Eileen Munro

Formal risk assessment instruments or intuitive knowledge?

Marie Kamphuis-lezing 2003

Co-referaat:
Corine de Ruiter

Met een woord vooraf van Lou Jagt

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Bohn Stafleu Van Loghum
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Woord vooraf

Het centrale thema van de lezing van dr. Eileen Munro is verbonden met wat zij noemt 'the eternal debate about art and science, heart and head, and formal knowledge versus individual skills of empathy and intuition'.

Sporen van dit thema zijn al aanwezig bij Muller-Lulofs, een van de pioniers van het maatschappelijk werk in Nederland, die in haar boek *Van Mensch tot Mensch* (1916) zegt: 'De philantropie is thans niet meer slechts het antwoord op de roep van het warme impulsieve hart, zoals ze dat was in de Middeleeuwen. De caritas der 20e eeuw heeft het gouden kroontje der mysterievolle voorzienigheid afgelegd, den blauwen kiel van de werkman aangetrokken en zich in dienst gesteld van de maatschappij.... De armenverzorging werd nu wetenschappelijk; naast het impulsief en warm gevoel werd aan het nuchter denkend koele hoofd een plaatsje ingeruimd.'

Na de ideologische beeldenstorm die in de jaren zestig van de vorige eeuw ook het social casework trof, constateert Marie Kamphuis dat het warme hart zijn 'ereplaats' uit de tijd van de filantropie heeft heroverd. Zij voegt daaraan toe: 'Geen kwaad woord over het warme hart, maar je moet er niet aan overgeleverd zijn.' Daarbij doelt zij op het paternalisme dat veelal hand in hand ging met spontane vormen van hulpverlening. 'Hoed u voor de liefdadigen,' zegt Theo Schuyt in 1993, 'mensen met een hart, gedreven door enthousiasme en betrokkenheid, maar onbekend met de gevaren en valkuilen die ontstaan wanneer het hart en goede bedoelingen in het spel zijn. Helpen is een delicaat soort activiteit.'

Het warme hart, goede bedoelingen, enthousiasme en betrokkenheid zijn essentiële ingrediënten voor verantwoord hulpverlenen. Maar de ervaring heeft geleerd dat hulpverleners die alleen daarmee toegerust zijn, mensen meer afhankelijk maken dan nodig is en hen soms van de wal in de sloot helpen.

Plaats inruimen voor het denkend koele hoofd is nog steeds nodig. Eenvoudig is het niet om een evenwicht te vinden tussen het warme hart en het koele hoofd, en

misschien wordt juist daarom zo vaak een keus gemaakt voor het een of het ander, voor nabijheid of voor afstand, voor mensen of voor technische handelingen.

In haar werk belicht Eileen Munro deze thematiek van verschillende kanten. Als maatschappelijk werker en wetenschapper is zij van oordeel dat maatschappelijk werkers bij hun werkuitvoering te weinig gebruikmaken van wat zij noemt 'a more formal and explicit knowledge base'. Dit standpunt werkt zij uit in haar boek *Understanding Social Work. An Empirical Approach* (1998). In het eerste hoofdstuk zegt zij: 'The dominant view in social work is that the skills of understanding and helping people are personal and private; they cannot be written out as formal theories which can be empirically tested. In the rest of the book, I shall defend the empirical practice movement[1] arguing that opponents have a false picture of science and it is possible for social workers to incorporate scientific methods into their current style of working.' Volgens Munro worden maatschappelijk werkers (in Engeland) door nieuwe wettelijke en managementrichtlijnen gedwongen de waardevolle maar lastig te omschrijven 'skills of understanding and helping people' beter zichtbaar te maken. Als zij hierin niet slagen, is de kans groot dat het management deze activiteiten niet kan ver(ant)woorden als noodzakelijke instrumenten bij het werken met cliënten. Munro voorziet hier problemen en concludeert: 'there is therefore a strong danger that they will be eradicated from social work.'

In *Understanding Social Work* uit 1996 breekt Munro vooral een lans voor de empirical practice movement, maar de oplettende lezer kan hier al een aanzet ontdekken voor het thema van haar volgende boek *Effective Child Protection* (2002). In dit boek pleit zij voor het samengaan van *risk assessment instruments* en *intuitive skills*, voor het op elkaar betrekken van formele kennis en *individual skills of empathy and intuition*. In haar lezing trekt zij deze lijn door.
In 1998 signaleerde zij al dat het social work het gevaar liep uitgehold te worden; deze vrees lijkt nu te worden bewaarheid. In de MKS-lezing schetst Munro een horrorscenario waarin overwegend managementrichtlijnen bepalen wat op de werkvloer dient te gebeuren. In de Engelse kinderbescherming is als gevolg hiervan een uittocht van werkers op gang gekomen. Is het samengaan van ambacht en wetenschap, van hoofd en hart, van formele kennis en persoonlijke vaardigheden, nog steeds een te zware opgave voor het beroep?

1 Een beweging die empirisch onderzoek van maatschappelijk werk interventies bepleit, met inschakeling van praktijkwerkers.

In haar co-referaat trekt dr. Corine de Ruiter deze lijn door naar Nederland, waarmee zij materiaal aandraagt voor een discussie over de verschillen en overeenkomsten die er op dit gebied zijn tussen Engeland en Nederland.

Lou Jagt,
Secretaris Marie Kamphuis Stichting

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Formal risk assessment instruments or intuitive knowledge?

