PROCEEDINGS

HIGHLIGHTS FROM FORUM PROCEEDINGS

"Sorting Out the Evidence for Interventions that Work in Child Protection: Intuition, Experience and Technology"

November 3, 2005

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INTRODUCTION

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We welcome you to the first in a Series of Interdisciplinary Forums that will focus on "Rethinking the Fate of Children in High-Risk Families."

We wish to acknowledge the support of Tom Scott, Director of the Center for Urban and Regional Affairs, for this inaugural forum. Tom was both enthusiastic and generous in making this forum possible. We also wish to acknowledge the keen support of Marcie Jefferys, Director of the Center for Advanced Studies in Child Welfare, School of Social Work. We are here today with our special guest, Professor Eileen Munro, because of their generosity and support.

The struggle for a coherent child welfare policy is an absorbing task for many scholars. Twenty-five years ago, the Adoption Assistance and Child Welfare Act was passed. Since that landmark legislation of 1980, additional reform initiatives have been legislated, emphasizing three principles: permanency planning; family preservation; and safety for the child. Sharply curtailed time frames were also legislated to quicken the pace of decision-making. And yet, the call for reform remains unabated. Perhaps a controversy is inevitable, since child welfare remains enmeshed in a triangle of competitive interests—the child, the family, and the State—and the weight of these interests shifts from time to time. Philosophical and political changes also contribute to changes in values among competitive interests. We ask the court to settle differences; that is why representatives of the judicial system have been invited to make their observations on sources of error, one aspect of the subject of today's inaugural lecture.

PLENARY PRESENTATION

Introduction to Eileen Munro

I first encountered Professor Eileen Munro some years ago, when I was doing some work at the London School of Economics. I was told that she was a rare bird: educated as a philosopher and as a social worker. Professor Munro's capacity to bridge the gap from "thinking" to "doing" has brought her international recognition.

We are very pleased that she would take time for from her visiting professorship at the School of Social Welfare, Berkeley, to visit with us.

Professor Munro received her degree in philosophy from Exeter University and achieved degrees in graduate and doctoral work at the London School of Economics. Professor Munro is well-prepared to open up piercing questions on how we translate knowledge into reasoning and finally into decision-making. This is especially hard work, when the focus is on the child welfare system.

You will see from the handout of some of her selected publications that Professor Munro's work is chiefly engaged in a systems approach to Child Welfare policy and practice. A glance at some of her published work—"Child Protection is a Systems Problem"; "Common Errors of Reasoning in Child Protection Work"; "Avoidable and Unavoidable Mistakes in Child Protection Work"—reveal that these are papers that indicate her reflections on errors in practice.

This has led her to a systems approach and a framework that could provide better outcomes for children in our care.

We are not unfamiliar with the hard work of "thinking and rethinking" child welfare practice, as exemplified in Joel Fisher's classic paper, "Is Case Work Effective"—a bombshell in its day, in 1973, and an early precursor to "evidence-based" practice.

It is of interest to note that the University of Minnesota has contributed ground-breaking work that has directed the pathways of research on attachment and resilience. In searching for the keys to improve outcomes for children in high-risk families, a question was asked: Why do some children survive relatively unharmed under adverse family circumstances? The work of Paul Meehl, Norman Garmezy, and others produced essential evidence—a trio of characteristics that can provide protective covering for vulnerable children: a moderately good intelligence; a cheerful temperament; and the good luck of having a caring person who keeps an eye on their welfare.

Professor Meehl coined a phrase that we often use when we are constructing profiles of children who seem to have escaped the ravages of adverse circumstances. They posses, in his words, "hedonic capacity," or simply, as he once put it, "joy juice."

This is just a reminder of the search for insight and the evidence from scholarly work that we pursue to improve practice.

In that context, we look forward to Professor's Munro's observations on essential questions: "What are the keys to effective work in Child Welfare? When we make errors, why are they so hard to correct"?

It is a pleasure and honor to have the good fortune of having Professor Munro share her ground-breaking thinking with us. We feel we have produced the right audience of "good thinkers," who have come this afternoon for the occasion.

Eileen Munro, Reader in Social Policy
London School of Economics
Zellerbach Visiting Professor, School of Social Welfare
University of California, Berkeley

The aim of my talk is to present an alternative way of looking at the problems of improving child welfare and child protection services. I am not presenting a solution. Rather, I am offering an alternative way of framing problems and suggesting avenues to follow different from what has become the traditional way. I'm hoping it will trigger thinking on your part and elicit a good discussion.

Both in Britain and in America, we share very common aims of wanting to improve child welfare: wanting to improve both children's safety and children's well-being. We have been working very hard at that for many decades. I think we have also learned some very valuable lessons. We have some very good ideas about how to help families, but when we actually look at what is happening in the field, it is very disappointing. For the amount of effort that we put in, there is not the output that we want. To be honest, I think in Britain, there are some features of the recent developments, which even suggest we are going backwards rather than forward, in some respects. As a researcher, I became concerned about why it is that frontline workers are not improving. I discovered an entire wealth of literature, in both medicine and engineering, in general, about understanding human performance, how to understand the factors that influence it, and how to improve the frontline work so that the number of surgeons cutting off the wrong leg is brought down by using this method. So I thought this was worth trying for child welfare as well. To give you a hint of it, I am going to ask you to begin by doing a little task.
[Time was taken here in which the audience was asked to participate in memorizing and recalling English and American cell phone numbers. The American numbers were easier to recall, because

the sequence of numbers was divided into three chunks.]

The human short-term memory can handle seven items. So if you give the task of memorizing eleven random numbers, memory fails. What happens in England is that this is the way your cell phone number is presented. People have total trouble remembering other phone numbers and even their own. They get very embarrassed by it and even apologetic. Everyone says it's human error, but it just illustrates that if you present the task in a way that is tailored to human skills better, you can get a big drop in human error. I learned my number in America much quicker than I learned my home number. I learned the one in England, because I learned to divide it up into three chunks to memorize it. But that's not the standard way it's written for you, so you're not being trained to think of it that way and memorize it. It's a very trivial point but it illustrates the key point.

