Accountability Options

CHAPTER 6

Policy makers have an interest in knowing whether the child protection system is working effectively.

In Chapter 1, we noted that Minnesota state government has a smaller role in the direct provision of child protective services than most state governments. In Minnesota, child protective services are provided by county agencies, and more than half of the funding for services comes from local property taxes. Still, state law establishes the policy framework for Minnesota's child protection system, and state policy makers have an interest in knowing whether the system they have established is working effectively.

Partly because counties' maltreatment-related records are not public data, it has been difficult for the public, policy makers, and professionals who work with families to know whether child protection agencies have acted appropriately.[1] In addition, the restrictions on child protection data limit the ability of agency officials to explain their actions when questions about cases arise. We asked:

- **What mechanisms might provide the public and policy makers with greater assurance that child protection agencies have acted responsibly and observed good social work practice?**

- **How can the performance of child protection agencies be monitored?**

In this chapter, we discuss various accountability options for the Legislature or Department of Human Services (DHS) to consider. For example, the Legislature could consider requiring county child protection agencies to periodically undergo external reviews by staff from DHS or similar counties, or such reviews could be conducted by boards of knowledgable citizens. In addition, DHS has not actively monitored local agency compliance with laws and rules in recent years, and there may be a need for at least selective compliance monitoring. Other options for improving accountability include ongoing performance measurement, opening certain case proceedings or records to the public, improving oversight of child protection decisions by

1 County child protection records are private data, according to *Minn. Stat.* §626.556, subd. 11. The subjects of the data can review county records upon request, and the agencies are also authorized by law to share certain information with local law enforcement agencies, prosecutors, medical examiners, coroners, maltreatment reporters, child mortality review panels, and selected others.

agency supervisors and county boards, and ensuring that key child protection records are retained for a reasonable period of time.

EXTERNAL REVIEWS

The Department of Human Services has not closely scrutinized county practices.

One way to increase the accountability of child protection agencies would be to periodically have someone outside of the agencies review their performance. State law requires the Commissioner of Human Services to "design and implement a method of monitoring and evaluating social services, including site visits that utilize quality control audits to assure county compliance with applicable standards, guidelines, and the county and state social services plans."[2] If counties are not in compliance, the department is authorized to withhold portions of the counties' federal or state funding.[3] Between 1988 and 1991, the department twice reviewed county child protection agencies' compliance with state regulations. But we found that:

- **The department has not systematically monitored county compliance with state child protection regulations since 1991.**

DHS officials told us that compliance monitoring consumed a lot of their staff's time, and responses to the monitoring took a lot of county staff time. While they believe that compliance monitoring prompted counties to make some worthwhile changes, state officials decided that department staff could provide more useful assistance to counties by providing training and other forms of technical assistance.

If DHS decided to resume compliance monitoring, there are some state requirements for which compliance could be routinely monitored by analyzing the state's computerized database of county maltreatment reports. For example, DHS could use this data to evaluate how long counties took after receiving a report to begin an investigation. But there are numerous requirements in law and rule that could only be reviewed by examining case files in county agencies and talking with staff. This could be very time-consuming, especially if DHS annually examined each county's compliance with existing requirements. Unless there is evidence of widespread compliance problems, DHS could limit the scope of compliance reviews by (1) establishing a cycle of county reviews, such as reviewing all counties every three to five years, and (2) focusing the reviews on selected issues of interest, rather than trying to examine compliance with all requirements.

An additional type of external review would focus on the *appropriateness* of child protection decisions, not compliance with regulations. After all, county child protection agencies could comply with state regulations yet still provide inadequate services. Reviews of agency practices and decisions could be

2 *Minn. Stat.* §256E.05, subd. 3 (e).

3 *Minn. Stat.* §256E.05, subd. 3 (f) and subd. 4.

