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Assessing safety culture in child welfare: Evidence from Tennessee

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ABSTRACT

States continue to search for ways to prevent harm to children and families within the child welfare system. Recently, states and researchers alike have looked to other high hazard sectors that have experienced harm-free performance by creating and sustaining a strong safety culture – an organizational focus and priority on safety. Safety culture is enabled by leader actions to prioritize safety (safety climate) and make it safe for employees to take an interpersonal risk (psychological safety). Safety culture is enacted by behaviors for detecting and correcting errors and unexpected events (safety organizing) and recognizing how stress affects work performance (stress recognition). However, despite their conceptual relevance and practical promise for child welfare, these and other safety culture constructs have yet to be subjected to rigorous empirical analysis in child welfare. This study draws on 1719 employees in the state of Tennessee's child welfare system to examine whether safety culture can be reliably and validly measured, can characterize organizations across a state (i.e., employees have shared perceptions of the safety culture), and be linked to relevant outcomes (e.g., employee emotional exhaustion). Our results confirm that components of safety culture can be reliably and validly measured in child welfare, perceptions of culture are shared within each of the Tennessee child welfare system's twelve regions, and that safety culture is generally associated with lower levels of employee emotional exhaustion, but also indicate that there is considerable opportunity for improvement as the levels of safety culture are low relative to other sectors.

1. Introduction

Child welfare agencies are charged with keeping vulnerable children safe. The scope of this responsibility is substantial (U. S. Government Accountability Office, 2011). For example, in 2013 child welfare agencies across the United States received an estimated 3.5 million referrals of abuse and neglect involving over 6 million children with over 1,500 of those referrals resulting in child fatalities due to abuse and neglect (U. S. Department of Health and Human Services, 2015). In addition, during any 12-month period, up to 50% of children in foster care experience the less fatal, but significantly traumatic disruption from their placements and have to be moved to another home or to a more restrictive setting (Smith, Stormshak, Chamberlain, & Whaley, 2001). The magnitude and frequency of harm in child welfare indicates that threats are always present (Rzepnicki et al., 2010). Failures in the child welfare system, be they fatalities or instances where a child is not removed from a home where he or she is later harmed, often generate significant media attention and public outrage that threaten the reputation and funding of agencies (Cull, Rzepnicki, O'Day, & Epstein, 2013; Gainsborough, 2009; Green & Tumlin, 1999; Rzepnicki et al., 2010).

Problems of harm persist in child welfare, in part, because it is an especially difficult context for change. Change is hard due to the concatenation of multiple factors. First, resources are increasingly scarce in child welfare as agencies face budget cuts and being forced to do more with less (Zell, 2006) while simultaneously experiencing greater media and public scrutiny and criticism (Chenot, 2011). Public outcry and scrutiny often results in child welfare agencies reacting defensively (Gambrill & Shlonsky, 2001; Orr, 1999) such that active reflection, problem-solving, and learning fail to occur (Committee on Ways and Means, 2012; Lachman & Bernard, 2006; Rzepnicki et al., 2012). In other words, child welfare agencies become rigid and risk-averse in order to minimize low-probability, high cost outcomes like child deaths (Macdonald & Macdonald, 2010). Second, child welfare workers experience these resource and structural conditions as high levels of job pressure with heavy and increasing workloads, often with life and death stakes (Barak, Nissly, & Levin, 2001; Rzepnicki et al., 2010; Tham & Meagher, 2009). An overwhelming workload coupled with inadequate training and staffing (Barth, Lloyd, Christ, Chapman, & Dickinson, 2008) further inhibits change to meet the pressing problems in child welfare. Third, Yamatani, Engel, and Spejeldnes (2009) find that heavy caseloads are often accompanied by significant pressure to process cases quickly.

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High production pressure and otherwise difficult working conditions also pose significant threats to child safety by inducing child welfare employees to make faulty judgments, exhibit inflexible thinking, and become behaviorally and cognitively rigid (McGee, 1989; Stevens & Higgins, 2002). More specifically, poor working conditions can result in cursory assessments, during a child welfare caseworker's initial meeting with a family, of threats to child safety or a family's ability to protect a child from those threats (Orsi, Drury, & Mackert, 2014).

Current risk and safety approaches intending to address persistent harm and difficult working conditions in the child welfare systems have tended to be piecemeal and lacking a comprehensive, systemic approach (Pecora, Chahine, & Graham, 2013). To find more systemic approaches to reducing persistent harm and breaking through difficult barriers to meaningful change, child welfare researchers have called for emulating other sectors ranging from aviation to health care that face similar complexity, risk, and high consequence decision-making and manage these conditions in a nearly harm-free manner (Cull et al., 2013; Munro, 2005; Rzepnicki et al., 2010). More specifically, the U.S. Department of Health and Human Services – Administration for Children, Youth and Families, U.S. Centers for Disease Control and Prevention, and the Casey Family Programs have all called for replicating the results other high-hazard sectors by strengthening the safety cultures of child welfare agencies (Committee on Ways and Means, 2012). More recently, the Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) reinforced the related calls for child welfare agencies to focus on creating safety cultures (CECANF, 2016). In fact, the final CECANF report specifically recommends funding pilot projects to evaluate the use of safety science in child protection and the use of safety culture measures (i.e., measures of the workforce, management, and supervision informed by safety science) in states' federally-mandated Child and Family Services Reviews (CSFRs) (CECANF, 2016).

