact centres as families are diverted from the Family Justice System due to the restrictions on eligibility for funding.

Under the new referral system, a self-referring non-resident parent who wishes to access a supported service will fill in an online referral form. This will be emailed to the self-referring resident parent who will check the information and fill out their own form. If no safety/welfare concerns are raised, the case will go straight to a supported centre. However, if safety/welfare issues are raised the case will go to a 'hub'. The 'hub' is staffed by qualified social workers who will speak with both parents on the phone to ascertain further details. Based on this information, the social worker will make an assessment of the case and send it to a contact service. The contact centre can still at this point, choose to accept or reject the case. In December 2013 the pilot was operating in 21 centres and the 'hub' was staffed by six social workers.²¹

The findings of the current research suggest that if this pilot were expanded to include all contact centres, it may have the potential to improve the appropriateness of the case load in supported services, in some respects. Where parents identify a safety/welfare issue, this system presents the opportunity for some assessment by a qualified social worker to occur. However, there are a number of limitations to the new system. Firstly, the system currently only caters for self-referrals and so does not address the referral problems identified in this research in relation to cases referred through third parties. While cases referred by the courts, solicitors and Cafcass may decrease, they will not disappear. It is difficult to predict the impact of the changes in Legal Aid on cases

²⁰ These changes came into force on 1st April 2013 and are governed by the Legal Aid, Sentencing and Punishment of Offenders Act (LASPO) (2012). Under the act most private law services are only available to the victims of domestic violence. In order to be entitled to legal aid, the client has to produce 'trigger evidence' proving that they are a victim of abuse.

²¹ Personal communication with senior NACCC representative, December 2013.

referred to contact centres. Nonetheless, current research provides some useful indicators. Hunt and Macleod's (2008) research suggested that 52% of all parties in contact applications were legally aided. Based on this the changes to Legal Aid will have no effect on around 48% of litigating families. Moreover, some of those who previously received Legal Aid will still be eligible to receive it.

Secondly, the changes to the Family Justice System may also simply relocate referral problems to a different group of professionals. Due to the reforms (Ministry of Justice, 2011), NACCC expects an increase in referrals from family mediation services (NACCC, Spring 2013). However, research has raised concerns about the capacity of mediators to effectively screen for issues relevant to child protection (Greatbatch & Dingwall, 1999; P. Morris, 2013; Trinder et al., 2011). Moreover, like solicitors, mediators do not have access to safeguarding checks with local authorities and police.

Thirdly, under the new system, there remain limitations to the way information is collected. Fundamentally the system relies entirely on parents to raise concerns through a brief, once-off, single method screen i.e. an online questionnaire. However, as previously discussed, research suggests that there are real challenges to disclosure of information relevant to child protection (Aris et al., 2002; Gilbert, Kemp, et al., 2009; Kelly & Radford, 1996; Robinson & Moloney, 2010; Stanley et al., 2012). It seems that this is particularly the case where screening is brief and involves only a single method, rather than adopting an ongoing and holistic approach (Munro, 2008; Robinson & Moloney, 2010). Indeed, as previously discussed, research examining the C1A and C100 forms, used by the family justice system to screen cases seeking a court order, found that in the study's sample, a third of applicants in 'no-harm' cases in fact had convictions or cautions relevant to child protection (Aris & Harrison, 2007). Similarly, Trinder's (2011) study drew its sample on these apparent 'no harm' cases but found they included a significant minority of safety issues: 20% of mothers reported that there had been a non-molestation or occupation order at some point, including 10% with a current order in place. Such evidence would seem to suggest that this form of one-off, paper-based screening is ineffective even in screening out cases involving already established evidence of safety concerns. Importantly, the new referral system also fails to provide any means for children's wishes and feelings to be heard or taken into account. Indeed, children seem to be entirely overlooked as a

source of important information on whether they are being or are at risk of being maltreated (Horwath, 2002; Munro, 2011, p. 39; Willow, 2002).

Where concerns are identified under the new system, interviews over the phone, rather than in person may present a more limited means of assessment compared to in-person interviews. In particular, phone calls may not be sufficient to build a trusting relationship and parents may not feel safe disclosing further information over the phone (Trinder et al., 2011). Again, at this point, children's voices are not included in the assessment and the assessment system remains a one-off process, despite the research, cited above, suggesting the limitations of this approach.

Fundamentally, the new system of referral does not address the lack of access to supervised services, which are not due to receive additional funding or changes to the fee-based system. In the absence of increased access to supervised services, the limited access to appropriate services to facilitate these cases will remain. The dilemma will therefore remain for centres, referrers and for social workers managing self-referred cases through the 'hub': they will have to decide either that the case cannot be facilitated at a contact centre (which may lead to no contact or to less safe contact) or that the case will be facilitated at a supported service which is inappropriate to the case. Ultimately, this new system is therefore unlikely to fully address the problems centres experience in appropriately managing cases on referral.

Since the fieldwork there have also been changes to the training provided by NACCC to centres. Previously centres could purchase modules of training (including safeguarding training) from NACCC for £50 per module. The modules are delivered by centre coordinators/managers. These training modules are now free to supported services. However, these measures do not address barriers to training identified in this research including, the time required to do it and negative attitudes towards training from some volunteers. Moreover, the reliance on coordinators to cascade training may be misplaced, given the misconception some (though not all) coordinators had on issues of child welfare. Moreover, the level of training remains relatively informal, at a level below professional qualifications.

7.3.2 Implications for systems approach and research

The findings also present some implications for systems approach and for research. The findings suggest the need for research to investigate how top-down guidance, including the ‘Working Together’ guidance, combines with factors in other organisational contexts to produce particular (potentially unexpected and unwanted) effects. In addition, it emphasises the need for further research to investigate what factors may influence individuals in other organisational contexts in managing their commitment to protect.

The use of a systems approach in this research contributes to the systems literature which has highlighted areas which, it can be argued, should be the focus of future research into child welfare and safety in other contexts. This included the need to begin research into safety by seeking an in-depth understanding of what constitutes ‘normal work’ (Dekker, 2008; Rasmussen & Svedung, 2000) in the organisational context under investigation. As the findings in Chapter 3 demonstrated, indirect indicators of practice can be misleading and so there is a need for direct observation of practice.

Secondly, the research highlights the importance of seeking to establish workers’ ‘local rationalities’ (Woods et al., 1994). This research provides further substantiation to the systems contention that people do not usually come to work to do a bad job. Rather people usually do what they do because they believe it is the right course of action, given their local perspective (Dekker, 2002; Reason, 1997; Woods et al., 1994). In the absence of research which seeks to establish a thorough understanding of how actions made sense to actors on the ground, research findings risk falling into the positivist fallacy that the work of protecting children will be experienced in the same way by everyone. This risks missing the goal conflicts, misperceptions, resource limitations etcetera on which actors’ experiences and understandings may be built. Thereby it risks telling actors what to do without understanding the potential barriers to them doing so.

The research also contributes to the systems literature which emphasises that reforms and tools introduced into the system should not be viewed as neutral or assumed to

have positive effects (Dekker, 2008; Hoffman & Woods, 2000; Hollnagel, 2003; J. R. Wilson et al., 2003; Woods & Cook, 1999). In this research, investigation of the Standard Referral Form, Protocols for Referral and Definitions of Levels of Contact demonstrated how these reforms and tools can in themselves influence practice in unexpected and, at times, unwanted ways. The findings imply that reforms and tools should themselves be the subject of investigation, with research seeking to understand how these influence factors on the ground. In this regard, research should be designed to be open to potentially unexpected effects. The findings in relation to problems in interaction between the Standard Referral form and its users further contribute to the systems literature which highlights the importance of investigating, not simply how well people use tools, but how well actors and tools interact (Hoffman & Woods, 2000; Hollnagel, 2003; Woods & Hollnagel, 2006). This is an important conceptual re-framing which moves research away from the unsubstantiated assumption that the problem lies solely with the user.

In the current research, the examination of the accreditation system, as the available feedback mechanism, provided a deeper understanding of how actors in the system can retain misperceptions concerning the work of other parts of the system. This is a key aspect of understanding 'local rationalities' across the system and appreciating the availability of mechanisms to enable the system to learn and adapt. This finding substantiates the systems position that research into safety should examine the mechanisms available to the system to gain feedback for the purpose of learning (Dekker, 2008; Reason, 1997; Woods & Cook, 2002).

Finally, this research provides support to the overall systems approach of focusing on the 'whole' and simplifying for the purpose of understanding by abstracting up rather than reducing the system down to the sum of its parts (Dekker, 2008; Hoffman & Woods, 2000; Reason, 1997). Indeed, in the current research the focus on interactions between referrers and centre workers (rather than on these groups in and of themselves) was key to revealing the mismatched role perceptions which contributed to problematic practice. In addition, the focus on abstraction in this research led to the positioning of problematic practice in contact centres within the context of the institutional position of the service and its relationship with the state. While this

argument rests, to some extent on the theoretical literature, it provides a new way of looking at the issues, which hopefully contributes a more nuanced understanding.

7.4 Conclusions

This research suggests that in the empirical context of child contact centres, the 'Working Together' (2010) guidance to organisations that work with children does not in itself produce predictable effects which will fulfil the guidance aims. Rather, when the guidance combines with local factors it produces unexpected effects. The findings contribute to the growing body of research which argues that policy makers need to focus not simply on telling organisations what to do, but on enabling them to do it. In addition, the findings contribute to the systems approach literature, which suggests that safety needs to be understood within the socio-technical system that actors inhabit.

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Appendix 1.1: NACCC National Standards

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Appendix 1.2: NACCC Definitions of Levels of Contact

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Appendix 1.3: Protocols for Referral

1.3.1 Protocol for Referral by solicitors

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1.3.2 Protocol for referral by judges

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Appendix 2.1: Interview guide

coordinators/volunteers supported services

Introduction: Before we start, I just want to mention a few things.