Eileen Munro

I am very pleased to be asked to give this lecture in honour of Marie Kamphuis who played such an important part in establishing social casework in the Netherlands. When I read about the history of social work, I am struck by what an important part a few key individuals played in changing social attitudes and helping to transform social work from a system of voluntary compassion for individuals in distress to an organised and professional social response. We have been blessed with a number of highly intelligent, forceful, and committed people who have dedicated their lives to improving the help given to people in difficulty in our societies. In the nineteenth century, social work was mainly seen as a task for female volunteers with kind hearts and a devotion to serving others. In the twentieth century, there was an increasing emphasis on professional training, a proper career structure, and a scientific knowledge base. In the twenty-first century, we face a new set of challenges and it is these that I want to talk about today.

I share Marie Kamphuis' interest in developing the scientific basis of social work, so, in many ways, things are looking very good. We are gradually moving away from the personal, intuitive style of helping to a more systematic approach where front line workers are increasingly helped by guidelines and assessment or decision making instruments as well as being able to draw on a steadily growing body of empirical research. These are developments I have argued for, so I should feel pleased, but I don't. The problem is that along with all these exciting innovations there is depressing evidence that social work practice is not improving, as I would expect, but in some ways getting worse. The front line workers don't like the changes; they are not using them properly and they are voting with their feet and leaving their jobs. One explanation is that this shows how resistant to science most social workers continue to be. We could blame them for being woolly brained, preferring to rely on empathy and intuition instead of the more intellectually rigorous work now being asked of them. Alternatively, we could take their resistance seriously and ask whether they have any good reasons for questioning the way we are trying to improve practice. I think they have, and, in this lecture, I want to outline why I think they have cause for concern and to suggest how we should respond to it.

For me, this marks a significant shift in my view of how social work can be more scientific. In the eternal debate about art and science, heart and head, and formal knowledge versus individual skills of empathy and intuition, I have always been arguing for a more scientific approach. My academic background is in philosophy, mainly the philosophy of science, and I have long argued that we can, and should, improve our skills and knowledge by looking to the model of the natural sciences. Therefore, I would have expected to be pleased that the profession is apparently sharing my view and developing a more formal and explicit knowledge base. But I don't, and this paradox has forced me to look more closely at what is being done to try and make sense of why it worries me so much.

As a result, I have come to a greater understanding of why there are limits to how much we can create a formal knowledge base. And also, how easy it is to misuse science, to hijack its language and status to exaggerate a crude set of ideas. Pseudoscience is as big a problem now as outright hostility to science. In the past, when I was arguing with people opposed to science, I wasn't forced to consider this issue, because I was dealing with their criticisms of scientific social work. But now that I am looking critically at what has been done in the name of science, I have been made to see what happens if you try to eliminate the personal from a helping service.

Perhaps the shift in my views can best be illustrated by saying that I used to think that the personal skills of empathy and intuition were *inferior* to formal, tested knowledge; they were less reliable, more idiosyncratic, more vulnerable to bias. So, like many in social work and other caring professions, I thought that we should be trying to gradually eliminate them and replace them with explicit, precise theories and therapies. Now I would argue that our intuitive skills are essential in some parts of work and cannot be replaced. We cannot make sense of people's behaviour without using our intuitive knowledge of human psychology and the rules and values of their culture. We cannot create the relationship in which people are willing to tell us what they are thinking and feeling without using our intuitive knowledge. And we cannot respond swiftly to the changing mood and dynamics of a human interaction without using our intuitive knowledge. Intuitive skills are irreplaceable. They should not be seen as inferior but *different.*

I also think the difference has been greatly exaggerated by seeing them as two distinct categories, which are often presented as if they were in direct opposition. When we look at how people reason in real life situations (and not in a philosophy textbook or a psychology lab) it makes more sense to see them as on a continuum rather than polar opposites. Even the most formal risk assessment instrument, in reality, requires some degree of intuitive reasoning as social workers use it. Even the most

intuitive judgement can, on reflection, to some degree, be analysed; it is not mysterious and beyond scrutiny. Both can be taught and developed and both can be used more or less critically.

Basically, I shall be arguing that the traditional approach to improving social work is to see the human element as the problem; social workers are fallible and the source of mistakes, so that improvements have been aimed at reducing the part for their intuitive reasoning, and replacing it with rigorous formal methods. So, for instance, in Britain, when assessing a child's needs, social workers no longer conduct an interview in their own particular style, but have a twenty page booklet setting out the areas they should cover and they should systematically work their way through it. I shall be arguing that we should stop seeing intuitive social workers as a problem, but reverse the picture, putting the expert social worker at the centre. Instead of trying to cut them out or control them, we should see them as the key factor and ask 'what do they need to help them work better?', 'how can guidelines and instruments support (not replace) their judgement and decision making?'

I shall be mainly talking about problems in Britain, but I know there are similar problems in the United States and Canada. I leave you to decide whether it is happening, or is in danger of happening, here in the Netherlands. Perhaps you are not following the same route and, if so, you can learn from our mistakes and avoid them.

British social work is in serious trouble. Public opinion of social workers is at an all time low; there are major problems in recruiting, as well as keeping, staff; and studies of social work services report a worrying drop in standards. We recently had a public inquiry into the death of a child, Victoria Climbie, and I shall be talking about it more later, but one awful lesson from it is that it shows us what practice can be like when people *don't* use their intuition or empathy and just follow procedures in a rote, mechanical way. Staffing is now a major problem. The application rate to social work training courses fell by two thirds between 1996 and 2001. Some London boroughs now have vacancy rates of 40 percent and even this alarming figure masks worse problems. Staff in post are increasingly inexperienced, untrained, short-term agency staff, or recruited from overseas so they do not know British law or British customs. Experienced social workers are leaving front-line work. This is destroying the resilient, close-knit teams that used to be a source of shared wisdom and emotional support. How can this be happening? We have more knowledge than ever before about how to help people effectively; the country is richer than ever. What is going wrong?