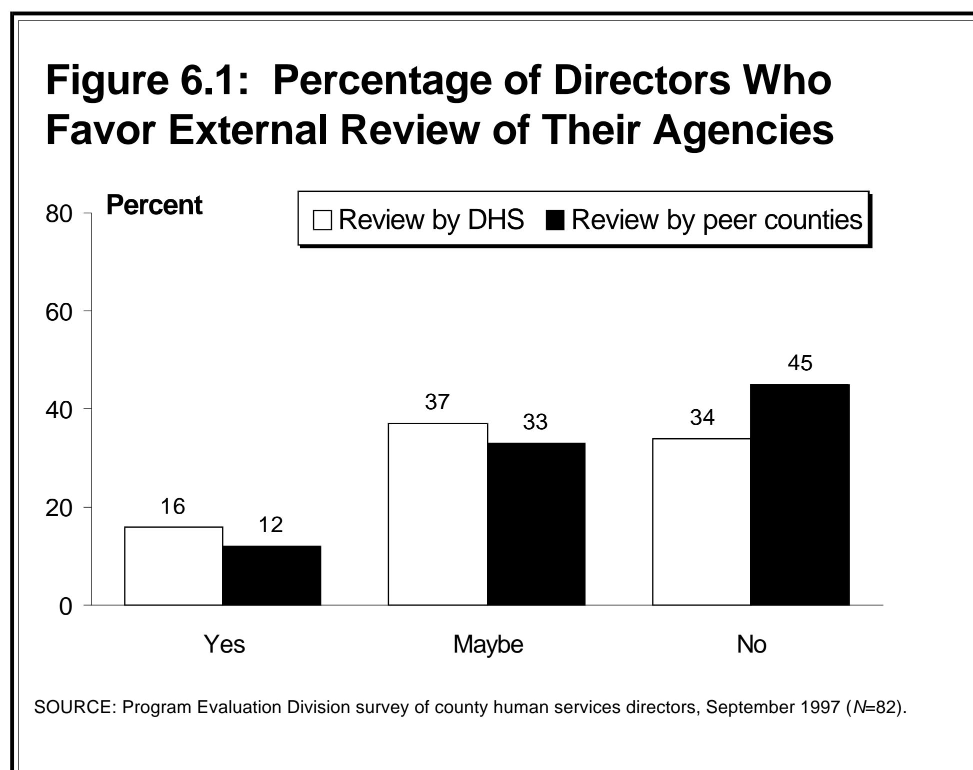
conducted by DHS staff, staff from other counties, or citizen review boards. The 1989 Legislature required the Commissioner of Human Services to establish a pilot program for review of two counties' child protection assessments and services by staff from similar (or "peer") counties.[4] The law required a peer review panel to review the counties' compliance with rules, appropriateness of actions, and case determinations in a random sample of cases. But in 1991 DHS decided not to establish the pilot projects due to county concerns about the time required.[5]

In a September 1997 survey, we asked county human services directors for their opinions about periodic external reviews of their agencies—either by DHS or by staff from similar county child protection agencies. As shown in Figure 6.1,

- **A small percentage of directors said they favored external reviews by DHS or peer counties, and many others said that they might support this idea.**

To date, the main external reviews of Minnesota child protection agencies have been those conducted in cases involving child deaths. State law requires

County directors expressed limited support for external reviews of their agencies.



4 *Minn. Laws* (1989), ch. 282, art. 2, sec. 203.

5 Natalie Haas Steffen, Commissioner of Human Services, letter to Rep. Kathleen Vellenga, Chair, Minnesota House of Representatives Judiciary Committee, March 11, 1992. The letter noted that the department instead focused its efforts on statewide implementation of multi-disciplinary child protection teams, child mortality review panels, compliance monitoring, and training.