Instead of just saying human beings just keep getting it wrong, you say why do they get it wrong and what is it in the way they learn the task and do the task that explains why it doesn't come out well. Can we then change the task so that the results come out right?

If I go back to the child welfare field, I was very struck by the way that you have a whole policy code—"No Child Left Behind." We have one called, "Every Child Matters." It makes me think that Bush and Blair talk to each other too much [laughter] on more issues than this one. I find it really bizarre that George Bush is apparently quite a right-wing Republican. And Tony Blair (you may not realize this) is meant to be the leader of a Labor Party, which is a left-wing socialist government. Yet they agree on everything. It is puzzling to me. Their sentiments about children are excellent, however, and nobody could seriously criticize them. The trouble is how do you actually make them come true, when we haven't ever managed it before.

I think there are three key features that we want of a good system: first, we want it to be effective; we obviously want it to help children's welfare and safety; and I think we also want it to do no harm. We do certainly notice when a child dies, but we are very poor at checking out what harm we might be doing in the process of trying to help children. I think there is evidence that we traumatize quite a few families in the process of trying to help them. We traumatize children. We turn some parents and children away from professional help by the way that we respond to maltreatment reports . . .a forensic type of investigatory approach. I think that we should actually be putting a lot more attention into studying the harm that we do, rather than just concentrating on whether we're having the desired effect. We need to look at the unintended consequences of our intervention.

Going back to key features of a good system, the second feature is that we want it to be efficient. Good use of public money is something that has become even more politically important in recent decades, as the whole of public spending has come under scrutiny. A Labor government is just as keen as a Republican government on cutting back on taxation.

The third feature, of course, is that we want it to be ethical. We're dealing with human beings. We're not dealing with animals or objects—actually animals still deserve ethical consideration, but it's not quite so complicated. But it does raise the issue about the privacy of the family. Both in Britain and in America, we have the very strong tradition of the family being a very private space away from the State— a place where you can do your own thing. Obviously, for child welfare, big problems are raised when we actually interact with families in balancing respect for their privacy and the child's safety.

We are not yet providing a service that adequately meets all these three features. Of the problems that have been going on in both our systems, the most headlined one is that of children known to us, who have been abused and end up being killed. It doesn't happen on a very large scale, but in Britain, the public reaction to these tragedies is very large, and I understand that it is also the case here. You keep getting cases that capture public and media attention, and you get a great deal of focus on child protection services and how incompetent they are. It has certainly been a major driving force in the way things have developed in Britain. But the other poor

outcome that is at the top of the political agenda, in both our countries, is that we are failing to help the families who are struggling with lower level problems, whether they are of abuse or of other kinds of difficulty in raising their children. Promoting children's welfare and improving that side of it is very much at the core of the "No Child Left Behind" and "Every Child Matters," . . . broadening child welfare concerns beyond very serious abuse cases.

How can we improve practice? Let me start by looking at the traditional way that has been called "the bad apple approach." When we have come across problems and we ask, "Why did it happen," we start to go back through the causal sequence of events to see how, for example, the fatality arose. In any kind of search for explanations, you go on until you get to a point where you find something that satisfies your curiosity—an adequate type of explanation.

One of the most satisfactory explanations you encounter is human error. For example, you come across the train driver who went through a red light or the social worker who failed to respond to a report that a child was being abused. You come across something like that—it's human error and a satisfactory reason as to why the whole thing went disastrously wrong. In fact, in the major inquiries that have occurred across the board, not just in child abuse but in plane crashes and surgical operation mistakes—all of those—you actually find a very consistent result of about 70-80% being blamed on human error. But the blame is not totally on human error, because some equipment can break. Rather human error is a significant part of the mistake. So the underlying impression from that is this: The system is fine, it is just the human beings in it that mess it up. And if somehow we could keep them under control, little would go wrong. One of the things that really helps us with this type of reasoning is what I call the "charm of the counterfactual." It is such a simple, convincing story: if only the worker had stopped at the red light as he should or had responded to the report, as she should, then the tragedy wouldn't have happened. You can see that that is a true statement, and it looks so satisfying. It also makes the world look as if it is a much safer place, because it implies that, at least in theory, it is possible to prevent every tragedy—that there is actually a solution out there.

It also gives us somebody to blame. Psychologically, this is satisfying. It is actually quite difficult to accept the notion that something happened because of random chance—you just happened to be in the wrong place, and that's why the consequence was so disastrous. There is a great deal of satisfaction in this blaming style of reasoning, but of course it becomes problematic, when you turn it into a general rule. If we now expect workers to follow the rule, is that going to be a good thing in all the other circumstances? What happens in child welfare is that you get something like an early inquiry saying, "If only they had checked the father's criminal record, then they would have known this really important piece of information." So you add another sheet into the page of procedures to say you must do a police check on the criminal record of the parents. And then you get another inquiry which says, "If only they talked to the schools," so add another one, and you don't actually think of the impact of that on all the other cases where it wouldn't have helped predict risk, but it just becomes the general rule and adds to the time and energy needed to follow the guidance. Also, you've only picked up on one of the things that could have gone differently and not looked at the whole process. If that one thing had happened differently in that one case, it might have gone differently, but you haven't looked at the big picture of what went wrong. You get hooked on little soluable problems and kid yourself that you can get it right. But if your approach is basically thinking it is human beings that make mistakes, then the whole thrust of your challenge is bringing those erratic human beings under control and making them behave better. It has been very much the case in our child protection system that we have focused on increasing top-down control of frontline work to improve practice.

Three strategies are typically initiated. First, put psychological pressure on frontline staff to perform better. The media coverage gives a very clear message to social workers to pull up their socks and work to a higher standard. Secondly, you also try to cut the human being out of the story, as much as possible. So, you formalize, mechanize, and reduce the role of individual

judgment, as much as possible. The third strategy is to increase surveillance on these erratic frontline workers to make sure they are following all the instructions.