This is a big question and there can be no simple answer or one single cause. Developments within the profession are only one factor. I don't want to spend much time in considering other factors, but the social and economic changes in the United Kingdom have been so significant I have to mention them briefly. When I joined the social work profession in the 1970s, society was in an optimistic mood. Since the Second World War, Britain had been enjoying economic growth that was shared by all members of society. The welfare state had established comprehensive services to meet the population's needs for education, income support, health care, and housing. Social work seemed like the final piece in the jigsaw puzzle, offering skilled and personalised help to those experiencing particular difficulties in coping with the demands of parenting, or with physical or mental health problems. The social work profession was growing in status and power. More and more staff had postgraduate training and it was a popular and respected career choice for graduates like myself.

Then the oil crises in the 70s changed the mood. They threatened the sense of economic security; they made people more worried about their own survival, and consequently made them less generous to the disadvantaged. Margaret Thatcher brought in the radical changes of neo-liberal economic policy that undermined the welfare state provision of social services. She valued the efficiency of the private sector and the powers of the market and was very suspicious of public service workers, seeing them as self-serving and wasteful. This period in British society was also marked by a rise in individualism replacing a community spirit, again undermining public sector services and those who worked in them. Those in need who were increasingly seen as 'undeserving' and a burden on society, rather than fellow citizens in trouble.

These major social changes have had a big impact on the way social work is carried out. There is less trust in public sector services or respect for professional skill and there is a stronger demand for accountability and transparency. People want to see that their tax money is being spent well. This has led to a rise of managerial control of front-line work, and of the increasing formalisation and prescription of what services should be offered to users. In our child protection service now, for instance, there are detailed instructions about how to conduct an investigation into an allegation of abuse, strict time limits set out, and clear specification of when and where decisions should be made. Staff now have to complete detailed paperwork to show managers they have complied with procedures. Central government has set out precise performance indicators and targets by which their work will be measured, and praised or criticised. League tables showing local governments' scores on the performance indicators get wide publicity in the newspapers and on television, and local authorities are given a star rating depending on their scores. Those who get a zero star rating are noisily 'named and shamed'.

At least on the surface, these management changes look scientific and the kind of developments academic social workers have been arguing for. They are providing more guidance to help practitioners and, by setting out a formal procedure, are making sure social workers don't forget essential tasks. They look very sensible. And certainly, managers take the credit for being rigorous and objective. Numbers can look very impressive, and the way information is now collected lends itself to graphs and pie charts. But the impact on practice is not what was expected. Instead of boring you with research details and statistics, I think I can best give you an idea of the impact they have had by taking one case as an illustration. The case I'll talk about is that of Victoria Climbie, an eight year old who was murdered by her great-aunt and partner in 2000 after months of horrific abuse. I think her death was reported in the press here, so you may already be familiar with some details. She had recently come to Britain from the Ivory Coast after a short stay in France. Her parents had entrusted her to her great-aunt, whom she had not previously known, in the hope that she would be able to have a better life in Europe. There was a huge public reaction when Victoria died, not just because the details of her death were so horrible, but because she had been known to so many professionals in our child protection system that it seemed incredible that no one had noticed what was happening to her.

The inquiry produced a very, very long, detailed report (which is available on the Internet) and it provides a vivid picture of what is happening, at least in London. I have read every public inquiry report since 1973 and none of them have been remotely as bad as this one. In other reports, there were always several examples of good practice. A quarter of them concluded that professionals had all acted well and no one could have predicted or prevented the child's death.

In the other, critical reports, only a few professionals were ever criticised. They had failed to understand the significance of key evidence; they had rejected information that conflicted with their optimistic view of the family; they had got too close and too concerned about the parents and so they didn't give enough attention to the child.

In Victoria's case, the childminder (a non-professional) acted intelligently and compassionately, as did a junior doctor in a Casualty Department, but he, unfortunately, only had a fleeting contact with Victoria. It is difficult to find a good word to say for anyone else. And yet, there was no shortage of professionals with some knowledge of Victoria. In the few months she was in London, she was known to four social services departments, two police child protection teams, two housing departments, and she was admitted to two hospitals because of suspected abuse. She was not left in danger because one person made a big mistake, but because many, many people made many, many small errors. The inquiry found 12 key occasions when her plight should have been noticed and acted on.

I'll describe one error in detail to give you an idea. Her great-aunt had alleged that Victoria was being sexually abused by her new partner. There are standard procedures to follow when such an allegation is made, so, as prescribed, Victoria was interviewed by a social worker and a police officer. We now have detailed guidance on interviewing alleged victims of sexual abuse. Its main aim is to ensure that any evidence obtained can be used in a criminal prosecution, and cannot be discredited by the defence barrister as being gained through asking leading questions or rehearsing the child. Neither of the professionals involved in interviewing Victoria had had this training; neither of them had conducted this type of interview before. Understandably, they felt worried about carrying out the interview. They were unsure how to question her on such a delicate matter. However, they had to do it because it was prescribed in the procedure manual for dealing with an allegation of sexual abuse. They did follow the rules and interviewed Victoria. They did the part that got recorded. Now, you might be expecting me to complain that the quality of the interview was poor, that they were clumsy in how they established a rapport, how they raised the sensitive issues, how they responded to her distress. All of these criticisms would be justified, but they are overshadowed by one astounding error. They spoke to Victoria in English, but Victoria spoke French! Not surprisingly, they reported that Victoria said little, and what she did say they suspected was rehearsed. It does not seem to have occurred to them that her silence was due to a lack of language.