Minnesota's child mortality review panel was recently reinstated after not meeting for two years.

the Commissioner of Human Services to establish a statewide child mortality review panel, and the commissioner may also require county agencies to establish their own child mortality review panels. The purpose of these panels is "to make recommendations to the state and to county agencies for improving the child protection system, including modifications in statute, rule, policy, and procedure."[6] However, cases involving a child death are a small fraction of all child protection cases, and the state's child mortality review board has only issued two reports (in 1991 and 1994) since its creation in 1989. In fact, DHS disbanded the panel in 1995, subsequently reinstating it in November 1997.[7]

The 1996 amendments to the federal Child Abuse Prevention and Treatment Act required states receiving federal grants to establish at least three "citizen review panels."[8] The stated purpose of the panels is to evaluate the extent to which agencies are effectively discharging their responsibilities. To do this, the panels may examine state and local policies and procedures, and, where appropriate, individual child protection cases. DHS officials told us they intend to submit proposals to the 1998 Legislature for three such panels, serving individual or multiple counties. If such reviews are done, we think they should be conducted by reviewers with a sufficient understanding of relevant laws, rules, and social work practices.

It is important to consider that case files can take a considerable amount of time to review. Many families' case files are thick with documents and caseworker notes, sometimes spanning years of events. Even if external reviewers can reach reasonable conclusions about whether the child protection agency made appropriate decisions, it is likely that they would have to limit the number of cases reviewed per county to a relatively small number. Still, reviews of even a few cases might help to reassure the public that there is some scrutiny of child protection decisions, and they might result in useful suggestions to the agencies for improvement.

Some states have created special agencies or units to oversee the activities of child protection field offices, respond to complaints, or monitor cases. For example, Illinois has an Office of the Inspector General for its Department of Children and Family Services. This office responds to and investigates complaints filed by the courts, foster parents, biologicial parents, attorneys, and others. It also investigates child deaths and studies systemwide issues that have been a source of complaints. Following investigations, the office makes recommendations to the department and monitors their implementation.

Minnesota has a state ombudsperson for families who, among other duties, "shall monitor agency compliance with all laws governing child protection and placement, as they impact on children of color."[9] Staff from the

6 *Minn. Stat.* §256.01, subd. 12 (a).

7 DHS staff told us they were unsure exactly why department officials decided to discontinue the child mortality review panel in 1995.

8 *Child Abuse Prevention and Treatment Act Amendments of 1996*, P.L. 104-235, sec. 107 (c).

9 *Minn. Stat.* §257.0762, subd. 1.

ombudsperson's office told us they try to respond to any concerns brought to their attention, not just concerns regarding families of racial and ethnic minority groups. The office issues reports and makes recommendations to agencies, but it does not have authority to require agencies to act.[10]

PERFORMANCE MEASURES

Another option for improving accountability is agency self-monitoring and reporting. State law has required each county since 1981 to prepare annual reports on "the effectiveness of the community social service programs in the county."[11] The reports are to include descriptive information on program recipients and "an evaluation on the basis of measurable program objectives and performance criteria for each county social service program." But,

- **While counties have prepared information on the number and type of their social service recipients, most have not regularly evaluated the effectiveness of their programs.**

Counties have had difficulty measuring the performance of child welfare programs.

Since 1994, state law has required counties to include measures of program "outcomes" in their biennial social services plans, but many counties have had difficulty doing so. We examined the child welfare portions of half of the community social services plans submitted by counties for the 1998-99 biennium. Some of the plans proposed potentially useful performance measures. For example, almost one-third of the plans proposed to evaluate services by examining the incidence of repeated maltreatment, although they varied in the ways they defined their measures. In addition, some counties proposed to measure school attendance of children deemed educationally neglected, family satisfaction with services, and the percentage of children who are placed in permanent homes within 6 or 12 months of being placed out-of-home. Many agencies proposed measuring activities rather than program outcomes—such as the number of days children are in out-of-home placements, the number of cases with maltreatment determinations, and the number of families served by in-home services. Long-term trends of activity measures can provide useful information, although these measures generally will not inform counties or others about the effectiveness of agency interventions.

Overall, the social service plans tended to have limited measures of program performance and little historical data. The Department of Human Services has worked with counties in recent years to help them improve their performance measures, but it appeared to us that many counties still have a good deal of

10 Court monitors are another form of external review mechanism. For example, the Minneapolis American Indian Center has a court monitor who reviews Hennepin and Ramsey County cases for compliance with the federal Indian Child Welfare Act. The monitor attends court hearings and produces reports that highlight compliance issues. Similarly, a non-profit organization called Watch monitors Hennepin County court cases involving crimes against women and children.