SOUND RECORDING CONSENT

- Firstly there are no right or wrong answers to any of my questions; I am interested in understanding, as best I can your opinions, experiences and interpretations. I want to see the contact centre and the work you do through your eyes.
- Secondly, you are under no obligation to answer any of my questions; you can end the interview at any time and can decide not to answer any question.
- Everything will be reported anonymously. When I report the findings of the study I will never use your name or the name of the contact centre and any information that could identify you will be removed.
- Finally, I am very interested in hearing about examples you can give me of experiences you have had with families but it is important that we protect their confidentiality so please do remember throughout not to mention family member's full names to me.

Are there any questions?

Background

- Could you tell me a bit about how the centre came to be set up?
 - What were the aims at that time?
 - Why was it needed?
 - Who was involved?
 - How did you become involved?

Change

- Has anything changed in that time in terms of your aims?
 - What are your aims today?
 - Is protecting child part of what you do or is that outside your responsibilities?
 - What are you protecting them from?
- Has anything changed in the way that the centre is run?
 - The rules you follow?
 - Your responsibilities?
- How do you feel about those changes?

Accreditation [Coordinators only]

- When did you become a member of NACCC and how have you found being a member of the National Association?
 - How do you feel about the process of reaccreditation?
 - Is it practically easy to fulfil all of the criteria for accreditation?
 - Do you receive enough support to fulfil all of the things you are meant to do? Is anything difficult?

Their role:

- Could you tell me a bit about your role in the centre?
 - What are your responsibilities as coordinator?

- How often do you volunteer at the centre?
- How many other hours per week do you put in?
- How do you feel about the voluntary nature of most supported child contact centre services?
- How many volunteers do you have? **[Coordinators only]**
 - How often do they volunteer?
 - Do you have sufficient volunteers?
 - Has this changed over time?

Training:

- I am interested in the support that contact centres receive. Have you [and the volunteers at your centre] had training to support you in your role from NACCC or other organisations?
 - What was the training on?
 - When was it?
 - How long did it take?
 - Was it booklets or a course?
- Have you done safeguarding/child protection training?
 - Who delivered the training?
 - How did you find it?
 - When did you do it for the first time?
 - When was the last time you did it?
 - Who did it?
- How easy or difficult is it to access training?
 - Do you pay for it?
- Is there any other training that you would like to have?

Necessity of centre

I'd like to talk a bit about the cases you deal with as a centre and discuss why families need a contact centre

- In your experience, why do families need the centre?

- Could you tell me about the families you have at the moment or in the last year and explain why they needed a contact centre?

[If mentioned]

- In the cases where parents are in conflict and the resident parent doesn't want to see their ex-partner, why is this?
- Do you have cases where the resident parent finds it difficult to trust the non-resident parent?
- why is this?
 - How frequently is domestic abuse an issue?
 - Physical, psychological, sexual?
- Do parents ever have convictions?
- Are there ever accusations of or proven cases of child abuse whether emotional, physical or sexual?
- Do parents or children ever have mental health problems that affect their parenting?
 - What kind of cases do you deal with in this regard?
- Do parents ever have drug or alcohol misuse problems?
- Is there ever a risk of abduction?
- Which cases are the most common, which cases do you only see occasionally?

Experience of cases

- How have you found dealing with these different types of cases?
- Have any cases in the past few years been particularly difficult to deal with?
 - why? What were the circumstances?
- Have you ever had to ask a family to leave the centre?
 - why? What were the circumstances?
 - how often does this happen?

- Have you ever been concerned about your own safety or that of the volunteers or families?
 - what were the circumstances?
- Are there particular types of cases that you have found the centre works very well for?
 - Which? Why?
 - Could you tell me about some cases where you have found the centre worked well for families?

Referral [Coordinators only]

I'm interested in the way that the referral process works and how this affects contact centres. I'd like to talk a bit about this.

Solicitors [Coordinators only]

- Could you tell me about how the referral process works, maybe starting with when a solicitor has a case that he would like to send to your centre, what happens from here?
 - Do they fill in the referral form?
 - What information do they put on this?
 - Do they need to tell you all of the information about the case?
 - Is there anything you don't need to know? What is this?
 - Do they always include all of the relevant information?
 - If not: why not, in your opinion?
 - How does this affect the centre?
 - How could this problem be solved?
 - Do they always tell you if Cafcass or social services have been involved in the case?
 - Do you always get a copy of the court order?
 - Do you then get to also speak to Cafcass or social services? What do they tell you?

- Whose responsibility is it to find out the background to the case, for example to establish if there has been domestic abuse or a concern about child maltreatment? Is it the referrers responsibility or the centres'?

Cafcass **[Coordinators only]**

- Do Cafcass Officers ever refer directly to you centre? (without a solicitor)
- How often are Cafcass Officers involved in the cases that are referred to your centre?
 - Why are Cafcass involved only in some cases referred from the courts?
 - What difference does it make to your work having Cafcass involved?
 - Do they help with referral? Deciding the appropriateness of the case to the centre? Moving on?
 - Do you always know when a Cafcass Officer is involved?
 - Do they pass on information to you about the family? All of the information? Anything they don't pass on?
 - Do you always get the Cafcass report?

Social services **[Coordinators only]**

- How often do social services refer cases to the centre?
 - What difference does it make to your work having Social Services involved?
 - Do they help with referral? Deciding the appropriateness of the case to the centre? Moving on?
 - Do you always know when a Cafcass Officer is involved?
 - Do they pass on information to you about the family? All of the information? Anything they don't pass on?

Inappropriate cases **[Coordinators only]**

- Do you ever come under pressure to take on cases that you feel a bit uncomfortable taking on?

- Examples of cases?
- Who referred?
- Why are they referred to you?
- Did you accept? Why?
- Are cases that you feel should be referred to a supervised centre ever referred to your centre instead?
 - Why?
 - Who refers them?
 - Where is the nearest supervised centre?
 - Can parents afford it?

Self-referral [Coordinators only]

- You take on some self-referral cases, could you tell me about how referral works for this?
 - do they fill in a form?
 - do an interview?
 - who does an interview? Mum, dad, child? Separately?
 - What questions do you ask?
 - do you ask all families if there has been domestic violence or worry about the child?
 - What do you need to find out in this interview?
 - Are there any practical problems with the centre being responsible for doing these interviews?
 - why do you take on self-referrals?
 - Are many cases self-referrals?

Interviews [Coordinators only]

- In general, do all families referred through a solicitor etc do an interviews?
 - What is the purpose of the interview?

- What questions do you ask?

Refusing Cases **[Coordinators only]**

- Does the centre ever refuse cases?

YES:

- Which cases?
- Why?

NO:

- What is the thinking behind never refusing a case?
- Where do you think does this ethos come from?

Intervention

- Would you ever intervene between a parent and child?

YES:

- In what circumstances?
- Why?
- What would you do in each case?
- Supported centres are different from supervised centres in that supported centres don't monitor conversations between children and parents. What is the thinking behind this?

- Could you give me an example of a time you intervened?

- What were the circumstances?
- How did you intervene?
- What was the result?

NO:

- What is the thinking behind not intervening?

- How much do the volunteers know about the background to each cases?
 - What information do they need to know/not need to know?
 - Why?

Thresholds

- Have you ever been concerned for a child and considered reporting your concerns to children's services?
 - What made you suspect?
 - What did you do? Did you report it? To who? Why?
 - What was the result?
 - Did you get support from NACCC? In what way?
 - (If didn't report) why not?
- In what circumstances would you feel it necessary to report a case to children's services?
- Has a non-resident parent ever told you they suspect the child is being abused/neglected at home? How did/would you deal with this?

Children's decision making:

- In your opinion, how important is it for children to have contact with their parents? Why?
- Are there any circumstances where children should not have contact? What are these? Why?
- Should children have a say in decisions about their contact?
 - Why?
 - Are children competent to be involved in decision making?
 - [If say dependent on age] what age?
- What happens when a child doesn't want to have contact?

- When this happens, why, in your experience, does it happen?

Moving on

- Could you tell me about moving families on-either to supported contact (where centre is supervised) or to independent contact? How does this work?
 - When is it appropriate for a family to move on?
 - What factors need to be taken into account?
 - Is space at the centre ever a factor?
 - How is the decision made?
 - Who makes the decisions?
 - Could you give me an example of a recent case that has moved on from the centre?

Support [Coordinators only]

I'd like to understand more about the support that contact centres get.

- What is your experience of funding?
- How well are you supported by NACCC?
- How important is NACCC to your work?

Wind down

- Is there anything I haven't asked about that you think is important?

Appendix 2.2: Interview guide managers supervised services and both services

Introduction: Before we start, I just want to mention a few things.

SOUND RECORDING CONSENT

- Firstly there are no right or wrong answers to any of my questions; I am interested in understanding, as best I can your opinions, experiences and interpretations. I want to see the contact centre and the work you do through your eyes.
- Secondly, you are under no obligation to answer any of my questions; you can end the interview at any time and can decide not to answer any question.
- Everything will be reported anonymously. When I report the findings of the study I will never use your name or the name of the contact centre and any information that could identify you will be removed.
- Finally, I am very interested in hearing about examples you can give me of experiences you have had with families but it is important that we protect their confidentiality so please do remember throughout not to mention family member's full names to me.

Are there any questions?

Their role:

- Could you tell me a bit about how long you have been working at the centre and your role?
 - Any changes in that time?
 - Way centre run?
 - Families?

- What do you see as the aim of the work at the contact centre?
 - Is protecting children part of your role or is this outside your responsibility?
 - Protecting them from what?
 - Different aims in supervised and supported?