These three mechanisms happen very strongly in child protection. I think they are all having adverse effects. They've all got a core of sense to them. I'm not knocking them as having a place in the whole solution, but it is the extent to which they've been used that is damaging. I particularly question the psychological pressure on the frontline worker. If you seriously think that people who enter a caring profession like medicine or social work don't actually feel concerned about a child's safety, then it is probably worth reminding them that that is what they should be concerned about. It does seem to me that you really don't need to tell them that. And the impact of the public blame has been that we are, in Britain, having serious problems about both attracting people into social work and into child welfare parts of social work and then in keeping them. This is a situation that has deteriorated in the past ten years, in fact, quite dramatically. If you go back to the 1980's, child protection work was the most prestigious and desirable part of social work and the hardest to get into, and you had very experienced people in the job. And now, in a recent public inquiry, it was discovered that in the London Borough, which was dealing with the child, Victoria Climbie, in the duty team there was no social worker who had been trained in Britain. They were all people who had been brought in from Zimbabwe, New Zealand, Australia, Canada. We go around the former British Empire trying to bring in people. We actually get a steady supply who come, briefly, and then leave again. Therefore, we actually have people in posts, but we don't have the build up of established, experienced teams supporting each other. Another consequence of the blame approach is that it leads to blame prevention and blame avoidance. You get into defensive practice. You start covering your back. I can certainly think of places in England where you get the strong impression that the primary purpose of the work is to protect both the worker and the agency, and protecting the child comes third in the line of priority. A simple example of what can happen is that the procedures say that if you consider a case of serious abuse, you should arrange a case conference of the various case professionals who know the child, and it should be arranged within 28 days. But in reality, 28 days may not be enough time for you to get everyone together and to get their information. You know, someone can be off on annual leave or sick, and so it might be much more sensible to wait a few more days to get all the information, so that you have a better assessment and plan for the child. But you will find that social workers say, "I prefer to go with the timetable, and I know that that means I have poor information; I make a poor assessment; I make a poor plan, but I have covered my back, and I will not get into trouble." So by not putting the child's needs first, but the procedure's needs first, they don't get into trouble. This is actually is happening in a very pervasive way on very small issues that add up to a big distortion of practice.

The second set of adverse effects comes with the formalization of procedures. This leads to an increase in paper work. Everyone complains about paperwork, but they now have strong reason to do so. In Britain, they used to spend a third of their day in direct contact with children and parents in child welfare. Now, if you think of an eight-hour day, they spend one hour a day instead of three, with parents and children. The rest of the time is spent doing paperwork and dealing with other professionals. If at the heart of your policy is improving outcomes for children, a system that is actually keeping professionals away from contact with children does seem to me to be fundamentally flawed. I know the same thing is happening here. In Wisconsin, where I've just been, they've done studies of how workers spend their time. This was their discovery: workers used to have 1/3 screen time and 2/3 contact time; now it is reversed—2/3 screen time and 1/3 contact time.

And in addition, increased paperwork gets to the point where it is unusable. The social worker in the Victoria Climbie case, who was heavily criticized for her work, did have the help of procedure manuals to give her guidance on how to work. But there were, in fact, eight of them. It would have taken her a good few months to read through the whole lot. The fact that she

hadn't read them all was actually very understandable. Because people just keep adding to these things, they actually become unusable. I worked in the 70's in a mental health clinic, as a duty social worker (staff member). You had to deal with mental health crises, as well. If you had to use the legal power to have someone admitted to the hospital against their wishes, you had a card with a flow chart telling you how to do it. You actually took it with you on any visit. You looked at it. It was usable. Now, in London, they have a procedure manual to deal with an allegation of child abuse. It is 300 pages long; weighs a kilo; and you would never put it in your case and carry it around with you. It sits on a shelf in the office. I think there is probably scope for having more than one page, but I think we should be cutting down to a very, very thin document that can be used.

You also get inconsistent paperwork because the system proliferates so much. You can't keep it all linked up, and you have different people producing different things. We have just had a whole flurry of publications in Britain from different parts of the government. We've now got two major documents on child protection services, which actually contain radically different definitions of abuse. One of them defines abuse in terms of anything that causes significant harm to the child. The other one defines abuse as deliberate action or omission that causes significant harm. The two definitions are not synonymous, at all. The inconsistency also arises from the fact that a lot of our paperwork has a dual purpose. It is not just to feed into the frontline worker's reasoning and decision-making, but it is also to collect documentation for the accountants, for senior management, who prepare the evidence for politicians on how they have been spending public money. As a result, the forms can be collecting things of no value to the frontline worker, but that are being collected for other parts of the system.

One thing that our system of audit and inspection has generated is incredible ingenuity for people in working out how to score well on the performance indicator, by hook or by crook. There is one example I find amusing, but it's actually shocking as well. In the Health Service, they have a great concern about waiting times—waiting for an appointment, waiting for an operation. One of the waiting times is concerned with the time it takes to be seen in the emergency room. So they have a performance indicator that anyone who arrives in the emergency room, as a result of an accident, should be seen within four hours. You may be rather shocked at how long that is, but this is a national health service. Obviously, if you come in bleeding to death, you get seen urgently, but if you don't, you should now be seen within four hours. One hospital, in its ingenious effort to score well on this indicator, put up a tent in the car park area so that when an ambulance came in with somebody, they put them in the tent until they had time to see them in the emergency department. Once they got to the emergency room, the four hours time clock started. So while you left them in the tent, the four hours didn't count. Now, I don't know if you've ever had to go to the hospital in an ambulance, but I don't think that ending up in a tent for a couple of hours is going to add to your well-being in the slightest. But yet, that was done seriously, without any thought of patient welfare, but purely obsessed with meeting the performance indicator, because so much funding gets attached to these things. We, in Britain, actually get stars, you know, like children in elementary school. The social services departments are zero rated, one star, two star, or three star. The senior management is obsessed about increasing their stars or holding on to their stars. It sounds quite childish, but this is, seriously, what they are concerned with. Achieving those stars does not mean measuring whether the children in your area are actually any better off for your efforts. That is one of the things that is not measured. Of course, child well-being should be at the heart of it all. This monitoring system involves huge amounts of money, huge expenditures, and a lot of well-intentioned good effort. The whole outcome is that people are absorbed with paperwork and obsessed with the wrong goals. We are still finding the same errors in the professional practice, at the frontline, of people not doing a thorough assessment, not making a well-reasoned decision, not making a good plan.