Their behaviour is in striking contrast to the childminder's. When she was worried by injuries on Victoria's body, she took her to her son's school and asked the French teacher to talk to Victoria in French and ask her how she got the injuries. The explanations she offered were implausible, so the childminder then took her to the local Casualty Department where she was admitted for further investigations.

The inquiry concluded that Victoria died because people failed to do basic things properly. Lord Lamming, who chaired the inquiry, said at the end that he was still amazed about the work that had been described to him. Everyone who has read the report has the same feeling. And a sense of despair. The report revealed human error on a massive scale, and yet it comes after 30 years of similar inquiries, each of which has produced a list of recommendations, designed to prevent human error. So why are things getting worse, not better?

I have probably plunged you all into depression, but I am pleased to say that I am now going to get more positive.

In my search for solutions, I found an answer in a rather surprising place: in engineering literature. People trying to prevent accidents in nuclear power stations or plane

crashes had faced remarkably similar problems to social work. Like social work, they have a long history of investigations into disasters that have generally concluded they were due to human error. Like social work, they have tried to improve human performance by writing more and more detailed procedures and creating tools to replace or reduce the human element. And, again like social work, they found their solutions were not having the right effect and were, in fact, making some problems worse.

In 1979, there was a serious nuclear accident at the Three Mile Island power station in the United States of America that was blamed on human error. Investigators found one piece of faulty equipment, but concluded that it played only a small part in the disaster; most of the blame fell on the operators. They did not take the correct steps to solve the problem, but, in fact, made things worse by misinterpreting the signs of trouble. The official inquiry followed the traditional pattern of being satisfied by the explanation that incompetent humans were to blame. So it also came up with the traditional solution of controlling these unreliable people. It recommended cutting out the human element by having more automation, improving the human performance by giving even more detailed guidelines to follow, and ensuring people followed these instructions by having stricter monitoring by management.

But a new type of investigation was later carried out. This rival analysis of the situation did not stop at uncovering human error, but asked *why did the operators make the mistakes.* This cast a completely new light on the situation. Whereas the official inquiry gave the impression that the staff had been careless or stupid, the new analysis suggested that they were victims of the way the system had been designed. To make it easier for people to notice if anything was going wrong, engineers had created warning systems for each component that might malfunction. Each one on its own looked sensible and added to safety, because it alerted the operators to the fact that something was going wrong. But the overall effect was to create a control room in which there were more than 600 alarm lights. When a serious accident occurred, there was confusion, as so many alarms went off that the operators could not easily grasp what was happening.

Because engineers had concentrated on reducing the human element, they hadn't thought about the impact their solutions were having on the tasks left for the operators to do. Expecting a human, with an ordinary human brain, to interpret two hundred flashing red lights accurately is just stupid. We know we are no good at that type of task. So, yes, the disaster was due to human error, but any human would have made a mistake in dealing with that information. Blaming them is unreasonable and will not solve the problem.

The new type of investigation produces new types of solutions. Instead of trying to control erratic people, the aim is to understand them; to see why, from their local point of view at the time, it made sense to do the action that hindsight tells us led to things going wrong. It is assumed that their behaviour is rational, so the purpose of an investigation is to find out the reasoning behind their choice of action.

Reading the engineering literature transformed the way I was looking at the problems of improving social work and I think it offers a really creative way of understanding what has been going wrong.

A few years ago, I carried out a piece of research analysing the reasoning errors identified in child abuse inquiries, so I was very familiar with the form the investigations had taken and could see that they followed the traditional pattern. They also produced the traditional solutions:

1 reduce the human element: risk assessment and decision making instruments are increasingly used to replace human intuitive reasoning;
2 increase the guidelines for them to follow: the Climbie report noted that the social workers had extensive guidance to help them; so extensive, in fact, that it filled 13 books. Perhaps we should not be surprised that it turned out that the staff had not read them all.
3 increase monitoring to make sure they are following the official guidance and rules: management has produced lots of forms for staff to complete, so that they can keep an eye on whether are doing as they are told.

The Victoria Climbie inquiry is in this same mould. Lord Lamming said he was amazed at the errors he found, but he said this at the end of his investigation. In the new form of analysis this should be the starting point, not the conclusion.

At this point, we move into the area where I am talking about work in progress, not giving you a polished, completed account. The engineering literature has provided a framework for analysing the human contribution:

1 Did the worker have the appropriate knowledge and skills to do the task?
2 Where was attention focused at the time, what other demands were being made?
3 What conflicting goals did the worker have to choose between?

At this stage, I can only offer sketchy answers, but I think even so they illustrate how much more useful this approach is in making a real impact on the quality of social work.

If we look at the first question: did the worker have the appropriate knowledge and skills to do the task? The answer, in Victoria's case, is clearly 'no'. The key social worker was new to the agency and had never investigated an allegation of abuse before. Staff shortages meant that many posts were filled with people who lacked the necessary

knowledge and skills and many of those who gave evidence to the inquiry were honest about how unprepared they felt. One duty social work team had no permanent staff and no-one trained in Britain.

If we had a shortage of brain surgeons, it is hard to believe that any hospital would try to cope by asking medical students to do complex brain operations, yet this is the kind of solution being adopted in social services departments. The key social worker in Victoria's case has now been sacked and banned from working with children ever again. I think the blame lies with the agency that employed her knowing she lacked the expertise. It also reflects a lingering belief in society in general that social work is not a skilled job, but can be done by anyone who is kind and caring.