Necessity of centre

I'd like to talk a bit about the cases you deal with as a centre and discuss why families need a contact centre

- Could you tell me about the families you have at the moment and explain why they needed a contact centre?
 - Drug/alcohol abuse
 - Domestic violence. Accusations? Convictions? Refuge?
 - Accusations of abuse/neglect of child? Emotional, physical, sexual?
 - Proven abuse of child or resident parent?
 - Child on child protection register?
- Why is it not suitable for them to have contact outside of a contact centre?
- Do you have rules about the types of cases you will and will not accept for contact?
 - What are these?
 - Why are these the rules?
 - Have you ever rejected a case?
- How do you deal with accusations of domestic violence where the parent is not able to provide tangible evidence?
- Are there differences in the issues families have between supported and supervised contact?
- When is it appropriate for a case to go to supported/supervised?

- Have you ever experienced cases that possibly should be in supervised but have ended up in supported? Why does this happen?

Experience of cases

- Do you ever decide that contact cannot continue at the centre?
 - In what circumstances?/why not?

Differences as you understand them between supported and supervised. What are the differences in each:

- To what extent need to hear every word in supervised contact? How deal with this?
- How much does staff/volunteers know about the family's background?
 - Is it important for them to know?
 - Why?
- While a child and a parent are at the centre, would a supervisor or volunteer ever intervene between them?
 - Why do you intervene?
 - How do you intervene?
- How is it decided when it is appropriate for a family to move on from the centre?
 - Would you ever suggest to a family that they should move on?
 - Is cost ever a factor in moving families to supported contact?

Contact versus safety

- In your opinion, how important is it for children to have contact with their parents? Why?
- Are there any circumstances where children should not have contact? What are these? Why?

Children's decision making:

- What happens when a child doesn't want to have contact?
- When this happens, why, in your experience, does it happen?

- How much say should children have in decisions about contact with their parent?
 - Why?
 - Are children competent to be involved in decision making?
 - At what age? Does it depend on level of maturity?
- Should children have any input into decision about contact? How much? Should they be allowed to decide?
- Do parents ever not want contact to take place? Why?

Referral

I'm interested in the way that the referral process works and how this affects contact centres. I'd like to talk a bit about this.

- To what extent are you aware of the reasons why they have been referred to a contact centre?
 - How important or unimportant is it for you to be aware of this information? Why?
 - How do you use this information?
 - Is there anything you don't need to know? What is this?
- Whose responsibility is it to find out the background to the case, for example to establish if there has been domestic abuse or a concern about child maltreatment? Is it the referrers responsibility or the centres'?
- Do you do risk assessments in deciding whether to take on a case?
 - What is involved in this?
 - Who does it?
- Whose responsibility is it to decide whether the case is appropriate to the centre?
 - Do you accept all referrals at the centre or do you sometimes refuse referrals?

- In what circumstances? Why?
- How do you decide which cases you will accept?
- How much do the supervisors or volunteers know about the families?
- why?

Information sharing

- Do families visit the centre before contact?
 - What happens on this?
 - Always or are there exceptions to this?
 - Interviews?
 - Who is interviewed?
 - Separately or together?
 - Who interviews them?
 - Children?
 - What is the purpose of the interview? What information are you aiming to get?
- What information do you provide to referrers?
 - Are there circumstances when you would immediately report to the referrer if something happened?
 - Do you provide them with a report? What info is in this?
 - Recording of what happened during contact?
 - Assessment?
 - Recommendations?
- Do you receive self-referrals (where families refer themselves?). How do you deal with these?
 - How do you find out the background info about them? Interviews? Who does interview? With whom? Separately?
 - How easy or difficult is it to get all of the background info on self-referrals?
 - Have you seen any increase in self-referrals?

Referrers:

- Have you had any difficulties in dealing with referrers (solicitors, social services, Cafcass?)
 - How well do referrers understand what your centre does?
 - Do you find that court orders and referrals in general are always appropriate to the family and the centre?
 - If no-in what way? How do you deal with this?
 - Do referrers always provide you with all of the information about the families?
 - Solicitors, social services, Cafcass?
 - If not: why not, in your opinion?
 - How does this affect the centre?
 - How could this problem be solved?
- If the referrer is solicitors, do they always tell you if Cafcass or social services have been involved in the case?
- Do you always get a copy of the court order? Cafcass report? Supervised and supported?
- Do you then get to also speak to Cafcass or social services? What do they tell you?
- Do you get any support from Cafcass or SS if you need advice for a case?

Thresholds

- Have you ever been concerned for a child and considered reporting your concerns to children's services?
 - What made you suspect?
 - What did you do? Did you report it? To who? Why?
 - What was the result?
 - Did you get support from NACCC? In what way?

- (If didn't report) why not?
- In what circumstances would you feel it necessary to report a case to children's services?
- Has a non-resident parent ever told you they suspect the child is being abused/neglected at home? How did/would you deal with this?

Funding

- Cafcass doesn't seem to always pay for supervised contact, do you have a sense of in what circumstances Cafcass will and won't pay for supervised contact?
- How many sessions? Re-referral when needed?
- How much families pay if they pay for it? Include assessment?
- How does this situation affect families in your experience?
- Do you have a waiting list?
- To what extent can your centre meet the level of need for your service?
- Do families ever end up in supported contact because of the cost of supervised contact?
- Are there any other services you would like to be able to provide for families, if you had the funding or that you would like Cafcass or some other government agency to provide?

Training:

- **What was your background before you came to work at the centre?**
- What experience or training did you need to have or undertake to become the manager of the centre?
 - Qualifications?
 - What training?

- What issues did it cover? Child safeguarding? DV?
- What level?
- Training from Naccc? What did you think of it?
- Have you had any more training since you have been working at the centre?
- What training do people need to have to become a supervisor at the centre?
- Do people receive training at the centre?
- Why do you feel that this level of training is important?
 - What would be your concerns if people didn't receive training?
- Is there any other training or support that you would like to have?

NACCC

- How important is NACCC to your work?
 - How do they support you?
 - Why are you a member?

Wind down

- Is there anything I haven't asked about that you think is important?

Appendix 2.3: Interview guide supervised services

Introduction: Before we start, I just want to mention a few things.

SOUND RECORDING CONSENT

- Firstly there are no right or wrong answers to any of my questions; I am interested in understanding, as best I can your opinions, experiences and interpretations. I want to see the contact centre and the work you do through your eyes.
- Secondly, you are under no obligation to answer any of my questions; you can end the interview at any time and can decide not to answer any question.
- Everything will be reported anonymously. When I report the findings of the study I will never use your name or the name of the contact centre and any information that could identify you will be removed.
- Finally, I am very interested in hearing about examples you can give me of experiences you have had with families but it is important that we protect their confidentiality so please do remember throughout not to mention family member's full names to me.

Are there any questions?

Background

- Could you tell me a bit about how long you have been working at the centre and how you came to work here?
 - Had you done similar work before coming to work here?
 - qualification?
 - How long was the course?
 - How provided it?
 - What did you learn? (engage with children?)
 - Have you been on additional training since?

Change

- Has anything changed in the way that the centre is run?
 - The rules you follow?
 - The responsibilities of the centre?
- How do you feel about those changes?
- Has the profile of families coming to the centre changed at all in that time?
 - are the issues any different?
 - are they being referred by the same agencies? Why?

Aims:

- What do you see as the main aim in the work you do?

Probe:

- (if not mentioned) Is protecting children part of your role or is this outside your responsibility?
 - Protecting them from what?

Necessity of centre

I'd like to talk a bit about the cases you deal with as a centre and discuss why families need a contact centre

- Could you tell me about the cases that you have been supervising recently and why the family needed a contact centre?
 - Where referred from?
 - What are the issues?
 - How long at centre?
 - How long likely to be at centre?
- Domestic violence
- Drug/alcohol abuse
- Refuge?
- Accusations of abuse of resident parent
- Accusations of abuse/neglect of child?
- Proven abuse of child or resident parent?
- Child on child protection register
- Mental health

Procedures:

- How do you deal with cases where there are accusations of abuse of the resident parent or the child?

Handovers

- Do you do handovers? How does this work?
 - Are there rules on who arrives and leaves first or can parents decide this?
- How long do parents have to wait before they leave?
- Are there any exceptions to this? For example if someone had to go to work? Why?

- Why that long?
- If there is an incident outside the centre, what is the procedure?

Contact

- Could you tell me about your role during a supervised contact session?
 - To what extent do you listen into conversations? Every word? Why?
 - When would you intervene?
 - How do you intervene?
 - Do you help with parenting? How?
 - If there is an incident during contact, what is the procedure?
 - How many supervisors are allocated to each case? Why?
 - What information is contained in your report?
 - Record factually what happened in the session?
 - Make an assessment?
 - what do you base the assessment on?
 - Do referrers always request a report?
 - If they don't, do you record anyway? Why?

Information sharing:

- Do you accept all referrals at the centre or do you sometimes refuse referrals?
 - In what circumstances? Why?
 - How do you decide which cases you will accept?
- [If they personally conduct the pre-visit interviews] Could you tell me about the pre-visit interview?
 - What is the purpose of this?
- To what extent are you aware of the issues families have, the reasons why they have been referred to a contact centre?

- How important or unimportant is it for you to be aware of this information? Why?
- How do you use this information?
- What information do you provide to referrers?

Referrers:

- Have you had any difficulties in dealing with referrers (solicitors, social services, Cafcass?)
 - How well do referrers understand what your centre does?
 - Do you find that court orders and referrals in general are always appropriate?
 - If no-in what way? How do you deal with this?
 - Do referrers always provide you with all of the information about the families?
 - Solicitors, social services, Cafcass?
 - If no-how does this affect your work? Examples?

Contact versus safety

- How important is it for children to have contact with their parents? Why?
- Are there any circumstances where children should not have contact? What are these? Why?

Thresholds

- Have you ever been concerned about the welfare of the child while they are with the resident parent?
 - how do you deal with this?