It is as if we are tackling everything except the problems that actually relate to the child's safety and well-being.

Let me now turn to the alternative systems approach, which I think is potentially much more fruitful. This assumes that when you come across human error, you don't stop there and just say it's because the human is stupid or lazy or malicious or whatever. Rather, you say, "why did they make the mistake?" When you look at a series of child fatality reviews, the kind of mistakes that are made are so regular—there are just these constant patterns of mistakes. Crucially, in this approach, you assume that the worker meant well; that the worker was trying to do a good job; at the time, this seemed the sensible thing to do. For instance, in the Victoria Climbie case I mentioned earlier, the social worker was heavily condemned for receiving a medical report, which contained clear information that the child had been physically abused. This social worker did not read the entire report; so didn't notice the evidence that the child had been physically abused; and therefore kept the case as a low risk issue. So, the coverage at the time of the public inquiry criticized her for not reading the entire report. "If only she had read it, then she would have seen that there was physical abuse." You know what good practice is: if you receive a medical report, you read it. It looks like a rather simple criticism, but if you go and look at the real situation in which she received that report, then it looks quite different, because the report was faxed over from the hospital. It came through on a machine that was very dirty, so it was already smudged and very difficult to read. It was a very long report. The pediatrician hadn't written the report specifically for her; it was just the report that she had written in language suitable to other doctors. It wasn't geared to social workers. On the first page the pediatrician wrote, "I have no concerns about child abuse." So the social worker had struggled to read this dirty fax, seen that statement and thought, "I don't need to read the rest of it." When you know this, her mistake doesn't look quite so stupid or careless. Also, when you look at the other demands on her that day—that she had a heavy caseload, much higher than was officially sanctioned, and on that day she had six cases that were on the boil and had serious issues of child safety—the fact that she didn't read the whole thing is absolutely rational, when you look at it within the total scenario. It was an imperfect decision made in imperfect circumstances.

I have spent the first two days of this week down in Madison, accompanying them on what they call their Qualitative Service Review, which is a really intensive look at a small, random sample of cases. I've actually been in a social work office and done a home visit with a family. (It has been some years since I've had to do that.) It brought back to me, looking at this one case, just how much noise there is in daily working life. There is so much information around us, so much emotion, so many people you have to relate to in different ways: you have so many duties and so many demands on your time. Unless we start to conceptualize the way the worker is facing the task, we're not going to identify what help we can give them that helps them do it better. One of the things we know from psychology is this: if people are in a situation with a lot of incoming data that is more than they can handle, a standard way of dealing with it is to focus on one part and you out the rest. You can actually see this happening in many of the child protection cases. In the Victoria Climbie case, the social worker got hooked on the housing problem the family had. The incoming information about abuse kept being dismissed as irrelevant or low level and so never became central to the picture. She ended up with this very clear picture of the case, which was, in fact, just a tiny microcosm of it, and missed out all this other stuff that was available to her, but wasn't getting her attention. This selective attention can also be seen, when you look at the quality of assessments. People don't do broad enough assessments. I keep hearing workers criticized for not looking at the big picture. The big picture is big, and it takes a lot of time and energy to look at it. But they also keep being criticized for not looking deeply enough into the family. This is something that is showing up in the Wisconsin families—they keep finding families where the parents, themselves, were seriously traumatized as children, and they remain damaged. The workers are not, then, actually exploring the nature of

that trauma and whether it can be dealt with. They are just taking it as an adequate explanation of what's going on today, but not going deeper into it.

While deepening and widening assessments looks like a very good strategy, I think we have to be much more sensitive to the size of the task that we are asking of frontline workers and the difficulty of the task. To ask a frontline worker to stop and think, when she has a heavy caseload and is under pressure to prioritize the paperwork, is to ask the unreasonable. It should not surprise us that the recommendation gets ignored. You need time; you need energy; you need quality time for thinking, not tacking it on at the end, as if it is the least important activity. If we want practitioners to find time to reason more critically and rigorously, then we have to help them alter their work patterns so that the time to do this is available.

Instead of thinking of the frontline worker as the person who keeps getting it wrong, acting autonomously or making mistakes, you start thinking of them as belonging to this huge system. You may also think of what's going on in the wider context and how that might influence them.

In using a systems approach, there are three key areas for understanding what contributes to the final outcome, whether good or bad practice: factors in the individual, in the resources, and in the organizational context.

First, there are factors in the individual worker. In this category, I have grouped their skills and knowledge, their emotional wisdom, and supervision.

Whether we are training them with the right kind of reasoning skills and knowledge to actually do the kind of assessments we want is a question. One of the things I keep finding in fatality reviews is clear evidence that workers do not have adequate skills in interviewing children, and they do not have adequate skills in interviewing men. There is a very strong tendency to focus on the mother. Workers find it easiest to talk to the adult mother rather than to either of the partners or the children. Yet, a wide range of sources of information are needed to make a proper assessment.

Emotional wisdom is something I've added to the systems approach. Oddly enough, in engineering, they rarely mention feelings. I think they are wrong, because emotions influence plumbers and pilots just as much as childcare workers. They are part of human experience, and they are there all the time. It's very important in child protection, because of the power of family dynamics on those working with them and also the impact of child abuse on each worker. It has to be dealt with. I think we were much better at dealing with it in the days when we had a psychosocial casework approach and actually talked much more about feelings. In the British system of guidance and documentation, you wouldn't know that human beings had feelings. They just are not in the language, which has come from management rather than practitioners.