The reason for the desperation in filling posts is because experienced staff are leaving in their thousands. When asked why they are leaving, the main factor is the heavy load of paperwork, which interferes with their work, followed by too heavy caseloads, and a lack of autonomy. The very factors that were meant to improve practice are causing fundamental damage to the workforce.

Engineers talk mostly about intellectual factors, but I think the emotional dimension is just as important. You all know how emotional social work is and how much you need support and help in dealing with it. One of the most upsetting aspects of reading the Climbie report was that, unlike any other report, I found a lack of kindness in the professionals. You have the impression that no one ever looked directly at Victoria and tried to empathise with her. The newspapers made much of this and were very critical, but I think we should see it as cause for concern not complaint. People don't join caring professions with hard hearts, so what had happened to them to lose their emotional concern for the families they were working with? They have been damaged by working without proper emotional support.

Let us consider the second question: where was attention focused at the time, what other demands were being made? The answer can only be guessed at, because the inquiry in typical style concentrated on the work that had been done in relation to Victoria. The social worker was criticised for *not* doing something, but they did not ask what she was doing *instead.* It might have been more important. She certainly was not just gossiping or doing her knitting; she was doing something that seemed important to her. We do know that she had a very large caseload, a total of 19, 7 more than the maximum set down in the staff handbook (you will notice that senior management was happy to ignore the rules when it suited). Since they were all active cases, she would have been receiving information about all of them, so a phone call about Victoria would have been only one item in a vast quantity. And being so inexperienced, she would have great difficulty in making an intuitive judgement about which bits were serious and which could be ignored.

The third question is: what conflicting goals did the worker have to choose between?

Child protection work has always had the fundamental conflict between supporting parents and protecting children, but, besides this classic dilemma about what risks to take, there is a new pervasive conflict. Workers have to choose between following procedures and spending time talking to families or reflecting on their work. You would expect the procedures to encourage talking to families and thinking about your work, but, in practice, they do not. The reasons are twofold. The system in place at the moment is too crude, but, even if we improve it, I don't think we can ask it to do the job of *replacing* human expertise.

Let us first look at the crudity of the current system of paperwork. It has been created to serve two different purposes. One is to improve professional practice by giving guidance and checklists so that social workers do not leave out important elements of the work. The second purpose is to allow senior management, accountants and politicians to monitor what is being done. Professional and management needs are significantly different. Paperwork that meets management's needs does not necessarily link well with professional needs.

The fundamental problem in the current system is the level of language used to describe practice. At the heart of social work, traditionally, has been the relationship with the person we are trying to help, and we had not created a language for talking about this in great detail, so when, in the 1980s, accountants and management tried to create a way of recording practice they had to create the categories. I have not got time here to go into this process in detail, but I would make two points: first, this is a big task, secondly, they were under enormous political pressure to do the job quickly. The result, of course, was that they chose performance indicators that described the simpler and easily seen details: whether a form had been completed, not whether the content was accurate; whether an interview had taken place, not how well it had been done. Quantity dominated over quality. The effect of creating this level of language for talking about social work has not just been to *describe* but also to *shape* practice. The choice of performance indicators has been carried out by central government officials with, at best, some discussion with senior management. Front-line workers have had little say in the creation of a system for monitoring their work.

The key problem with current developments is that:

- what gets measured gets attention;
- what gets measured gets rewarded;
- and, in the final analysis, what gets measured gets done.

Now, you might say that making sure it got done was the reason for introducing the whole system, so where is the problem?

The question is that if we are only capturing the surface elements of practice, what is happening to the rest? It isn't getting attention; it isn't getting rewarded; and, sadly, it is increasingly not getting done. And that, I think, is why so many excellent social workers are leaving the front-line jobs. They are unable to carry out the job they are trained for, that they are good at, and that gives them a sense of work well done.

The changes in supervision give a good illustration. Traditionally, supervision focused on the casework process; it was a time to discuss how the work had gone, a time to reflect on the assessment made, and a time to review the plan of how to help. Now, when supervision takes place (which is less and less often, since it is not measured by any performance indicator), the main function is to check whether procedures have been followed and the paperwork has been completed. The supervisor is becoming a manager, not a more experienced professional advising a junior.

The effect of switching attention from the complex and largely intuitive dimension of helping a fellow human being to the simple, easily measured aspects of work, coupled with strict monitoring of these simple aspects leads to the kind of practice described in the Climbie report. It shows a set of professionals all engrossed in following procedures, doing the tasks allotted to them *and not stepping outside this limited role.* No one took responsibility for Victoria's welfare. The doctors looked only at her medical needs; the police looked for evidence of criminal activity; the social workers focused on whether she was a victim of abuse, not on whether she had any other welfare needs.

I hope by now I have convinced you sufficiently for you to agree that the recommendations of the Climbie inquiry are unlikely to work. The strongest recommendation is that there needs to be a clear line of accountability throughout the agency so that senior management monitors front line workers so closely that they can be sure they are following procedures. This will only work if we assume that the staff failed to follow procedures for feckless reasons and that they can choose to act competently if there are enough threats and coercion. It also assumes that following procedures will in itself lead to good practice, but this is clearly not so. Victoria's social worker followed procedures in interviewing her about the sex abuse allegation, yet it was clearly a useless exercise since Victoria did not understand what was being said to her.

To sum up, I said that recent developments had made me re-think my views on science and social work. I still think that the profession should try to be more scientific. We can be clearer about what we are doing; we can subject our practice to more rigorous evaluation; we can meet the demands being made of all public sector services for greater transparency and accountability. However, we need to turn the picture inside out.