- Have you ever been concerned for a child and considered reporting your concerns to social services when they are not already involved with the family?
 - What made you suspect?
 - What did you do? Did you report it? To who? Why?
 - What was the result?
 - (If didn't report) why not?
 - How comfortable do you feel reporting to social services?

Reluctant child

- Have you dealt with cases where the child didn't want to have contact?
 - What are the reasons for this?
 - How do you deal with this?
 - What do you say to the child?
 - What are your aims in this situation?
 - Do children have a choice about whether they have contact?
 - How do you deal with situations where there is a court order for contact?
 - Should children have a say about contact?
 - To what extent? What circumstances etc?

Moving on/Funding

- When is it appropriate for a family to move on?
- How does Cafcass funding work for supervised contact?
 - How many sessions does Cafcass fund?
 - What happens when a family runs out of Cafcass funding?

- Do you have a sense of the circumstances in which Cafcass will and won't fund contact?
- How does Social services funding work for supervised contact?
 - How many sessions do SS fund?
 - What happens when a family runs out of SS funding?

Wind down

- Is there anything I haven't asked about that you think is important?

Appendix 2.4: Interview guide solicitors

[Highlighted sections were prioritised where time was short]

Informed consent:

Post out and post back? Email signature?

Introduction:

Thank you for agreeing to take part in this interview. Just to reiterate that all information will be reported anonymously; it will not be possible to identify you from the research; you may end the interview at any time or decline to answer any question. There are also no right or wrong answers in the questions I ask; I am simply interested in your experiences, opinions and perceptions.

I am particularly interested in your experiences and opinions on how child contact is arranged at [CASE STUDY] child contact centre and your perceptions of what happens when families have contact at the centre.

Warm up/background

- [warm up]To start with, could you briefly tell me about your current role and your involvement with [case study] child contact centre in that role?
 - How often do you refer families to this centre?
- How long have you been referring families to [case study] contact centre?
 - Have you seen any changes in the operation of centres in that time?
 - Have you seen any changes in the issues that clients you refer to the centre present with?
- How frequently do you refer families to [CASE STUDY] CCC?

Necessity of CCCs

- In your opinion, are contact centres needed? Why/why not?

- In the cases you have referred to [CASE STUDY] CCC, why have these families needed a contact centre?

Have the cases involved:

- Accusations of domestic violence? Physical? Sexual? Emotional?
 - Convictions for DV (non-molestation/occupation/ restraining order)?
 - Some evidence of DV? Court finding of DV?
 - Accusations of physical, psychological or sexual abuse of the child?
 - Proven child abuse?
 - Alcohol addiction?
 - Drug addiction?
 - Abduction threats?
 - Previous abduction?
 - Mental health problems? Which ?
 - Conflict between the parents but none of these other issues?
 - Homelessness?
 - Children reluctant to be alone with parent?
 - Children on child protection register?
 - Other issues?
- How common are each of these issues in the families you have referred to [CASE STUDY] centre? Which are the most common?
 - In your experience, are there any types of cases that the centre will not accept? If not: why not?
 - Has a case you have referred to the centre ever been refused? If so: why?
 - Are there any circumstances in which you would not refer a family to [CASE STUDY] child contact centre?
 - In your experience, how common are orders for no direct contact? In what circumstances is no direct contact ordered?

Service definitions

- Could you tell me how you describe [CASE STUDY] child contact centre to your clients?

Could you tell me what you know about the set up at [CASE STUDY] child contact centre? There are no right or wrong answers here; I am just interested in people's perceptions of the centres.

- What would you expect the ratio of workers to families to be?
- Would you expect workers to listen in on families' conversation at all times?
- Would expect that someone is always present in the room when families have contact, or not?
- When would you expect workers to intervene during contact?
 - Would you expect them to intervene if a parent behaved in a certain way? What circumstances?
 - Would you expect them to intervene if a parent said something inappropriate to a child? What would you consider to be inappropriate?
 - How would you expect workers to intervene in these circumstances?
- Do you expect the centre to report back to you in any circumstances? What would you expect them to report back to you?
- Would you expect parents to be interviewed prior to the case being accepted at the centre?
 - Are children interviewed? Separately or with resident parent?
 - What does this interview involve/what is its aim?
 - What are the qualifications of the person that does the interview?

- What is the purpose of the interview? Introduction? Risk screening? risk assessment?
- When you refer a client to the centre, do you expect the centre to screen for risk and to risk assess?
- Do you expect that a separate waiting area is available for resident parents? What safety features would you expect this to have? Is the provision of this important? Why?
- What training or qualifications would you expect the coordinator and other workers in the centre to have?
- Would you expect them to be paid staff?
- Would you expect workers to accompany children to the toilet?
- What level of physical security would you expect at the centre? Panic alarms? Emergency response? Two exist?
- How do you expect handovers to work?
 - Who arrives and leaves first?
 - What is the time delay?
- What would you expect would be the practice in the centre if a child didn't want to have contact?
- What is the process of moving families on from a contact centre in the cases you have referred?
 - Who decides when it is appropriate for the family to move on? (inc cases that have not been to court)
- Would you ever expect a centre to cease contact between a parent and child? In what circumstances?
- What would you see as the main aim of the work at [CASE STUDY] child contact centre?

Visiting (if it hasn't come up naturally)

- Have you been able to personally visit the centre [case study] centre?

IF NO: why you have not visited?

Responsibilities

- When you refer a case to a contact centre, in your opinion do you have any particular responsibilities or duties? What are these?
- Who decides whether the centre is appropriate for the family?
 - In cases where the courts are involved?
 - In cases where only solicitors are involved?
- If they decide: how do you decide?
- [If not already mentioned] Do the families that you have referred to this contact centre need to be screened for risk issues prior to being accepted at the centre?
 - Why? Why not?
- Whose responsibility is it to screen for risk issues?
 - The referrers or the centre's?
- IF THEY SCREEN: How do you screen for risk issues?
 - Interviews with parents? **Children**? others?
 - Safeguarding checks?
 - Who do you check with?
 - police? GPs? Cafcass? social services?
 - How comfortable do you feel doing this? Have you had any training to support you in this?
- How much information do you need to give the centre about the family?
 - If parents make **accusations** are they relevant?
 - Emotional abuse?
 - Parents fears?
 - Past convictions?
 - Involvement with other services?
 - Feelings of the children?

- Do you ever meet the children?
- Do you speak to them? What do you say to them in that conversation?
- If they don't provide info on an issue: What are the reasons that information is not needed on [stated] issue?
- Do you always use a referral form or can you sometimes refer the families without using this?
 - How have you found using the referral form?
- Have you experienced any problems or issues in referring families to [CASE STUDY] centre?
- FF: What is the purpose of the reports produced?
 - Do you read them or just the parents?
 - Would it be your responsibility to act on what is written in the reports or the centres or courts?

Child's voice:

- Do you ever meet the child?
- In your opinion, should children be involved in decisions about contact?
 - How should they be involved?
 - Should they make decisions?
 - How should they be involved?
 - What should happen when children say they don't want to have contact?

Supervised Service provision:

- Have you ever referred a family to supervised contact?
- In what circumstances would you refer to supervised?
- When you feel a case should go to supervised contact, is it always possible for the family to attend a supervised centre?

IF NOT:

- Why not?
- Could you give me an example of a case?

- Are there enough supervised services in the area?
- Is the cost of services an issue for families?
 - Do families who you feel should be in supervised contact ever end up in supported contact because they cannot afford the fees for supervised?
 - Is Cafcass funding an issue?
 - In your experience how long do Cafcass fund supervised contact for?
 - Do cases ever move to supported contact because funding for supervised has run out?
 - Do you have a sense of which types of cases Cafcass will and won't fund for supervised contact?

Assessments

- In your experience does the court always appoint a Cafcass officer when one is required?
- Are family or child assessments always ordered and carried out when they are needed?

FJR changes

- Do you think that your relationship with contact centres will be affected by any of the recent proposed changes to the family justice system or Legal aid?
 - Expect more families coming through solicitors without attending court?
 - What impact will this have?
 - Expect more families self-referring?
 - What impact will this have?
- Is there anything you would like to see change in terms of the environment in which contact centres operate?
- Is there anything you would like to see change in terms of the way contact centres themselves operate?

Safeguarding responsibilities

- In your opinion, do contact centres have a responsibility to safeguard children?

- [if not already alluded to] In your opinion is the Statutory Guidance in Working Together to Safeguard children relevant to contact centres?

Wind Down:

- That is all of the questions that I have, is there anything else you would like to add that you think is important for me to consider in my research on contact centres?

Appendix 2.5: Interview guide social workers

****highlighted sections were prioritised in shorter interviews**

Introduction:

Thank you for agreeing to take part in this interview. Just to reiterate that all information will be reported anonymously; it will not be possible to identify you from the research; you may end the interview at any time or decline to answer any question. There are also no right or wrong answers in the questions I ask; I am simply interested in your experiences, opinions and perceptions.

We won't mention the names of any families so that we protect their confidentiality. If you mention the names of any contact centres this will be helpful for me to understand context but I won't report the names of these centres in the research or any information that could identify them.

Warm up/background

- [warm up]To start with, could you briefly tell me about your current role and your involvement with [case study] child contact centre in that role?
 - Does the LA have its own contact service? In what circumstances do you refer to private or voluntary sector centres?
- If you don't mind me asking, which contact centres? [the names of centres will not be reported neither will any information that could identify them, this is just to provide me with some context to your experiences]
- Are you familiar with the terms supervised and supported contact?
 - Have you referred to both services or just one?

Necessity of CCCs

- In the cases you have referred to [CASE STUDY] CCC, why have these families needed a contact centre and which service were they referred to- supervised or supported?

Have the cases involved:

- Accusations of domestic violence? Physical? Sexual? Emotional?