To me, supervision is the key place for helping people think, because it is in supervision that they get this sort of encouragement and the kick to do more thinking through the information they've got. It's something that most supervisors and workers value very strongly. I was in a focus group in Madison of frontline workers, and one of their complaints was that because of the reduction in supervisors, the amount of supervision they were getting and the access to supervision was dropping markedly. Supervision was a major support, both emotionally and intellectually, in managing their caseload. Reduced time for supervision is a serious matter. I don't know how true it is in America, but in Britain supervision is getting more and more tilted toward checking that you've done the paperwork, rather than checking that you have thought through the information that you put on to the paperwork. In fact, as far as I can tell, in Britain, the emphasis is on whether the report has been filled in, not on the quality of what has been written. Under the category of resources as contributory factors, I have listed: the availability of support services; the tools designed to improve practice; and the audit and inspection system. The availability of support services makes a great deal of difference. I do not know what is happening here, but we have a very patchy record of developing support services. They tend to be

things that get funded for three years, rather than being permanently established. The Labor Government has done some good things trying to improve educational and social care services. We have imitated your Head Start, in some of the most disadvantaged areas, so I am not condemning them. They have done some very good things, but the more resources available in terms of supporting families, the more help the frontline worker gets in doing something effective.

I have already discussed the audit and inspection system that is, I think, seriously distorting practice, because it measures surface features of practice and does not get down to the core skills that would really transform the quality of children's outcomes. We have very few measures of children's happiness, of whether they are well and happy and flourishing. The nearest we might get to it is their exam results. Everyone is getting very cynical about the performance indicators in Britain. When students do better on the exams, it is assumed that they have lowered the pass mark, not that students have really improved. With my philosophical background, it might surprise you to know that I think a huge element in the audit system should be to reward people who think. At the moment, what is rewarded is putting a mark on paper, but should be the accuracy and usefulness of what is written that is the key focus.

Let us turn to the third factor in this group: the numerous tools that have been developed in both the UK and the US. When we are designing these tools, do we start by saying what does the frontline worker find difficult? Where do they need the help? Or are we coming in with a different agenda saying, "this is what we can do, and let's impose it." When you find that tools are not being used properly, the standard response is more in the traditional mode of treating the practitioners as the bad apples. The explanations given are that the frontline workers are nuisances; they are resistant, they don't like technology, they don't like change. It's their fault. Is this an adequate explanation? If General Motors produced a car and the first person who got in it drove and veered over to the left and went into the ditch, you might say that that driver was possibly careless. But if you found that every driver who got into that car ended up in the ditch, you would start thinking that the car was badly designed. I think that's just what you should do when you find that there is a wholesale rejection of some of the decision-making aides that are around. We should go back to thinking about how human beings think, make assessments, make decisions, and then develop tools that assist that natural process, instead of trying to bring in a totally alien process and impose it on them. One of the clear examples for me is what we have in England called the Assessment of Need Framework. It has all the right material in it on how to assess a broad range of the child's well-being to get the big picture. The idea is to break out from the narrow focus of the child abuse incident and look at the child's well-being. It is an excellent idea, and it has the right kind of information in it. But the way it is implemented is that the social worker goes to the family with a 20-page document, and they write down all the information. At the end, they pull it together into an assessment and into a care plan, which all looks very rational and sensible. But what they find, in reality, is that social workers are using it—there is a strong pressure from the government to use it—but they are not filling in the final page. So they are basically collecting the information, but not pulling it together to develop an assessment and a plan that gives direction on what to do with the child. As a useful planning tool, it has a major flaw.

What do we know from research on how people make assessments? A lot of work has been done on expert doctors on how they make assessments and how they make a diagnosis. What you find is exactly the opposite picture of what the instrument encourages you to do. A doctor who is very experienced in the subject area will go into a situation with a patient and immediately start conjecturing on what is wrong. They start forming a picture. They then test it out—they reject it, they add to it—but they are actively dealing with the information as they go through the assessment. They do not go in and get a whole load of information, which then just overwhelms them and paralyzes them. I don't know if any of you have ever been taught study

skills on reading, but you are taught never to read passively: take notes; and then try to write an essay. You should actively think beforehand, “Why do I want to read this? What do I hope to get out of it? Am I getting anything out of it?” So, you are actually actively reading and thinking and working on the material.

In terms of helping people with assessments, if we start by thinking how people actively work and conjecture and test, we might be able to devise a tool that collects the same information, but collects it in a way that they could actually interpret the information and use it, instead of just putting it onto paper.

Let me now talk briefly about my third main category of contributory factors: the big organizational context. What concerns me most here is the difference between the overt messages practitioners are getting and the covert messages. This is something that occurs in virtually all industries and services. A crucial and pervasive underlying conflict is that between cost and safety. This happens in aviation just as much as in child welfare: “You shouldn’t take off if ‘this’ is happening, but if you do not take off, then we have to pay extra for this airfield, and so you should not do it unless it really matters.” There is always this conflict. In Japan, recently, they had a train crash for the first time in recent history. I was there, and trains really do run on time to the minute. It is quite amazing. They blamed the train driver for the crash, because he was driving too fast. But the reason he was driving too fast was because he was going to be two minutes late. This was death and dishonor—totally unacceptable. He was speeding to try and catch up the two minutes. The company said, “No, we always tell train drivers that safety is more important than efficiency.” You think to yourself that is just not so. The covert message is that you must arrive on time, or it is a black mark against you.

Another big conflict we have is not an overt but a covert one. It is the conflict between putting the child’s well-being first or putting the whole of the audit system first. As far as I can see, in England, if the frontline worker has the choice between going off to talk to a child and getting a piece of paperwork done within the time frame that is required, the senior person will always tell them to do the paperwork. There might be, in some extreme cases, the reverse, but the general pattern would be to always prioritize the paperwork over the casework. You can see this in the way the time spent has shifted from direct contact time to paperwork or computer time. If you are actually saying to frontline workers, “We want you to spend time doing all these administrative tasks first, and then, if there is time, you can visit the family,” you shouldn’t be surprised that you’re not seeing an overall improvement in the well being of children . . . unless, of course, social work has such a damaging effect that the less you see of them the better [laughter], which I hope isn’t true.