At present, the formal elements – the procedures, risk assessment instruments, audit systems – dominate the foreground and have high status. The human elements – intuitive reasoning, empathic understanding, and kindness – are in the background and are not just being ignored and undervalued, but are also being destroyed. People are needed to implement the formal measures, but they are, at present, seen as the primary source of error. They don't follow procedures, they are biased, and they are fallible. The aim seems to be to reduce their role as far as possible.

I have been arguing that we need to reverse this. At the core of a social work is one human being trying to help another. We need intuition and empathy to relate to each other, and these are skills that can be developed and used more critically. We can be helped by empirical research, by guidelines and by good quality supervision, but these need to be designed to support human reasoning, not as a mechanical alternative.

If politicians, accountants and managers succeed in eliminating the human element from social work, then the experience of Britain shows that they also eliminate the human beings. Professionals who joined social work to help others do not want to be turned into administrators following rote commands and completing countless forms. Efforts to do just this have led to their voting with their feet and leaving front-line work.

Dr. Eileen Munro, Reader Social Policy, London School of Economics.

Co-referaat bij de lezing van Eileen Munro

Corine de Ruiter

Introductie

It is with great pleasure that I accept this opportunity to give my reflections on dr. Munro's lecture and to provide you with some food for thought, which will hopefully be of help in the continual improvement of the quality of social work in the Netherlands. I will now continue my presentation in Dutch in order to make sure all Dutch colleagues can take part in this discussion.

Dr. Munro schetst een droevig beeld van de toestand waarin het maatschappelijk werk in Groot-Brittannië verkeert. Door een steeds maar toenemende druk vanuit de overheid om productiecijfers te leveren en standaardprocedures te volgen, is een afrekencultuur ontstaan. Munro's voorbeelden komen voornamelijk uit het veld van de kinderbescherming, maar ik neem aan dat haar observaties ook gelden voor andere sectoren waarin maatschappelijk werkers actief zijn.

De vorm lijkt belangrijker te zijn geworden dan de inhoud. Als alle formulieren maar juist zijn ingevuld en de deadlines voor afhandeling van zaken gehaald, is de manager tevreden. De menselijke maat verdwijnt op zo'n manier langzaam uit het maatschappelijk werk, en veel werker verlaten gedesillusioneerd de professie. Deze ontwikkeling heeft in Engeland desastreuze gevolgen voor de kwaliteit van de kinderbescherming, getuige de casus van het meisje Victoria Climbie. Onlangs afgestudeerde maatschappelijk werkers worden voor de bijna onmogelijke taak gesteld om in korte tijd informatie te verzamelen over een ingewikkelde casus, deze informatie te wegen en aan de hand daarvan cruciale beslissingen te nemen. Door een tekort aan werkers is de *caseload* vaak te zwaar en ontbreekt tijd voor reflectie en supervisie. Geen wonder dat er ernstige fouten gemaakt worden!

Eileen Munro hoopt dat wij van de fouten die in Engeland gemaakt zijn, zullen leren. Dat hoop ik ook! Want ook in Nederland is er een tendens gaande richting standaardisering van procedures en afrekenen op productie en prestaties, enkel uitgedrukt in kille cijfers. En cijfers alleen zeggen niet zoveel. Wat kunnen wij doen om een ontwikkeling als in Groot-Brittannië te voorkomen?

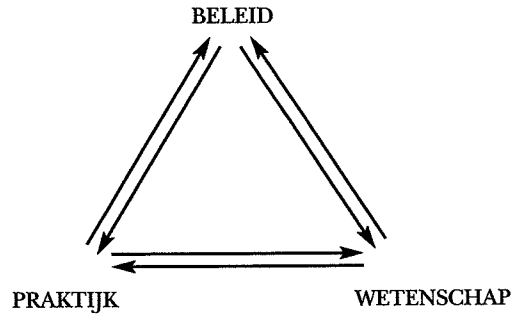
Het belang van de driehoek 'Beleid-Praktijk-Wetenschap'

Reeds een aantal jaren is ook in Nederland het beleid vanuit de overheid erop gericht binnen de verschillende sectoren van de zorg te komen tot standaarden, richtlijnen en protocollen. Verschillende beroepsorganisaties leveren daaraan, veelal met overheidssubsidie, een bijdrage. In vergelijking met professionele organisaties van artsen en psychologen, is deze ontwikkeling minder ver gevorderd in de wereld van het maatschappelijk werk. Ook hier treedt echter verzakelijking in, en wordt op diverse fronten gewerkt aan een systematischer en transparanter methodiek. Een voorbeeld hiervan is de ontwikkeling van een op wetenschappelijke bevindingen ontwikkelde methodiek voor begeleiding van delinquenten door reclasseringswerkers (Menger & Krechtig, 2003). Uit onderzoek in Angelsaksische landen is inmiddels aangetoond dat resocialisatietrajecten die gericht zijn op het verminderen van criminogene risicofactoren effectief zijn in het tegengaan van delictrecidive (Hollin, 2001). Volgens deze methodiek dient de reclasseringswerker, voorafgaand aan het opzetten van een begeleidingstraject, een uitgebreide inventarisatie van criminogene risicofactoren te verrichten, waardoor het begeleidingsplan optimaal is toegesneden op de behoeften van de individuele cliënt.

Deze systematische werkwijze geeft de werker houvast en inzicht tijdens het begeleidingsproces. Bij de ontwikkeling van deze methodiek door de Stichting Reclassering Nederland wordt de kennis van ontwikkelaars, praktijkwerkers en wetenschappers gebundeld. Door uitgebreide veldtesten wordt ervoor gezorgd dat de ervaring van praktijkwerkers in de methodiek geïntegreerd wordt.