11 *Minn. Stat.* §256E.10.

work ahead. We recognize that it may be difficult to find ideal measures of program performance for child protective services, and it may not be feasible to isolate the impact of public agencies from other factors.[12] Still, we think there is considerable room for DHS and counties to improve performance measurement and the accuracy of child protection data already collected, as we recommend in Chapter 7. The need for improved performance measurement was underscored by recent congressional legislation that required the federal Department of Health and Human Services to (1) adopt a system for rating each state's performance in operating child protection and child welfare programs, and (2) develop a method of linking state funding to performance on these measures.[13]

Federal funding may be linked to state performance in the future.

OTHER ACCOUNTABILITY ISSUES

Appeals and Complaints

Until 1997, alleged perpetrators and child victims had very limited means to appeal county maltreatment determinations. They could contest "the accuracy or completeness of public or private data" under the Minnesota data practices laws, but it was unclear that such appeals could challenge whether the maltreatment determination was justified.[14]

The 1997 Legislature authorized a procedure that individuals or facilities can use to appeal child protection agencies' maltreatment determinations.[15] The law allows individuals or facilities to request that agencies reconsider maltreatment determinations, and they are entitled to a fair hearing before a state human services referee if their requests are denied or not acted upon. As of November 1997, only one hearing request had been filed with the state under the new law.

Aside from information on these newly-authorized hearings, Minnesota does not have centralized information on the number or nature of complaints about county child protective services. For example, we noted in Chapter 4 that many mandated reporters have been frustrated by the absence of county feedback on the cases they have reported. People can convey complaints to county agencies, DHS, the state ombudsperson for families, or others, but there is no uniform method of recording or responding to complaints.

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12 It is difficult to find ideal measures of agency performance in providing child protective services. For example, incidents of repeated maltreatment within families could indicate failures of county interventions, but it is also possible that more incidents are identified when a county increases scrutiny of problem families. Also, county staff often evaluate the progress made by individual families toward goals in case plans, but it is difficult to translate information on families with varying needs into general measures of performance.

13 P.L. 105-89, sec. 203, signed by President Clinton in November 1997.

14 *Minn. Stat.* §13.04, subd. 4.

15 *Minn. Laws* (1997), ch. 203, art. 5, sec. 29.

Data Access

Some people believe that child protective services would be more accountable if the public had access to more information on cases. Child protection records are classified by Minnesota law as private data on individuals.[16] In addition, the public usually cannot attend court hearings involving children in need of protection or services; only persons with "a direct interest in the case or in the work of the court" may attend.[17] Likewise, records of juvenile court proceedings are not public, although they may be disclosed by order of the court.

The public has very limited access to information on child protection cases.

In 1997, the Supreme Court Foster Care and Adoption Task Force explored the idea of allowing the public to observe hearings involving children in need of protection or services (CHIPS) and termination of parental rights. Through statewide surveys, the task force found that 58 percent of judges, 79 percent of county attorneys, 86 percent of public defenders, and 89 percent of social service agencies said that these hearings should never be open to the public.[18] Still, the majority of the task force members favored open hearings. They said that opening hearings would expose inadequacies in children's services and encourage citizens to engage in discussions about community standards. Other task force members contended that the publicity associated with open hearings would harm maltreatment victims and make children less willing to report abuse in the future. The 1997 Legislature considered but did not pass legislation to open CHIPS hearings.

Because the task force examined the issue of open CHIPS hearings in some depth, our study did not address this topic. But we did ask human services directors in our September 1997 survey whether they thought there were instances in which child protection agencies' case records should be opened to the public. As shown in Figure 6.2,

- **A majority (57 percent) of directors said that they favor or might favor making agency child protection records public in cases involving child deaths. A smaller percentage of directors (39 percent) said they favor or might favor opening records of cases involving serious injuries, and a still smaller percentage (21 percent) said they favor or might favor opening records of all cases where maltreatment has been determined.**

