No room for failure

With more state resources and a new approach, Minnesota can improve county-administered system for protecting children

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There is nothing more gut-wrenching than looking at the face of a child with obvious and significant injury to his face and neck peering out of the newspaper with a shy, endearing smile. Anyone willing to look at the misery reflected in that image would wonder why our child-protection system failed to save his life.

This image, and the accompanying story about how teachers and neighbors sought intervention as many as 15 times, caused the governor of Minnesota to establish a task force to examine our child-protection system, which was a colossal failure for this child.

Was this incident an anomaly or a reflection of a systemic failure?

To be sure, Minnesota prides itself on its progressive attitude about government's role in the care and protection of vulnerable children and adults. Our citizens assume that children's welfare is a high priority. Such a stark visual confrontation of that shared belief generated outrage by the public, alarm by legislators, and concern from those who work in child protection.

The governor was criticized by many as overreacting to one incident, reported by one newspaper, by one reporter. But through his 2014 executive order, a task force with broad representation and expertise worked for many months studying Minnesota's child-protection system and recommending its reform.

This year, our state Legislature increased funding to improve our county-administered system and to help implement the task force's recommendations.

Two approaches to child protection

Prior to 2000, Minnesota's child-protection system employed a strict "forensic model": focus on fact-finding for evidence of neglect and abuse, in concert with law enforcement.

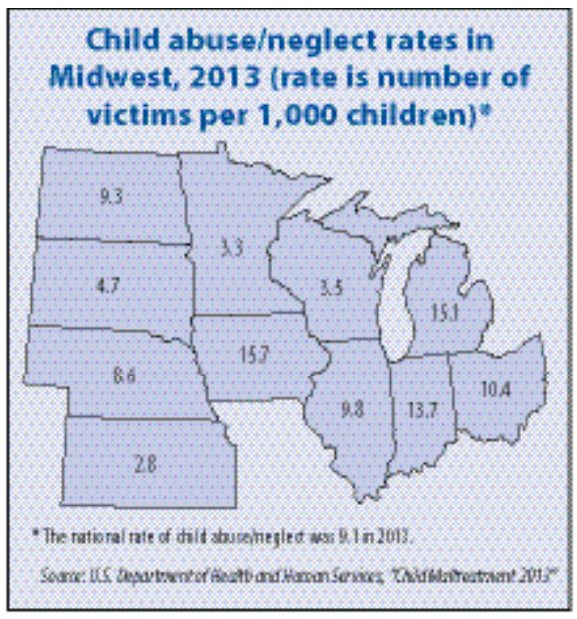
However, this approach was seen as threatening and undermining family engagement, while failing to consider the context in which neglect occurred. When factors such as poverty, alcoholism, or lack of understanding of growth and development were the problem, many thought legal intervention inappropriate. Also, the trauma experienced by a child being removed from the family caused many to seek an alternative approach.

More and more evidence showed, too, that some social-service supports might adequately restore child safety while strengthening families. This resulted in an alternative approach to reports of neglect and abuse: Seek to improve family engagement in order to create better outcomes, as measured by fewer and shorter times in out-of-home placement.

These changes gradually moved us away from viewing child welfare as the primary function of child protection. The focus became strengthening families, reducing social stressors and building family engagement.

As a result, a "family assessment" pathway (rather than the investigatory model) began being employed in response to some reports of child maltreatment.

Once a case was assigned to this alternative pathway, family participation was voluntary, not obligatory. With these cases, too, there was no



acknowledgement that neglect or abuse occurred. Protection workers could, and often did, reassign uncooperative families to the investigative approach. However, families that did not comply often did not receive further intervention.

Since past reports of maltreatment were not considered when investigating current ones, this cycle could be repeated often. Further, the standards for measuring child safety and welfare, screening decisions, criteria for pathway assignment, and the response to a family's failure to implement a service plan varied from county to county.

The original intent was to use the "family assessment" approach for minor concerns, not for situations in which sexual abuse was reported or for repetitious examples of abuse and neglect. But over time, use of this approach grew — ultimately reaching 70 percent of all cases and exceeding the figure for comparable states.

Our state found, too, that an alarming number of reports of maltreatment were never evaluated based on the initial screening. In part, this was due to restrictions on gathering information from the past, the need to seek corroboration from other mandated reporters, or failing to check with law enforcement about complaints of abuse and violence.

In different counties, there could also be great variation in the child-protection staff's workload, in risk analysis, and in dollars spent. A fundamental flaw was the lack of a baseline standard against which to assess a child's safety and well-being.

Safety of child will come first

In looking to improve our system, the task force made many recommendations, the first of which was to restore the child's best interest as the paramount concern when making decisions. While not dismissing the importance of engaging the family, this assertion clearly indicated that a child's safety should not be compromised.

After months of hearings, the resulting reform proposals focused on three areas: screening and transparency; family assessment and resources; and training and supervision.

To improve screening protocols, the task force recommended expanding access to information, engaging law enforcement and county attorneys sooner in the process, and improving oversight.

The second set of recommendations narrowed the use of the family-assessment approach and clarified when an investigative approach was instead required (substantial child endangerment). The task force also suggested that decisions not be made in isolation, but instead be supported by county-level interdisciplinary screening teams.

Strong assessment, intervention urged

Long-term, our protection response might be better focused on strong assessment and intervention rather than prematurely assigning a case to one of the two approaches (family assessment or investigative). The task force proposed seeking outside consultation to consider this change and to improve coordination with other social-service systems, such as those involving mental health and chemical dependency.

Regarding training and supervision, the task force recommended developing competency standards for child-protection workers and instituting an academy to provide scenario-based training for staff and supervisors. It was also suggested that a certification process with competency-based training and continuing education standards be required for all working in this field.

As for resources provided for child protection, the task force discovered a significant reduction of $41.8 million in annual funding from all sources of revenue between 2003 and 2014. Counties' increased reliance on property taxes to fill this gap likely explains the huge variation in their provision of protection services.

This year's state budget increased funding to counties by $42 million for staffing and training and to integrate the task force's proposals. More resources will also go to improve state oversight, data collection and quality assurance, and a legislative task force will review the progress being made.

Most fundamental to this effort is a proposed improvement in transparency mechanisms, allowing the public to assess the work of our system and its impact on children's well-being. Without this transparency, the hope for credibility and trust that the system can and does protect children will not be restored.

Sen. Kathy Sheran, a Democrat from Mankato, was one of four legislators named to the 26-member Governor's Task Force on the Protection of Children.

Submissions welcome

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