- Convictions for DV (non-molestation/occupation/ restraining order)?
- Some evidence of DV? Court finding of DV?
- Accusations of physical, psychological or sexual abuse of the child?
- Proven child abuse?
- Alcohol addiction?
- Drug addiction?
- Abduction threats?
- Previous abduction?
- Mental health problems? Which ?
- Conflict between the parents but none of these other issues?
- Homelessness?
- Children reluctant to be alone with parent?
- Children on child protection register?
- Other issues?

- In your experience, are there any types of cases that contact centres will not accept? If not: why not?
- Has a case you have referred to the centre ever been refused? If so: why?
- Are there any circumstances in which you would not refer a family to a child contact centre?

Service definitions

I'm looking at social workers, solicitors and judges perceptions of how contact centres operate. I'd like to talk a bit about this, if that's okay, but there are no right or wrong answers, I'd just interested in perception.

Could you tell me what you know about the set up at the contact child contact centres you have referred to?

[check supervised/supported if both services]

- What would you expect the ratio of workers to families to be?
- How closely would you expect staff to monitor families?
 - Would you expect workers to listen in on families' conversation at all times?
 - Would you expect that someone is always present in the room when families have contact, or not?
 - Would you expect them to intervene if a parent behaved in a certain way? What circumstances?
 - Would you expect them to intervene if a parent said something inappropriate to a child? What would you consider to be inappropriate?
 - How would you expect workers to intervene in these circumstances? Tell off? Stop contact?
 - If you refer a case where the non-resident parent has been accused of emotional, physical or sexual abuse of the resident parent, how would you expect the centre to manage the case?
 - What are your concerns?
 - What practical steps do you expect the centre to take?
- Would you expect parents or children to be interviewed prior to the case being accepted at the centre?
 - Are children interviewed? Separately or with resident parent?
 - What does this interview involve/what is its aim?
 - What are the qualifications of the person that does the interview?
- When you refer a client to the centre, do you expect the centre to screen for risk and to risk assess?

- What do you expect this involves?
- What training or qualifications would you expect the coordinator and other workers in the centre to have?
- Would you expect them to be paid staff?
- Would you expect workers to accompany children to the toilet?
- What level of physical security would you expect at the centre? Panic alarms? Emergency response? Two exist?
- What would you expect would be the practice in the centre if a child didn't want to have contact?
- Would you ever expect a centre to cease contact between a parent and child? In what circumstances?

Visiting (if it hasn't come up naturally)

- Have you been able to personally visit the centre [case study] centre?
- In what circumstances do you visit?

Responsibilities

- Who decides whether the centre is appropriate for the family?
 - In cases where the courts are involved?
 - In cases where only solicitors are involved?
 - If they decide: how do you decide?
- Whose responsibility is it to screen for risk issues?
 - The referrers or the centre's?
- How much information do you need to give the centre about the family?
 - If parents make accusations are they relevant?
 - How do you expect the centre to treat accusations?
 - Emotional abuse?
 - Parents fears?

- Past convictions?
- Involvement with other services?
- Feelings of the children?
- A full history or recent events?
- Do you need to outline how the case should be managed (e.g. what precautions are required) or does the centre decide how to manage the case?
- Do you always use a referral form or can you sometimes refer the families without using this?
 - How have you found using the referral form?
- How do you expect the centre to use the information on the referral form?
 - Would you expect everyone working with families to be given this information or just the manager?
- Have you experienced any problems or issues in referring families to contact centres?
- SUPERVISED: What is the purpose of the reports produced?
 - Between court dates do you read them or are they just for the parents?
 - In between court dates whose responsibility is it to act on what is written in the reports? E.g. if it is reported that a parent is behaving inappropriately or the child is refusing contact?
- What is the process of moving families on from a contact centre in the cases you have referred?
 - Who decides when it is appropriate for the family to move on? (inc cases that have not been to court)
 - How do they decide?

Child's voice:

- Are you always able to meet the child before and during contact? How often?
- In your opinion, should children be involved in decisions about contact?
 - How should they be involved?

- Should they make decisions?
- What should happen when children say they don't want to have contact?

Safeguarding responsibilities

- In your opinion, do contact centres have a responsibility to safeguard children?
 - [if not already alluded to] In your opinion is the Statutory Guidance in Working Together to Safeguard children relevant to contact centres?

Wind Down:

- Is there anything you would like to see change in terms of the way contact centres operate?
- That is all of the questions that I have, is there anything else you would like to add that you think is important for me to consider in my research on contact centres?

Appendix 2.6: Interview guide judges

The case(s)

- Approximately how many times have you referred to this centre?
- In your experience what issues have necessitated the use of this centre?
- Any allegations made by the parents? Which? Any findings of fact?
Drug/alcohol misuse, mental health issues, DV, abduction concerns
- Are contact centres a service that is needed?

Talk about the services available to support you in making contact orders: (before talking about your expectations of this centre specifically)

Supervised contact

- Have you ordered contact at a supervised child contact centre?
- Are the issues the families are experiencing always different in cases that are referred to supervised contact compared to supported contact?
- In your experience, is supervised contact always available and accessible when it is required?
 - If not, why not?
- In your experience, does a lack of funding for supervised contact ever prevent referral to this service?
 - What happens to families when they cannot afford supervised contact?
 - Do families ever end up in supported contact because they cannot pay for supervised contact?

- In your experience how frequently does Cafcass fund supervised contact?
 - o Do you have a sense of the circumstances in which Cafcass will fund contact?

Cafcass

- Do wider funding or other issues in Cafcass affect the contact cases you see?
 - In what way?
 - In contested cases do Cafcass or children's social services often hear the wishes and feelings of the child before a decision on referral to a contact centres is made? Why?
- Do you always feel you can appoint a Cafcass officer when you feel one is required?
 - If not, Why not?
 - What are the implications of this for families?
- In both public and private law cases, when you feel that an assessment of the family beyond a Schedule 2 letter is required do you always feel you can get this assessment?
- Are there any other factors that in practice affect contact cases that may be referred to a contact centre?

Perceptions

Could you tell me what you expect from the service at [CASE STUDY] child contact centre? There are no right or wrong answers here; I am just interested in people's expectations of the centres.

- o What would you expect the ratio of staff to families to be?
- o To what extent would you expect staff to monitor families?

- Would you expect workers to listen in on families' conversation at all times?
- Would you expect that someone is always present in the room when families have contact, or not?
- Would you expect workers to accompany children to the toilet?
- Would you expect workers to intervene during contact? In what circumstances?
 - Would you expect them to intervene if a parent behaved in a certain way? What circumstances?
 - Would you expect them to intervene if a parent said something inappropriate to a child? What would you consider to be inappropriate?
 - How would you expect workers to intervene in these circumstances?
- How much information would you expect the centre to be given about the family?
 - A full history?
 - Would you expect all staff working with families to be given this information? Why?
- What training or qualifications would you expect the coordinator and other workers in the centre to have?
- Would you expect them to be paid staff?
- What level of physical security would you expect at the centre? Panic alarms? Emergency response? Two exist?
- What would you expect would be the practice in the centre if a child didn't want to have contact?
 - Should the court order be carried out if the child objects?
 - What would you expect the centre to do in this circumstance?
 - [if mentioned] How do you define force/encourage?

Decision making between centres and referrers

- Would you ever expect a centre to cease contact between a parent and child? In what circumstances?
- Do you expect the centre to feedback back to the court in any circumstances? Which?
- Are there any circumstances in which you would not refer a family to X child contact centre?
- Would you ever expect X contact centre to refuse a case coming from the courts or negotiated by solicitors?
- In your opinion, when a case is referred to X contact centre, who is responsible for deciding whether the case is suitable for the centre -the court, the solicitor or the centre?
- Would you expect the centre to meet parents before contact?
 - what would be the purpose of this meeting?
 - Would you expect centres to screen families for risk and to risk assess them before accepting the case?
- In your opinion, do contact centres, as organisations working with children have a responsibility to protect children under for example WT?

Children

- To what extent do you think children should be involved in decisions about contact?
- What do you think of the current mechanisms available to you as a judge for hearing the wishes and feelings of the child?
- In your opinion, what should happen if a child objects to contact?

Wind- down

- Is there anything that you would like to see changed or improved in terms of how contact centres themselves or the wider system around contact works?
- Anything I haven't asked?

Appendix 2.7: Information leaflet and consent form for staff/volunteers

Introduction

My name is Louise Caffrey and I am a PhD student at the London School of Economics (LSE). The LSE have awarded me a scholarship to carry out research into Child Contact Centres in England over a three year period. I am working under the supervision of Professor Eileen Munro in the Department of Social Policy.

Before you agree to take part in the research it is important that you understand what is involved. If you have any questions, or if anything is unclear, please do not hesitate to ask me.

About the Research

The research aims to provide a better understanding of the work of contact centres in England, as a service working with children. I will be exploring the types of cases contact centres take on and how they deal with them in practice; the experiences of staff and volunteers and how they interpret the issues; as well as the factors that affect your work. I am interested in the differences as well as the similarities between centres.

Your involvement in the Research

The first phase of the research involved a survey of all child contact centres in England. From this six centres have been chosen as case studies. I will be spending time in each centre and will be asking members of staff and volunteers to take part in interviews with me.

Each interview will take approximately one hour. I will ask you to discuss with me aspects of your work, your experiences and your opinions on the work you do. There are no right or wrong answers: the purpose is for me to better understand your work, your perceptions of the issues and your experiences in it.

Your involvement in this research is entirely voluntary. You can decline to answer any question you are not comfortable with and you are free to end the interview at any time without providing a reason for this. All information will be strictly anonymised. Neither your name nor the name of the contact centre will appear in the PhD thesis or in any publication and no information which could identify you will be included. If you consent, the interview will be sound recorded and transcribed.