Federal law restricts the ability of states to make child protection records public. The law requires states receiving federal grants to have "methods to preserve the confidentiality of all records in order to protect the rights of the child and of the child's parents or guardians."[19] Records may only be made

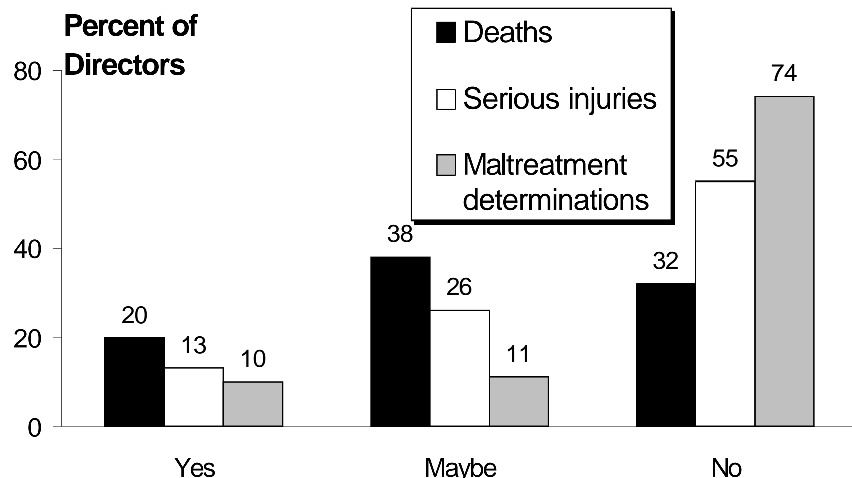
16 *Minn. Stat.* §626.556, subd. 11.

17 *Minn. Stat.* §260.155, subd. 1 (c).

18 *Final Report: Minnesota Supreme Court Foster Care and Adoption Task Force* (St. Paul, January 1997), 120.

19 P.L. 104-235, sec 107 (b) (2) (A) (v).

Figure 6.2: Types of Case Records That Agency Directors Favor Making Public



SOURCE: Program Evaluation Division surveys of county human services directors, September 1997 (*N*=82).

Federal law restricts public disclosure of child protection records but requires disclosure for certain types of cases.

available to: (1) individual subjects of maltreatment reports, (2) public agencies (or their agents) who need the information to protect children, (3) child abuse citizen review panels, (4) child fatality review panels, (5) grand juries or courts, and (6) "other entities or classes of individuals statutorily authorized by the State to receive such information pursuant to a legitimate State purpose."[20] However, the law also requires states to allow "public disclosure of the findings or information about the case of child abuse or neglect which has resulted in a child fatality or near fatality."[21]

Employee Supervision

All public agencies need supervisors who can effectively guide and scrutinize the efforts of staff. In our view, this type of internal accountability and coaching is especially important in child protective services, given that maltreatment definitions are open to interpretation, cases often have contradictory evidence, and decisions can significantly affect the lives of families.

We did not evaluate employee supervision in-depth, although we spoke with county staff about this issue during our site visits. Several line staff told us that maltreatment determinations are often their decisions to make individually, with little supervisory input or review. Some line staff expressed