The style of management is something that needs to be studied, as well, because one of the things that can help with safety is a management that protects the frontline workers from the noise from the wider system—so that there is space to do their professional practice. The manager who just gets the pressure from the senior manager and passes it down to the worker is making life even harder for the worker. It is a protective, nurturing role that seems to be better for allowing front-line workers to put their focus on children.

The other chronic conflict issue is the true professional dilemma of child welfare: the difficulty of balancing when it is right to take a child away and when it is better to leave them at home, even though you cannot be certain they are safe. This is never going to be solved, because of our limited knowledge. Removing a child from a family into alternative care is not a desirable thing to do, except when the home is even more dangerous. That is one of the dilemmas that is just inherent in the job, and helping frontline workers manage that uncertainty, psychologically, I think is a crucial element of management, as well. Again, what social workers get is a conflict from management: If you take a child into care it is expensive, and if you leave a child at home and then the child is harmed, or is some cases, killed, there is a strong negative public reaction.

For the system, it is expensive, indeed, to deal with the consequences. Just as in aviation, safety and cost are pulling you in opposite directions.

So if I could summarize my presentation, I would head this final section, "Possible Suggestions for You to Think About." First, I think we should stop blaming the frontline workers and start asking, "Why are they doing what they are doing?" If we assume they are probably reasonably intelligent and well-motivated and not really homicidal maniacs out to harm children, then we actually come up with some interesting alternative ways of looking at problems. Secondly, we also need to be realistic about how human beings think and operate. Instead of going to philosophy and to decision theory—to their very beautiful formal theories, which are not the natural process—we need to bring in more critical and rigorous thinking, but we somehow need to link it, properly, to the intuitive, so that it develops the intuitive rather than paralyzes it.

The third issue to mention that I find very difficult to analyze, but which also seems to have increasingly important consequences, is the area of political intervention. We are getting a great deal of political concern and loads of change in Britain in education, health, child welfare, and criminal justice. Every part of these systems is trying to change the way that they are dealing with children. Quite literally it is only at the frontline that you know how all the changes interact. Unless we actually have proper dialogues with families and with frontline workers, we are not going to know the effect these changes are really having in an interactive way. You have education coming up with some changes, but people in education are not going to know how it interacts with the changes the police are making. This is a very serious complication that needs to be studied—actually understanding how different parts of the system are all interacting, when it comes down to the real interface of a frontline worker and a family.

I think there is a great deal of hope for improving child welfare. I think we have some bright ideas. If we could only learn how to implement them well, we could make some progress. This summarizes my alternative way of looking at child welfare. [Applause]

COMMENTARIES

Introduction to Terri Stoneburner

When we began to think about this forum, framing the way to present critical factors in human error and the role of the organizational context, we began to search for data on these questions. We turned to the judicial system. Parents, who feel that an error in judgment has been made, regarding their capacity to parent, turn to the judicial system to speak their truth to the power of the system. The Court of Appeals appears to be a source for understanding errors from the point-of-view of parents. I turned to Judge Terri Stoneburner in the Court of Appeals and asked her whether she would tell us, briefly, what she could make of the appeals that have come to her most recently. What do the appeals reveal to us about where parents feel the system has gone wrong and errors have been made?

Judge Stoneburner graduated from the University of Washington School of Law in 1975. She served as a district court judge from 1990 to 2000 and was then appointed by Governor Jesse Ventura to the Minnesota Court of Appeals. She was elected to a six-year term on the Court of Appeals in 2002. Judge Stoneburner brings a wide background of experiences to her judicial post: the Council of Families; the Supreme Court task force on open hearings and juvenile protection rules. And to add to her broad view of the human condition, she has been around the world twice, backpacking.

Judge Stoneburner, what kinds of issues come to you in your appeals court?

Terri Stoneburner
Appeals Court Judge
State of Minnesota

Whether evidence was properly admitted, whether evidence properly admitted is sufficient to support the district court's findings of fact, and whether the findings support the district court's conclusions of law—these are issues routinely asserted in appeals from termination of parental rights. In reviewing the kinds of issues that come to us in the Court of Appeals, in Minnesota, the appeals panel ultimately has to weigh everything and say, "Does this amount to clear and convincing evidence that this child cannot safely be returned to this family."

What I see is a big lack of communication between the advocates for removing children and the parents whose children are being removed. Some of the programs [initiated by the court and other stakeholders in child protection]—other people in the room are more equipped to speak about them than I am—try to take this whole process out of the adversarial system. In these programs, facilitators sit down, up front, with the parents and the social workers and other interested parties and arrive at an agreement about what the problems are and what the problems are not, before a child protection issue ever gets into court. I think, in the long run, this early, non-adversarial problem identification may cut down on appeals. We know in one county that it certainly has. Since implementing this program, this county has had very few terminations, and the ones they have had have not been appealed. By the time a case gets to a recommendation for termination of parental rights, the parents have a clear understanding of why there is an issue, and have had an opportunity to discuss the issues in a non-adversarial setting rather than solely in the context of trial, where the evidence for removal is presented in a courtroom setting to be countered by the parents' evidence.

A trial often results in a dispute on appeal about whether a termination decision is supported by "clear and convincing" evidence, which is a higher standard than in most family-law cases. Some of the appeals involve questions of whether certain evidence should have been admitted at all. Of course, the parents are completely out of that picture. This is the attorney's realm, i.e., has the document been properly introduced? Is the social worker's report an administrative record? Is the psychologist's report that is in the social worker's file an administrative record? And, did the judge make a mistake by allowing it into evidence? Many of these issues come before us [and have very little to do with the child's best interests.]

Other issues raised on appeal have their origin in Minnesota laws and practices: For example, if you have had a child removed from your care involuntarily and you have another child, there is a presumption that second child can be removed and a social services agency does not have to make "reasonable efforts" for reunification purposes. But the parent can overcome that presumption, so a lot of the battles are over this: Did the parent overcome the presumption? Was the presumption correctly applied to this parent? Was the original removal voluntary or involuntary to begin with? [Again, the focus of these issues is not the best interests of the child in question.]