Informed Consent Form

I _____ agree to talk to Louise Caffrey as part of her PhD research into child contact centres in England.

I understand that:

- Louise will talk to me about my experience in and opinions on my work in _____ child contact centre.
- My participation is entirely voluntary. I am free to end the interview at any time and I do not have to answer any question I do not feel comfortable with.
- All information I give to Louise will be anonymised. Neither the PhD thesis nor any publication of the research will contain my name, the name of the centre or any information that could identify me.

Participant signature:

Signed: _____

Date: _____

Name (in print): _____

Researcher's signature:

Signed: _____

Date: _____

Appendix 2.8: Information leaflets and consent forms for referrers

2.8.1 Information Leaflet and Consent Form (judiciary)

Introduction

My name is Louise Caffrey and I am a PhD student at the London School of Economics (LSE). The LSE have awarded me a scholarship to carry out research into voluntary and private sector child contact centres in England over a three year period. I am working under the academic supervision of Professor Eileen Munro in the Department of Social Policy.

Before you decide whether or not to take part in the research it is important that you understand what is involved. If you have any questions, or if anything is unclear, please do not hesitate to ask me.

About the Research

The research aims to provide a better understanding of the work of contact centres in England. In particular I am focusing on how contact centres manage their commitment to safeguard children and the factors that may enable them to or prevent them from effectively managing this commitment.

As part of the research six centres in England have been selected as case study sites; they represent a range of centre “types”. I have been exploring these centres in detail; observing practice and conducting interviews with staff. I am now hoping to interview professionals who have ordered contact/referred families to these centres including judges, solicitors and social workers. I understand that you have ordered contact at one of these case study contact centres.

Your involvement in the Research

I would like to invite you to take part in a telephone interview to discuss with me your experience of ordering contact at one of the case study child contact centres. The

interview will take no more than 40 minutes and I can call at a time that is convenient for you. During the interview I will ask you to discuss with me your experience of ordering contact at the case study child contact centre, your perceptions of how that centre operates and the general availability of support for cases referred to contact centres.

Your involvement in this research is entirely voluntary. You can decline to answer any question and you are free to end the interview at any time without providing a reason for this. You will not be asked about specific cases. All information will be strictly anonymised: neither your name nor the name of the contact centre will appear in the PhD thesis or in any publication and no information which could identify you will be included. If you consent, the interview will be sound recorded and transcribed.

Informed Consent Form

I agree to talk to Louise Caffrey as part of her PhD research into child contact centres in England.

I understand that:

- Louise will talk to me about my experience of and opinions on ordering contact at a child contact centre.
- My participation is entirely voluntary. I am free to end the interview at any time and I do not have to answer any question I do not feel comfortable with.
- All information I give to Louise will be anonymised: neither the PhD thesis nor any publication of the research will contain my name, the name of the centre or any information that could identify me.

Participant signature:

Signed: _____

Date: _____

Name (in print): _____

2.8.2 Information leaflet and consent form for solicitors and social workers

Introduction

My name is Louise Caffrey and I am a PhD student at the London School of Economics (LSE). The LSE have awarded me a scholarship to carry out research into Child Contact Centres in England over a three year period. I am working under the supervision of Professor Eileen Munro in the Department of Social Policy.

Before you decide whether or not to take part in the research it is important that you understand what is involved. If you have any questions, or if anything is unclear, please do not hesitate to ask me.

About the Research

The research aims to provide a better understanding of the work of contact centres in England and the factors that might affect their work. The research involves analysis of ten years of survey data collected on all child contact centres in England. From this six contact centres in England have been selected as case study sites; they represent a range of centre “types”. I am exploring the work of these centres in detail, observing practice and conducting interviews with workers in these centres. The final part of the research involves interviews with judges, solicitors and social workers who have referred to a child contact centre in England.

Your involvement in the Research

I would like to invite you to take part in a telephone interview to discuss with me your experience of referring to a child contact centre/centres in England. Ideally the interview would take 40 minutes but any time you can give would be much appreciated. I can call you at a time that is convenient for you. During the interview we would discuss your experiences of referring to (a) child contact centre(s), your perception of the service that is provided and your experience of the support available for cases referred to contact centres.

There are no right or wrong answers; the purpose is for me to better understand your experiences and perceptions. Your involvement in this research is entirely voluntary.

You can decline to answer any question and you are free to end the interview at any time without providing a reason for this. All information will be strictly anonymised. Neither your name nor the name of the contact centre will appear in the PhD thesis or in any publication and no information which could identify you will be included. If you consent, the interview will be sound recorded and transcribed.

Informed Consent Form

I agree to talk to Louise Caffrey as part of her PhD research into child contact centres in England.

I understand that:

- Louise will talk to me about my experience of and opinions on referring to child contact centre(s).
- My participation is entirely voluntary. I am free to end the interview at any time and I do not have to answer any question I do not feel comfortable with.
- All information I give to Louise will be anonymised. Neither the PhD thesis nor any publication of the research will contain my name, the name of the centre or any information that could identify me.

Participant signature:

Signed: _____

Date: _____

Name (in print): _____

Appendix 2.9: Information leaflet and consent form for parents in supervised contact

Introduction

My name is Louise Caffrey and I am a PhD student at the London School of Economics (LSE). I am carrying out research into Child Contact Centres in England over a three year period.

The purpose of this information sheet is to tell you about the research that will be taking place at [Case study] child contact centre and to invite you to take part.

Before you agree to take part in the research it is important that you understand what is involved. If you have any questions, or if anything is unclear, please do not hesitate to ask me.

About the Research

The aim of this research is to provide a better understanding of the work of child contact centres in England. I am interested in understanding the work and experiences of staff and what might affect their work.

Amongst all the child contact centres in England, six have been chosen as study sites for this research. This means that I will be looking in detail at the work these centres do. [Case study] child contact centre is one of these sites. I will be doing interviews with staff and referrers. I also hope to observe a number of contact sessions at the centre in order to better understand the work the centre does.

Your involvement in the Research

I would like to observe the work of the supervisor during your contact session. If you consent to this I will be in the room during one (and only one) of your

contact sessions. I will not ask you any questions or interrupt contact in any way. I will simply be in the room looking at the work of the supervisor.

Your involvement in this research is entirely voluntary and there will be no consequences for you if you decide not to take part. If you agree to me being in the room, you can still ask me to leave at any time. Everything I report will be strictly anonymised. This means that neither your name, nor the name of the centre will appear in the PhD thesis or in any publication. No information which could identify you will be included.

Informed Consent Form

If you would like to take part, please complete the form below and give it to _____ at [case study] child contact centre.

I _____ agree to Louise Caffrey observing my contact session as part of her PhD research into child contact centres in England.

I understand that:

- Louise will be in the room during my contact session
- Louise will not interrupt the session or ask me any questions; she will only observe.
- My participation is entirely voluntary. I can ask Louise to leave at any time.
- Louise will not ask to be in the room during contact at any other time in the future: this is a “once-off”.
- Everything Louise sees and hears will be reported anonymously. Neither my name, nor the name of the contact centre will appear in either the PhD thesis or in any publication. Neither will any information that could identify me.

Parent's signature:

Signed: _____

Date: _____

Name (in print): _____

Researcher's signature:

Signed: _____

Date: _____

Name (in print): _____

Appendix 2.10: Informed assent form for children

Part 1: Information sheet

My name is Louise Caffrey. I am a student and I am doing research about child contact centres. “Research” means that I am trying to learn about it. This leaflet is to tell you about my research and to invite you to take part.

So that I can learn more about what happens at a contact centre I would like to stay in the room when you and your mum/dad spend time together today at Stephen’s Place child contact centre.

- I will only stay in the room if it is okay with you.
- If you say it is okay for me to stay, you can still ask me to leave at any time.
- I will only be in the room today not on any other day that you and your mum/dad spend time together.
- When I write or talk about what I have learnt about contact centres I will never tell anyone your name or your mum/dad’s name.
- If you would like to know more you can ask me any questions.

PART 2: Certificate of Assent

- I understand that if I say it is okay Louise will stay in the room when I spend time with my mum/dad today at Stephen's Place child contact centre.
- I understand that Louise is doing research (learning) about child contact centres.
- I understand that I can ask Louise to leave at any time
- I understand that when Louise writes or talks about what she has learnt she will not use my name or my mum/dad's name.
- I understand that I can ask Louise any questions about the research

I have decided that it is ok with me if Louise stays in the room while I spend time with my mum/dad today.



Signature: _____

I have decided that I would rather Louise did not stay in the room while I spend time with my mum/dad today



Signature: _____

Appendix 2.11: Information leaflet for parents at supported services

Research at [Case Study] Child Contact Centre

Louise Caffrey is a PhD student at the London School of Economics (LSE) carrying out research into child contact centres in England over a three year period.

Amongst all of the child contact centres in England, six have been selected as study sites for this research. [Case study] Child Contact Centre is one of these sites. I will be researching the work of the centre, but this will not disturb the contact sessions in any way. This leaflet is to provide you with some information about the research and to invite you to ask me any questions you may have.

Aims of the Research

The aim of this research is to provide a better understanding of the work of child contact centres in England. I am interested to understand the work and experiences of volunteers and the factors that might affect the work of the centre.

Child contact sessions on [Date], [Date] and [Date]

On these dates Louise will be visiting to observe the work of the centre. Louise will simply be present in the room; her work will not interfere with the contact session in any way.

Confidentiality

The name of the centre will not appear in the PhD thesis or in any publication, neither will your name or the name of anyone who works here. Any information that could identify the centre, families or workers will be removed.

Questions

If you have any questions about the research please feel free to ask Louise.