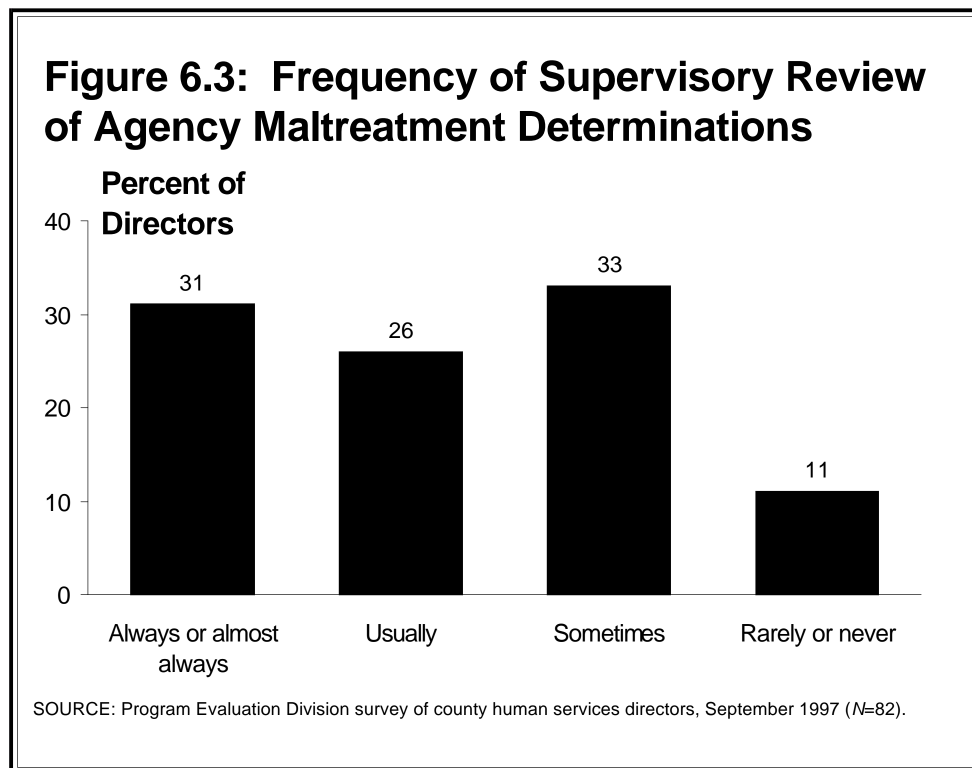
20 *Ibid.*

21 *Ibid.,* (vi).

concern to us about this, given the gravity of the cases and the relative inexperience of some staff. In September 1997, we asked county human services directors statewide about supervisory practices. As shown in Figure 6.3, we learned that:

- **In less than one-third of child protection agencies does a supervisor or administrator "always or almost always" review case evidence before maltreatment determinations are made.**

Supervisors do not always review case evidence before their staff make maltreatment determinations.



Some investigative staff told us that they regularly discuss the status of individual investigations with supervisors and sometimes involve peers and others in decisions about maltreatment. In other cases, staff told us that supervisors lack the time or expertise to provide effective oversight.

Elected Officials' Approval of Local Policies

In Chapter 2, we observed that federal and state laws set general policies for local child protection agencies, but many of the federal and state definitions are vague. For example, there is room for interpretation about what constitutes "maltreatment" or "imminent danger" to a child. Consequently, county child protection agencies often develop policies and procedures to supplement federal and state regulations.

We asked staff in the eight counties we visited whether their county boards had ever reviewed the criteria that are used by child protection staff to screen

cases. With one exception (Dakota), the county boards had not formally approved the criteria. Traditionally, the state has granted counties considerable flexibility about how to provide social services, thus enabling them to respond to community needs and standards. But given the variation among counties in the incidence of maltreatment investigations and determinations discussed in Chapter 2, it is important to consider *whose* standards are being reflected in agency decisions. While some counties may have developed standards with considerable public input, the standards of some other counties might largely reflect the preferences of staff. As we discuss in Chapter 7, an option for fostering public discussion and debate about child protection agencies' "standards" is to require public approval of the decision-making criteria used.

Records Retention Practices

In Chapter 2, we noted that counties have differing policies on the length of time they keep child protection records. In cases where counties have investigated maltreatment but made no determinations of maltreatment or a need for services, some counties destroy most records quickly, while others keep most records for four years, as allowed by law. Once records of child protection allegations or investigations have been destroyed, it may be difficult for external reviewers (or the agency itself) to comprehensively evaluate the decision-making process, to evaluate whether appropriate decisions were made in individual cases, or to reconsider cases in light of new information. Thus, a strategy to improve accountability should consider how long counties should keep child protection records.

SUMMARY

In our view, the child protection system can operate most effectively when it has the confidence of the public it serves. But Minnesota's system has operated with little scrutiny, even by some of those who work within the system. There are a variety of options that the Legislature, DHS, and local agencies could consider to improve accountability, ranging from external review to improved employee supervision. We offer our recommendations in the next chapter.