Safety culture is the extent to which an organization and its members' values, attitudes, and behaviors align to focus their attention and effort on safety and pursuing reliable, harm-free operations (Vogus, Sutcliffe, & Weick, 2010). In other words, a safety culture emerges within an organization, but applies to the services it provides and the constituencies it serves. Prior research suggests that leaders successfully enable safety culture through behaviors and practices that place priority on safety (i.e., safety climate) and make it safe for individuals to speak up (i.e., psychological safety) (Vogus et al., 2010). Frontline employees successfully enact a safety culture when they engage in behaviors and processes that proactively detect and correct the unexpected (i.e., safety organizing) and monitor themselves, their peers, and the service delivery system for signs of stress (i.e., stress recognition) (Singer & Vogus, 2013; Vogus et al., 2010). In child welfare, enabling a safety culture entails efforts to broaden and sharpen thinking regarding safety and risk assessment (Pecora et al., 2013). Enacting safety culture means moving beyond identifying high-risk situations to more effective interventions and ongoing support (Pecora et al., 2013).

Pursuing safety culture as a means of reducing harm in the child welfare system raises important questions regarding the costs and efficacy of doing so. Specifically, given the extremely high levels of emotional exhaustion – feeling emotionally depleted and overextended (Maslach & Jackson, 1981) – experienced by child welfare employees (e.g., Anderson, 2000; Kim, 2011), does safety culture increase demands and worsen emotional exhaustion or help front line employees cope with their difficult work? Looking to the effects of safety culture on employees is essential because a safety culture relies on frontline employees like caseworkers to enact and refine it. In other words, enacting a strong safety culture is especially cognitively and emotionally effortful and demanding (Schulman, 1993). However, emotional exhaustion is a function of employee ability or inability to obtain and retain valued resources (Hobfoll & Freedy, 1993). Safety culture may in the form of safety climate provide a form of supervisory support (Lizano & Barak, 2012) and in the form of safety organizing higher quality work relationships (Zeitlin, Augsberger, Auerbach, & McGowan, 2014) both of which have been associated with lower levels of emotional exhaustion and reduced turnover (Claiborne et al., 2011). Thus, exploring the safety culture – emotional exhaustion relationship provides an important initial test of whether safety culture is beneficial to or costly for child welfare workers.

Although there is a strong conceptual and empirical base regarding the value of safety culture in other industries and increasing calls for safety culture as a potential solution to persistent harm in child welfare systems, there is little direct empirical evidence regarding the applicability of safety culture to child welfare. Thus, we start with an attempt to assess the applicability of safety culture concepts in child welfare. In other words, do the findings of other high-hazard industries like health care delivery replicate in a similarly complex, high hazard (Rzepnicki et al., 2010), and morally ambiguous (e.g., Hasenfeld, 2009) child welfare system? Therefore, in this paper, we attempt to build an empirical foundation by answering a set of basic questions regarding safety culture in child welfare. First, can safety culture be reliably and validly measured in child welfare agencies? Second, how do observed levels of safety culture in child welfare compare to established benchmarks for assessing safety culture strength and with sectors with established records of harm-free operations? Third, are perceptions of safety culture shared within child welfare agencies? Lastly, in a test of predictive validity, does safety culture relate to an important outcome associated with harm in child welfare, employee emotional exhaustion (Armstrong & Laschinger, 2006; Boyas & Wind, 2010; Garrett, 2008; Glisson & Green, 2006; Halbesleben & Wheeler, 2011)? We answer these questions through a large survey study of employees in the Tennessee child welfare system in what we believe to be the first empirical safety culture study of child welfare employees.

2. Literature review

As noted above safety culture results from actions undertaken by leaders to enable it and by frontline employees to enact it (Singer & Vogus, 2013; Vogus et al., 2010). We describe two key ways by which leaders enable safety culture by prioritizing safety relative to other goals (i.e., safety climate, Zohar, 1980) and building psychological safety that encourages frontline workers to speak up and take interpersonal risks (Edmondson, 1999), ground them in child welfare work, and posit how they relate to emotional exhaustion. We then do the same for two ways in which frontline employees enact a safety culture by building capabilities for detecting and correcting errors and unexpected events (i.e., safety organizing, Weick & Sutcliffe, 2007) and how stress and fatigue affect work performance (i.e., stress recognition, Sexton, Helmreich, et al., 2006; Sexton, Holzmueller, et al., 2006).

To date, research in child welfare examining organizational culture's linkages to appropriate service delivery and employee outcomes has tended to focus on general characterizations of culture, such as the extent to which it is "constructive" (e.g., encouraging interactions and approaches that help staff meet their needs) (Glisson, Dukes, & Green, 2006; Glisson & Green, 2006, 2011; Spath, Strand, & Bosco-Ruggiero, 2013). Overcoming the persistent safety problems and barriers to improvement, however, requires a more specific and tailored approach. In other words, it requires a facet-specific approach to culture that emphasizes safety (e.g., Zohar & Luria, 2005). A facet-specific approach focuses on the organizational environment that shapes role behavior, that is, the extent to which certain facets of role behavior (e.g., safety) are rewarded and supported by an organization (Reichers & Schneider, 1990; Zohar & Luria, 2005).

2.1. Safety climate

Safety culture is enabled through safety climate or a specific set of leader actions including implementing safety-related procedures, giving safety highest priority (relative to other goals), broadly disseminating safety information, and otherwise working to assure safety (Naveh,