Appendix 2.12: Summary of published article for participants

Hearing the ‘voice of the child’? The role of child contact centres in the family justice system Summary

Policy context: hearing the ‘voice of the child’

- The family justice system in England generally accepts that children should be heard and their wishes and feelings taken into account where the court is deciding on an issue that affects the child’s future. This does not mean that the court should always do what children want: a decision could be against a child’s wishes but be thought to be in his/her best-interest.
- This position is supported by research which suggests that listening to children is central to protecting them from abuse and neglect since children are the most direct source of authority on their own safety and well-being. In the context of child contact it is also important to listen to children since a child refusing to meet a parent may be distressed by contact and on-going disregard for his/her distress may be damaging to the child.
- While there is consensus in the family justice system that children’s wishes and feelings should be taken into account, there is disagreement about how this should be achieved. There is disagreement about whether children should be heard directly by the courts or whether it is enough to hear them indirect through their parents or through a Cafcass Officer, as is currently the most common arrangement.
- This article contributes to that debate by examining a) the extent to which children’s wishes and feelings were heard and taken into account in child contact centres in England and b) the factors that seemed to influence the way contact centre workers engaged with children.

The study

The study involved the following:

- Analysis of two National Association of Child Contact Centre (NACCC) surveys (Annual survey 2000-2010 and November 2010).
- Six case study child contact centres were selected using these data. Three only provided supported contact, one only provided supervised contact and two provided both services.
- Observations of practice took place in each of the six case study centres (54 hours in total) and in total twenty-seven staff and volunteers were interviewed.

- Judges (3), solicitors (9) and social workers (8) who had ordered contact at/referred to a child contact centre were interviewed.

Services provided and cases facilitated

- There are two services in child contact centres: supported and supervised contact. However, most centres in England (around 75%) only provide supported contact.
- Supported contact does not involve close supervision and is usually run by volunteers. It should only be used when contact poses no known risk of harm to the child. However, previous research found that cases involving a risk of harm were routinely being facilitated at supported services.
- The findings of the current research suggest that supported services continue to facilitate contact in cases involving a child maltreatment risk. Across the case study centres this included cases where there were concerns relating to domestic violence (DV)²², parental drug/alcohol addiction, parental mental health and child abduction. Some centres had cases where the non-resident parent had been convicted of a violent crime and others had cases involving possible child sexual abuse.
- The findings suggest therefore that a high percentage of the children using contact services-both supervised and supported-may have suffered or may be at risk of suffering harm from abuse.

Hearing the ‘voice of the child’: a typology of child engagement

- The findings suggest that the ways in which contact centre workers engage with children is diverse.
- It was suggested that the ways in which workers engaged with children could be understood to exist along a spectrum from “coercive” to “limited” to “meaningful” engagement. These categories do not refer necessarily to engagement in whole centres but to the ways in which individual workers engaged with children at particular moments in time.

Coercive engagement

- ❖ The decision about what is best for the child is made in the absence of taking the child’s wishes and feelings into account.

²² It is sometimes assumed that DV only presents a risk to the resident parent. However, DV also involves a risk of harm to the child because research has found that DV often continues after the parents have separated and there is a strong relationship between DV and child abuse. Witnessing the abuse of a parent is also considered a form of emotional abuse. Babies and children of any age can be affected. Where conversations are not monitored, contact provides an opportunity for further emotional abuse. It also risks physical abuse where contact is used to find out information about where the child is living.

- ❖ Children's expressed wishes and feelings have no power to change the decision or to influence workers' evaluation of what is best for them.
- ❖ Children may only have power in so far as they can practically obstruct the process.

Examples:

- A child refused to have contact with his father. Workers did not ask the child why he was refusing to have contact and continued to encourage him to meet his father.
- A centre coordinator told a young person that while there was currently no court order in the case, if there were an order her mother "would be in contempt of court and would have to go to prison" if the girl did not have contact.²³
- No cases of physically forced contact were observed in the case study centres but there is some evidence that in another centre workers were "grabbing" crying children from resident parents and asking the parents to leave.

Limited engagement

- ❖ The decision about what is in the "best interest" of the child is not pre-determined.
- ❖ The child's wishes and feelings can influence workers' decisions about contact *e.g. Where children cried, looked distressed or said they did not want contact the case was not facilitated.*
- ❖ Engagement is not sufficient to achieve a wider understanding of the child's position or to support the child by addressing his/her issues or those of the parent(s). *e.g. all children were not met before contact to hear and take account of their wishes and feelings in deciding if the case should be accepted.*
- ❖ No scaffolding is provided so children are limited in their ability to communicate and be heard.

Meaningful engagement

- ❖ The decision about what is best for the child is not pre-determined.

²³ This also misrepresents the legal position

- ❖ The child's wishes and feelings can influence workers' decisions about contact.
 - ❖ Engagement with the child is based on the aim of deeply understanding the child's position and taking their individual needs into account.
 - ❖ Scaffolding is provided in order to enable the child's communication. *e.g. Before cases were accepted all children were met alone and discussed their wishes and feelings with a professionally qualified worker. Children were provided with unbiased information to inform their wishes and feelings. The case could be rejected if the worker believed that contact was not in the child's best interest.*
 - ❖ Support is provided to address child and parental issues affecting contact *e.g. Children and parents could receive counselling, a domestic violence intervention programme and parenting information programme.*
- "Meaningful engagement" was only observed in one of the case study centres: the supervised only service which specialised in domestic violence intervention. This form of engagement is likely to be rare.

Factors influencing Engagement:

- It was argued that worker's engagement with children was influenced not only by factors within centres, but by factors within the wider system which affects contact centres
- **Perceptions of children's best interest:** some worker's engagement with children seemed to be influenced by a belief that contact was in the best interests of all children. However, there is a lot of research against this belief. Research suggests that contact in itself is not necessarily good for children. Instead it is the opportunity that contact presents for *quality* parenting which may have positive outcomes. Where the child and parent do not have an established relationship or where the relationship is of poor quality, the benefits of contact should not be over-estimated. Where contact presents a risk of abuse of the child, the risks may outweigh the benefits.
- **Perceptions of children's capacity:** workers sometimes assumed that children who objected to contact had been influenced by their resident parents and so assumed that children's expressed wishes were not "real". Workers sometimes made this assumption without an in-depth discussion with the child about his/her wishes and feelings and without access to the full case history. In this situation there is no basis to the assumption made.
- **Contact centre worker's sense of empowerment:** Contact centre's role in the wider system was ambiguous. Some contact centre workers believed that

contact centres had a “*compliance-focused*” role: if the courts had ordered contact, the centre should try to facilitate it unless contact was practically impossible. Other contact centre workers believed they had a “*child-focused*” role: their role was to ensure the safety and well-being of the child. They felt empowered to assess the case and to challenge court orders on this basis.

- **The role of training:** In the centre where there was “meaningful” engagement, work was led by qualified social workers. Volunteers sometimes said they didn’t feel comfortable speaking with vulnerable children and making decisions about the case because they hadn’t been trained to do so.
- **System-wide ambiguity:** Social workers, solicitors and judges also differed in their understanding of a) the extent to which children’s wishes and feelings should be taken into account and b) whether contact centres should have a “compliance-focused” or a “child-focused” role. This suggests that these issues are ambiguous, not just in contact centres, but in the entire system.