The evidence is the biggest issue, and I believe that, as I said, reflects the issue of a lack in communication. Through the Children's Justice Initiative, and other programs initiated by the court and stakeholders in child-protection matters, we are trying to address the whole issue of how we can improve communication, identify a family's strengths, in an effort to keep child protection matters out of adversarial proceedings and subsequent appeals [while respecting the rights of parents and focusing on the best interests of the involved children].

Introduction to Inta Sellars

Inta Sellars is also part of our judicial system that provides a place where grievances of parents or perhaps even children can be heard. Her role is really very interesting, because it is within the Department of Human Services. Inta Sellars' role is to hear the appeals and grievances of people who felt they have been dealt with unfairly. Is this where some of the errors of the system are exposed?

Inta Sellars
Human Services Judge
State of Minnesota

I am a Human Services Judge at the Department of Human Services, and part of my job is to second-guess child protection workers in making their child maltreatment determinations. I think we fulfill part of that surveillance function that Professor Munro was discussing—the surveillance to reduce human error, which she said was a negative thing, and I agree. I think that our office's role in this process is what Professor Munro refers to as "professional review of the casework process." We're not really monitoring procedures, we are actually looking at the evidence that the counties bring forward, in showing that a maltreatment determination should be affirmed or upheld. Our review is not limited to the propriety of the agency's action; it is actually a review of all the relevant evidence. While some may consider our office an "enemy," I think it actually does serve the purpose of looking at the evidence versus looking at the process.

As Professor Munro went over some of the individual factors, I was struck by her note about the signs of burnout that we see in the child protection field, and I think this is reflected in some cases in our hearings. We see child maltreatment investigators who appear to be cynical, or in some manner, they depersonalize the situations they are involved in. They are accused, by the parents, of walking into a family's situation, assuming that maltreatment has occurred, and then identifying a particular individual as the perpetrator. I agree with Professor Munro's point that the managerial approach to social work exposes a routine and unfeeling approach . . . . I also want to put this into perspective. . . . We had 213 cases filed in the last year from November 1st, 2004 through November 1st of this year, and of those, only 73 cases went to a hearing. Of those, 57% were affirmed, where the maltreatment determination was upheld, and 43% were reversed. This is an interesting statistic in itself, and it is also consistent with the runs we have done with our data in the past. The issues we see most frequently, where we reverse the county's findings, are those related to the resources and restraints that Professor Munro mentioned. In many cases, we simply find that the county has not brought sufficient evidence to support its determination. If there were sufficient evidence, we would be able to uphold the maltreatment decisions. For example, very specifically, the county may have a picture of a bruise on a child, but they don't bring it to the hearing. They may not have a transcript of the child's interview. They may only have a child protection worker's summary. In the legal sense, that is hearsay, and it is not direct evidence of the maltreatment occurring. I also can attribute this issue to a lack of resources. Counties don't always have the resources to transcribe all interviews, and they have to rely on caseworkers' notes and summaries from those cases. I'd like to offer a suggestion to those who do have appeals in front of us. (This would help to reduce your workload, and I don't really care whether the process was followed in the child protection investigation.) I need to know that the county has sufficient evidence to show that maltreatment occurred. I don't need to see safety assessments or whether a safety assessment was completed. I don't need to make sure that all the documentation that workers are supposed to do, by rule or statute, is completed. I just need to see the evidence that the county has to show that maltreatment occurred. Again, perhaps cases are not generally reversed because of human error, but I think that is because people in the child

protection system don't understand what we are looking for in a typical hearing. Often, this is the rub between social work and the legal fair hearing system. Thanks. [Applause]

Introduction to Anita Fineday

Certainly, one of the issues that our state has grappled with and continues to grapple with is the differing perceptions of various components that make up the child protection system. Perhaps, nowhere is this issue more clearly identified than in our work with tribal children, whose fate is under the auspices of the Indian Child Welfare Act. ICWA standards are separate from other federal and state statutes. We all have had experiences in trying to interpret standards that relate to the best interests of the child. We are privileged to have Judge Anita Fineday with us today. Anita Fineday is Chief Judge with the White Earth Band of Ojibwe. She also works with the Leech Lake Band of Ojibwe and with the Red Lake Bank of Ojibwe. Judge Fineday has been a corporate council for the Mille Lacs Band of Ojibwe. Judge Fineday is undoubtedly one of our most experienced tribal judges. She has watched, with great concern, some of these differing perceptions of error and explanations—if we went wrong, where we did go wrong? And where, in fact, do we have some agreement? We all appreciate Judge Fineday's presence today.

Anita Fineday, Chief Judge
White Earth Band of Ojibwe

Thank you. I just want to say to all of you I am a lawyer by training—I'm not a social worker—and now, by trade, I'm a Judge. Just a little bit of background: I've practiced law for many years in the child protection system here in Minnesota. When the White Earth tribe expanded its jurisdiction over its tribal court to include child protection cases, in 1998, I became the Chief Judge, at that time. Don't let the title "Chief Judge" throw you. I'm the only judge. [Laughter.] When I worked in the child protection area, chiefly in Hennepin County, I saw a lot of social workers really struggle with possible cultural misunderstandings. I think that makes your jobs very difficult—having to work in different cultural contexts, with people from different cultural backgrounds—to try to interpret what really is going on in these contexts. One of my concerns, for a long time, has been the over-representation of Indian children, both within the juvenile delinquency framework and in the child protection system. And then there is the vast over-representation of Indian children in our prison system. When I became the Chief Judge at White Earth, and I now work as the child protection judge on the Leech Lake Reservation, I wanted to do things differently than the system that I had seen in place in the State courts. This is an incredible opportunity for me, because we are literally building a judicial system at the White Earth Reservation. One of the first things we did was change some of the ground rules that you use in your court systems in Minnesota. We created a Children's Court. Our court is truly focused on children. Children are always welcome at court hearings at our court. I know of at least one judge in Minnesota who does not allow children to be present during child protection hearings. And I find that so odd, because they are truly the reason that we are all there. So children are always welcome in our court system, and I welcome children to come and talk to me, in my chambers, with no one present. (I don't have to worry about some of the constitutional issues that may be present in the Minnesota court system.) So children come into my office, and they talk to me behind closed doors. They are able to be more honest, and they are able to tell me what is going on in their family. I was late getting started to come down here, because I had a teenager in my office this morning telling me that her father uses meth in front of her and that she was very afraid to go home. I think that if she had been sitting in a courtroom, and if she had her father sitting there, she would not have made those statements, and it might have been a long time before we found out. Because of our ability to have children come in and talk to me alone and not be intimidated by parents or social workers, I think we have an easier time getting at some of