Waarom geef ik dit voorbeeld? En waarom denk ik dat hier sprake is van een gunstige ontwikkeling, die niet de gevaren in zich draagt die dr. Munro zojuist noemde? Ook de methodiekontwikkeling bij de reclassering is mede ingegeven door de steeds luidere (en ook vaak terechte) roep van beleidsmakers om grotere transparantie, doelmatigheid en kwaliteit. Maar als de vraag vanuit het beleid gesteld wordt, betekent dat nog niet dat het antwoord ook vanuit het beleid geformuleerd en opgelegd moet worden. Ik zou zelfs willen zeggen: juist niet! Beleidsmakers staan vaak zeer ver af van de dagelijkse praktijk. Zij hebben vanuit de aard van hun functie een helikoptervisie op die werkelijkheid, een visie die door de inbreng vanuit de praktijk en de wetenschap moet worden gevoed. Ik zeg met opzet praktijk én wetenschap. De praktijk alleen is te eenzijdig. Onze feilbare klinische blik, waarvan dr. Munro in haar boek *Effective child protection* uit 2002 zo veel pijnlijke voorbeelden heeft gegeven, speelt daarbij een grote rol. Zo blijken praktijkwerkers een blinde vlek te hebben voor informatie die in strijd is met hun reeds gevormde beeld over een casus; de werker kan maar moeilijk geloven

dat de moeder die zo bezorgd is over haar baby tijdens de intake, ook degene is die haar met opzet zo hard door elkaar heeft geschud. In zo'n geval is kennis over de kenmerken van kinderen met het *Shaken Baby Syndrome* en hun ouders een belangrijke toetssteen voor de praktijkwerker. Het is mijn overtuiging dat door de samenwerking van praktijk en wetenschap een evenwichtig antwoord op de vragen van beleidsmakers om grotere doelmatigheid en transparantie geformuleerd kan worden.



De principes van *evidence based practice* moeten daarbij leidend zijn, zonder praktijkvaardigheden als empathie en intuïtie uit het oog te verliezen. In de driehoek tussen beleid, praktijk en wetenschap kan een effectieve en efficiënte zorg ontstaan, als de drie elkaar tenminste in evenwicht houden. Het gevaar van bureaucratisering dreigt als beleidsmakers niet luisteren naar praktijkwerkers en wetenschappers. Als de wetenschap de overhand zou krijgen dreigt technocratisering. En een te sterk overwicht van de praktijk biedt te weinig transparantie. De huidige regering voert een beleid dat meer verantwoordelijkheid bij de mensen legt. Dit kan slecht uitpakken voor mensen die te kwetsbaar zijn om die verantwoordelijkheid te dragen. Aan de andere kant biedt het kansen voor professionals zoals u en ik om minder aan de leiband van beleidsmakers te lopen en zelf initiatieven tot verbetering te ontplooien.

Wat werkt?

Dr. Munro is in Groot-Brittannië getuige van een grote uitstroom van ervaren maatschappelijk werkers, gedesillusioneerd door het gebrek aan waardering voor hun jarenlange praktijkervaring en de daarbij behorende vaardigheden. In het kinderbeschermingswerk heeft het gebruik van gestandaardiseerde risicotaxatie-instrumenten geleid tot een ontzieling in het werk, de nadruk is teveel komen te liggen op het rigide volgen van het stramien, dat blijkbaar een grote starheid in zich draagt.

Het kan ook anders. In Nederland hebben wij binnen de forensische psychiatrie inmiddels een aantal jaren ervaring met het gebruik van gestructureerde risicotaxatie-instrumenten (De Vogel & De Ruiter, 2003; De Vogel, De Ruiter, Van Beek & Mead, 2003). Dit zijn checklists die bestaan uit een twintigtal risicofactoren waarvan wetenschappelijk is aangetoond dat ze goede voorspellers zijn van nieuw probleemgedrag. Praktijkwerkers in de forensische psychiatrie ervaren het gebruik van deze instrumenten als uitermate zinvol. Het brengt systematiek aan in hun risico-inschattingen, zij zien minder vaak risicofactoren over het hoofd en zij ontwikkelen een gemeenschappelijke taal die hen helpt bij de onderlinge communicatie over risico's en de hantering daarvan. Veranderingen in risico kunnen, met behulp van deze instrumenten, objectief vastgesteld worden. De gestructureerde risicotaxatie-instrumenten, zoals de *Sexual Violence Risk-20* (Hildebrand, De Ruiter & Van Beek, 2001) zijn geen 'kookboeken'. Klinische ervaring en kennis van de wetenschappelijke literatuur zijn de gemeenschappelijke peilers waarop dit type instrumenten rust. De kwaliteit van het werk, in dit geval de nauwkeurigheid van de risico-inschatting, verbetert sterk door het hanteren van het instrument (De Vogel e.a., 2003; De Vogel, De Ruiter, Hildebrand, Bos & Van de Ven, 2003).

Om aan te geven dat er niet alleen kommer en kwel heerst in de kinderbescherming, zoals dr. Munro schetste, wil ik u deelgenoot maken van een onderzoeks- en implementatieproject, waarvoor het Trimbos-instituut onlangs een subsidie heeft ontvangen. Het betreft de ontwikkeling van een risicotaxatie-instrument voor gevallen van kindermishandeling, dat bedoeld is voor gebruik door vertrouwensartsen en maatschappelijk werkers van de Advies- en Meldpunten Kindermishandeling (AMK). Voordat ik de inhoud van dit project ga bespreken, wil ik kort stilstaan bij een casus, die wel de Nederlandse equivalent van de 'Victoria Climbie casus' genoemd kan worden.