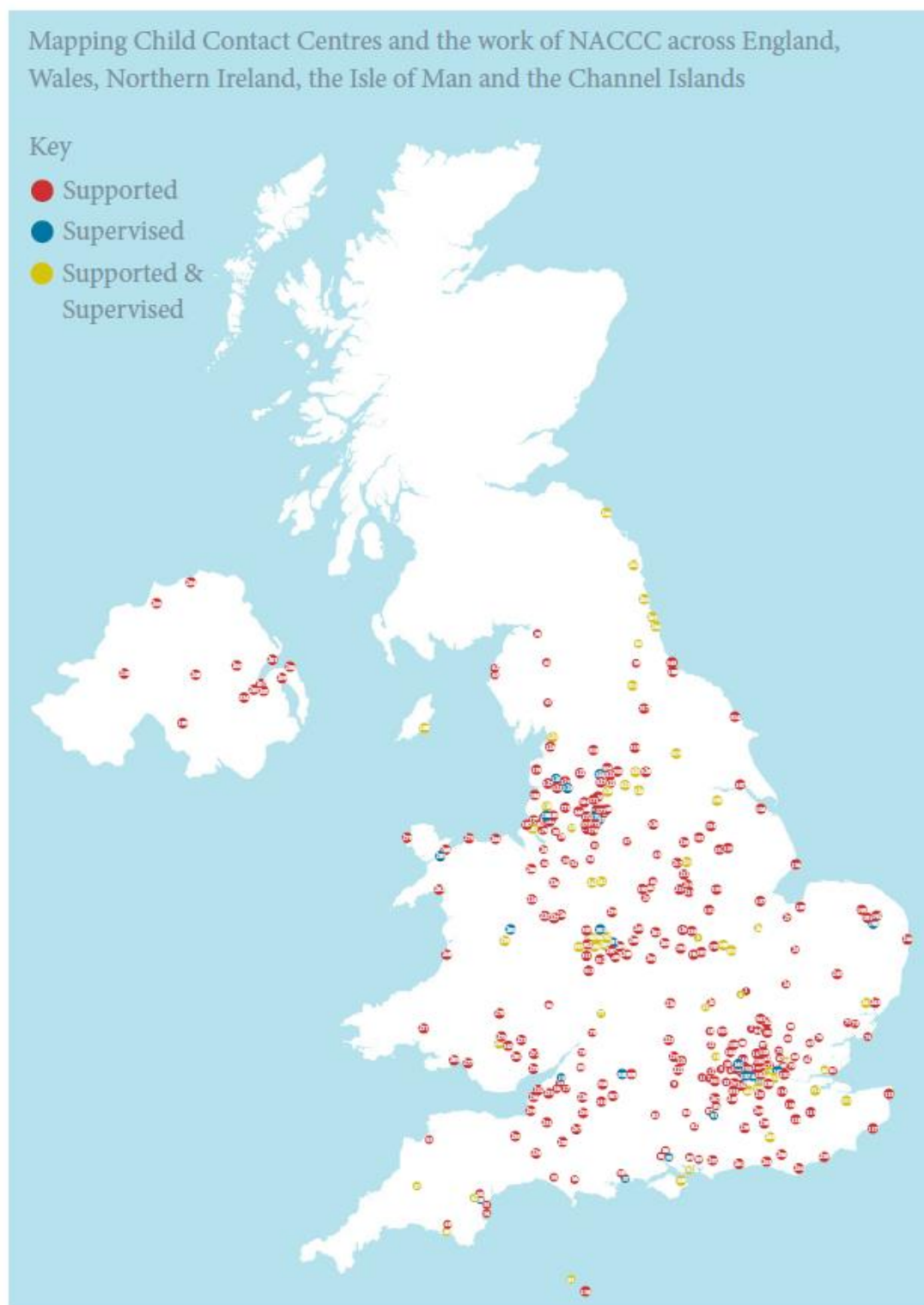
The capacity of the wider system

- It might be assumed that the work of hearing and taking into account children’s wishes and feelings is done before children arrive at a contact centre. By this logic, referrers would ensure that contact was in the best interests of the child and contact centres could just follow this decision. However, this is problematic for a number of reasons:
 - Children’s wishes and feelings may change over time.
 - Risk factors for child abuse/neglect may not be disclosed by resident parents, or they may not know of them: evidence may only emerge over time.
 - Where the referral has been made through solicitor negotiations there will be no independent assessment of the child’s wishes and feelings.
 - Where a case comes through the courts, the courts are limited in their ability to take account of children’s wishes and feelings before ordering contact at a centre. In private law cases children are usually heard indirectly through their parents (who may misrepresent them) or through a Cafcass Officer, where the court feels this is necessary. However, there are many questions over the quality of Cafcass Reports.
 - The interviews with judges also suggested that at the moment judges are experiencing severe delays in getting Cafcass Reports where they feel they are necessary. Contact is sometimes ordered at a contact centre before the report has been received.
- For these reasons contact centres cannot assume that because a case has been referred to the centre, the child’s wishes and feelings have been taken into account or that contact is in the child’s best interest. For this reason, from a child protection perspective, a “compliance focused” role for contact centres is problematic.

Conclusions

- The findings suggest that children who may have been abused or who are at risk of abuse often attend contact centres. In this context it is particularly important to take account of children's wishes and feelings.
- There is a pressing need to emphasise that children and babies of all ages can have and express (both behaviourally and verbally) wishes and feelings, which are important in terms of their safety and well-being.
- It also seems necessary to ensure that all contact centre workers and referrers are aware of the evidence which strongly suggests that contact cannot be assumed to be in the best-interest of all children.
- The findings suggest that the role of contact centres in the wider systems needs to be clarified and reconsidered from a child protection perspective.
- A "compliance-focused" role is incompatible with the aim of protecting this vulnerable group of children from abuse.
- Contact centres need to be enabled to adopt a "child-focused" role. For this to happen, workers in contact centres need to be empowered both within contact centres *and* within the wider family justice system to engage meaningfully with children.

Appendix 4.1: NACCC analysis of services by geographical region



Appendix 5.1: NACCC Standard Referral Form

This document has been removed as the copyright is owned by another organisation.

Appendix 6.1: Overview and discussion of typologies of child engagement

This discussion does not seek to review all of the work in this area but instead aims to build on some key models, relevant to the research. In conceptualising levels of child participation in organisations, Rodger Hart's (1992) 'Ladder of Participation' has been particularly influential (Barn & Franklin, 1996).²⁴ It is recreated below in Figure 6.1.

Figure 6.1: Hart's 'ladder of Participation'

This graph has been removed as the copyright is owned by another organisation.

(Hart, 1992, pp. 8-12)

Hart's (1992) model is particularly helpful in distinguishing forms of non-participation from degrees of participation. He suggests that while children and young people do increasingly participate, their participation is 'often exploitative or frivolous' (Hart, 1992, p. 2). His model conveys that where children do not understand the issues or where they have little choice about the way they express their views or the scope of the views they can express, they are not participating in a meaningful sense. Adults are engaging in 'manipulation', 'tokenism' or 'decoration'. Hart's Ladder was developed to conceptualise children's participation in community projects. The 'degrees of participation' on the ladder are useful in distinguishing the extent to which children have been involved in the design of the service, and this is relevant to child contact centres. However, it says less about their involvement in services once they have been decided upon. Hart's (1992) model (and Shier's discussed below) has also been criticised as it seems to suggest a hierarchy which sets out the aim to reach the highest level, where children are the main decision-makers (Franklin & Sloper, 2005). However, as discussed, neither WT (2010; 2013) nor the UNCRC (1989) nor the

²⁴ It should be noted that Hart's 1992 'Ladder of Participation' was influenced by Arnstein's 1969 'Ladder of Citizen Participation' (Arnstein, 1969)

Children Act (1989) confers on the child the right to be the main decider, nor do children necessarily want such a right (Bretherton, 2002; Butler et al., 2002; Campbell, 2008; Cashmore, 2011; Cashmore & Parkinson, 2008; Gollop et al., 2000; Neale, 2002; Smart, 2002; Smart et al., 1999). This aim may therefore be inappropriate, particularly in the context of child contact.

Butler and Williamson's (1996, pp. 87-90) Dependency/Autonomy model provides a typology for understanding children's participation in the specific context of child protection.

Figure 6.2: Butler and Williamson: 'Involving children in child protection'

This graph has been removed as the copyright is owned by another organisation.

(Butler & Williamson, 1996, p. 89)

Their model situates 'non-participation' as 'the passive kind of non-participation where the child is simply ignored'. It also includes 'manipulation', where the child is only required to play a part in the process for forensic or evidential purposes or simply for administrative convenience. 'Therapeutic terrorism' refers to the situation where the child is 'social worked over' (p.87). There is no regard for their agency and they may be expected to conform to the particular therapeutic regime. Within this typology the ends justify the means. 'Information giving' is, as in Hart's (1992) model, a form of 'tokenism' (Butler & Williamson, 1996, p. 88) where the child is told what may happen to them but is not given real choice. Butler and Williamson (1996) suggest that co-operation begins at the point of 'information exchange' where the involvement of the child might just make a difference. Here the wishes and feelings of the child are collected. This creates the opportunity but not the guarantee that what the child says will be valued. At the point of 'collaboration/partnership' what the child says is acted upon, at least in so far as it is permitted to alter the opinions and judgements of the adults involved. At the point of 'control' the involvement is wholly on the child's terms (Butler & Williamson, 1996).

Butler and Williamson's (1996) model is particularly helpful in adapting Hart's framework to a child protection context. It also supplements it by adding the category of 'non-participation'. This is important in the sense that while Hart's model creates a typology of forms of ostensible participation which are in fact non-participation it does not provide room for total non-participation. Given children's experiences of being ignored in statutory child protection (Butler & Williamson, 1996) it may be important that a model examining levels of participation in non-statutory organisations working with children includes this category.

The Butler and Williamson model suggests that 'collaboration/partnership' is the point at which the relative control of the adult and child dissects such that the child will be able to control some of what is happening with the support of a trusted adult. This is helpful in avoiding the problem, discussed above, of positioning decisions making by children as the aim. Nonetheless, the model does not explicitly provide a conceptualisation of the point at which meaningful engagement of children takes place; indeed this is not its purpose. The categories are, however, helpful and the model can be adapted to create an explicit dichotomy of forms of ostensible and actual engagement.

In terms of differentiating meaningful forms of engagement, Butler and Williamson's 'information exchange' category could be summarised as 'children are listened to'; 'collaboration/partnership' as 'children are involved in the decision-making process' and 'control' as 'children share power for decision-making'. These categories are similar to three of those developed by Shier (2001) to supplement the Hart (1992) model. Shier's model can also be used to supplement that of Butler and Williamson (1996) as it differentiates two additional forms of engagement at 'level 2' and 'level 3'. This is represented below in Table 6.1.

Table 6.1: Comparing models of child engagement	
Shier (2001)	Butler and Williamson (1996)
Level1: Children are listened to	Information exchange

Level 2: Children are supported in expressing their views	
Level 3: Children's views are taken into account	
Level 4: Children are involved in decision-making processes	Collaboration/partnership
Level 5: Children share power and responsibility for decision-making.	Control

Shier's model also conceptualises the degree of commitment the organisation has at each of the five levels. These levels of commitment are: 'openings', 'opportunities' and 'obligations' (Shier, 2001, p. 110). Shier (2001) suggests that at each level an 'opening' occurs when a worker makes a personal commitment or a statement of intent to work in a certain way. In an 'opening' the opportunity to make it happen may not be available. At the second stage, an 'opportunity' occurs when the worker or organisations is enabled to operate at this level of practice. This may involve the availability of resources (staff time, skills and training) or the development of new procedures. Finally, an 'obligation' is established when it becomes the agreed policy of the organisation that staff should operate at this level (Shier, 2001, p. 110). Shier's inclusion of levels of commitment is helpful in terms of addressing the issue that intentions to engage children are not enough; those working in organisations must also be supported to facilitate participation. Shier suggests that in order to endorse the UNCRC (1989), organisations must operate above level three ('Children's views are taken into account') at the stage of 'obligation' (Shier, 2001, p. 111).

Clearly there are times when it will not be appropriate for children to be involved in decisions above level three. Shier's (2001) model acknowledges this by suggesting that the benefits to sharing decision making and responsibility must be balanced against the risks. The model 'makes no suggestion that children should be pressed to take responsibility they do not want, or that is inappropriate for their level of development and understanding' (Shier, 2001, p. 155).