De casus 'Roermond'

In de nacht van 11 op 12 juli 2002 sticht een vader brand in zijn huis met daarin zijn vrouw en zes kinderen tussen 4 en 12 jaar oud. Alle kinderen komen daarbij om. De Inspectie Jeugdhulpverlening en Jeugdbescherming verricht een quick scan die reeds in augustus gepubliceerd wordt. De Inspectie constateert dat 2,5 jaar bemoeienis van jeugdzorginstanties niet geleid heeft tot een aantoonbare verbetering van de leef- en opvoedingssituatie van de betrokken kinderen. Vooral de gebrekkige informatieoverdracht tussen de verschillende instanties, onder andere het AMK en de Raad voor de Kinderbescherming, wijst zij aan als oorzaak van het drama (Inspectie Jeugdhulpverlening en Jeugdbescherming regio Zuid, 2002). Een gezinscoach, die als case manager fungeert, zou de oplossing voor dit probleem moeten bieden.

Het is de vraag of het onderzoek van de Inspectie diepgravend genoeg is geweest. Niet alleen de communicatie tussen de betrokken instanties was inadequaat, de vraag dient ook gesteld te worden of de kwaliteit van de risicotaxatie voldoende was in het Roermondse geval. Uit de casus blijkt bijvoorbeeld dat de diverse instanties nogal verschillende indrukken hadden over wat er in het betreffende gezin gaande was. Een systematische inventarisatie van risicofactoren voor kindermishandeling heeft nooit plaatsgevonden. Ook andere auteurs hebben hun twijfels geuit over de professionaliteit en de effectiviteit van de werkwijze van de verschillende instanties (Meuwese, 2002).

Tot zover 'Roermond'. Het onderzoeksproject dat wij gaan uitvoeren, behelst het ontwikkelen en toetsen van een risicotaxatierichtlijn, die gebaseerd is op een in Canada ontwikkeld instrument, de *Child Abuse Risk Evaluation* (CARE). De CARE bevat 14 risicofactoren, onderverdeeld in ouderfactoren, ouder-kind interactiefactoren, kindfactoren en omgevingsfactoren (zie kader). De 14 factoren zijn niet uitputtend, de professional kan besluiten om extra risicofactoren toe te voegen die hij in een individueel geval relevant acht. De CARE past in een traditie van risicotaxatierichtlijnen voor diverse vormen van geweld, onder andere op het gebied van partnermishandeling, seksueel geweld en geweld gepleegd door adolescenten. Gestructureerde risicotaxatie blijkt een nauwkeurige voorspeller van herhaling van het geweld en biedt effectieve aanknopingspunten voor interventies, de zogenaamde risicohantering (*risk management*).

CARE: Risicofactoren voor kindermishandeling

Ouderfactoren
eerdere mishandeling
ouder is zelf slachtoffer van kindermishandeling
suïcidale of gewelddadige gedachten
alcohol- en/of drugsmisbruik
cluster B persoonlijkheidsstoornis
niet meewerkend aan interventies

Gezinsfactoren
stressoren in het gezin
gebrekkige sociale steun
relatieproblemen

Ouder-kind interactiefactoren
zwakke opvoedingsvaardigheden
vervormd beeld van het kind

problemen in de ouder-kind interactie

Kindfactoren
kindkenmerken die kwetsbaarheid vergroten

Overige factoren

De CARE kan ingezet worden op alle momenten in het traject van risicotaxatie. Bij de melding bij het AMK moet direct getaxeerd worden of er (ernstig) acuut gevaar voor het kind is; daarbij worden acute risicofactoren als homicidale gedachten en impulsen bij de ouder nagegaan. Vervolgens kan globaal gescreend worden op de overige risicofactoren, die vervolgens in het uitgebreidere onderzoek dat het AMK verricht, nader worden belicht. Door de beoordeling van het risico middels de CARE ter hand te nemen, worden geen zaken over het hoofd gezien, en kan de besluitvorming over de casus (hulpverleningstraject, kinderbeschermingsmaatregel, etc.) gedegen onderbouwd worden.

Binnen het project zal de CARE-richtlijn getest worden op globale bruikbaarheid en in een retrospectief dossieronderzoek zal de voorspellende waarde van het instrument worden onderzocht.

Daarna volgt, als alles volgens plan verloopt, een implementatieproject, waarin opleiding en intervisie in het gebruik van de CARE in de dagelijkse klinische praktijk centraal staan. Een vaste richtlijn voor risicotaxatie bij kindermishandeling zal de uitwisseling van kennis en informatie tussen instanties in de jeugdzorg bevorderen. In het CARE-project wordt door praktijkwerkers en onderzoekers samengewerkt. Beleidsmakers zijn in deze fase volgend, maar hopelijk op termijn sturend in het voeren van een kwaliteitsbeleid waarin scholing in risicotaxatie en -hantering in gevallen van kindermishandeling standaard is. De kwaliteit van de zorg behoort het leidend principe te zijn. Als de kwaliteit verbetert, zullen er minder slachtoffers van kindermishandeling zijn. En dat betekent, op termijn, een enorme kostenbesparing, in zowel materiële als immateriële zin.

Prof.dr. Corine de Ruiter, die als co-referent optreedt, is programmahoofd Nationale Monitor Geestelijke gezondheid (NMG) van het Trimbos-instituut (Netherlands Institute of Mental Health and Addiction) en bijzonder hoogleraar Forensische psychologie aan de Universiteit van Amsterdam.

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