this information. Children call me, and I tell children that they can call me. I've had children call me when they're on runaway status. I've had children call me when they are in trouble. Children can speak at hearings, and they know that they have an opportunity to be present, physically, but also to speak and to be heard in these proceedings. . . . I know that Professor Munro mentioned that the number of hours social workers spend with children and families—because we're so busy filling out forms—has decreased dramatically over the years. The White Earth tribal court had 241 child protection hearings in 2004. So far this year, we have had 391, and I am hesitant—I am really hesitant to say this—but so far, we do things a little differently. We suspend parental rights. We do not always terminate them, though we have terminated them, as well, but it is not our preference to do that. We do suspensions of parental rights, and we do what we call "customary adoptions." But I am hesitant to say that of all those hearings that we've had (those are just the last two years of statistics), we have yet to have an appeal. I knock on wood, but I've had no parent appeal any of the decisions that we've made in our court system. I guess the other thing that I would say is that we have had no deaths of children who are under our tribal court jurisdiction. And I knock on wood also. I don't know if all of you saw the article in the newspaper this week. An Indian girl was found dead on the street. My heart sank, because I had a girl on run here in Minneapolis, and I was very concerned that that was a girl that I knew. It was not, but it was a tragedy nonetheless. I just want to thank all of you for this opportunity. I really welcome the input from Esther, as always, and the input from all of the social workers. I want to extend an invitation to all of you: we are a court system and a child protection system that is evolving. We are very young, and if there are any students here who are looking for research projects to do their masters or Ph.D. on, the White Earth tribal court welcomes you. We are open to anyone who is interested in doing research or who is interested in observing the way we are carrying out our work at White Earth. Thank you. [Applause]

It is our pleasure to introduce Erin Sullivan Sutton, Director, Child Safety and Permanency, Minnesota Department of Human Services. In a way, Erin Sullivan Sutton has bridged the judicial and child welfare systems. As both a lawyer and a social worker, she has provided leadership and experience in guiding most of the recent reforms that have been initiated in this State. As a member of the Supreme Court Advisory Committee and a frequent presence before legislative committees, she has championed crucial issues for improving child welfare. Erin Sullivan Sutton was one of the architects of the Children's Justice Initiative, which is our attempt in Minnesota to bring the judicial and the child welfare systems into a coherent response to the maltreatment of children. We welcome commentary from the "insider" of the Minnesota Department of Human Services.

Erin Sullivan Sutton, Director
Child Safety and Permanency
Minnesota Department of Human Services

Now, I know what most of you would want me to say after hearing Professor Munro's presentation: we will go back and take out half the screens and SSIS, which is our Social Services Information System. [Applause/Cheers] I'm not going to do that yet. [Laughter] What I was struck by is the similarities of the issues that we are dealing with. There were a number of us and some of you in this room who had the opportunity to meet with a couple of representatives from New Zealand about a week and a half ago. New Zealand is looking at implementing a differential response system similar to what we have developed in Minnesota. We talked a lot about the issues that we're struggling with, and I think the presentation that we had today is very similar. Today I spent a large amount of time talking with three different media organizations on

three different stories. Not all of them are bad, but I think it goes back to how we look at what this work is and what the expectation is of the system. Human error is, of course, the easy way out. I was struck in reading Professor Munro's article on how the emphasis on looking at systems and how the system really drives what happens in individual cases . . . We are reviewing unexplained deaths of children, using this framework. In this State and in many other States, we really have begun to question the system that was designed to protect children, when in fact that system, historically focused on protecting children, may have caused more harm to children. Looking at the system differently has led us down a different road than where we were originally designed to go. I think this has been a very positive thing. All of us are now engaged in what we now call "Family Assessment." We are challenging ourselves to look differently at the work in response to struggling families. In this, recognizing that placing blame and having a focus on determining whether parents did harmful things to children did not bring us to success. I think we have seen a large amount of success with retraining staff and recognizing that parents are the best resources for their children. The way, hopefully, to improve the well-being of children is to do so in the context of the well-being of their families. . . . talking with and engaging families about how they care for their children, what they need to care for their children . . . this is a more strength-based, positive focus. We have been able to demonstrate, in this State, that this process has improved child safety in a shorter period of time and has resulted in a number of other positive outcomes. These include improved housing, stability, satisfaction of social workers (who finally get to do social work, which is what they were trained to do in the first instance), as well as increased satisfaction of parents. Oddly enough, we have seen increased income for families. We think that, in the large part, this is due to flexibility and really changing the system. . . . We focus on the families and what they say they need to change their situation. This is a focus on those families who are reported to the child protection system, oftentimes because they lack resources. I think this is a move in the right direction. This is an example of really looking at the system as Professor Munro has challenged us to do.

One of our continuing challenges is our response to those situations where there are allegations of serious harm or serious risk to children. (In Minnesota, these situations are called egregious harm cases.) We have discussions around whether the judicial system that was designed to provide protection for children, as well as provide protection for the due process rights of parents, is the right forum for handling these difficult issues. Because of our tendency to move into legal arenas, when there are disputes, we have designed a system that really does cause [harm] . . . trying to find resolutions to tough problems. I think that is where our continuing challenge will be. We have talked a lot about recognizing that oftentimes it is difficult to achieve good outcomes when we are involved in prescribed legal proceedings. Yet, that is the system we now have in place. We need to beg the question as to whether this system is the one that should be in place, when we have families before us with the most challenging of problems. Again, we must rethink how we approach these issues. I think that is a challenge for all of us. I would like to mention one example . . . I am now referring to Anita Fineday. I was at a meeting not too long ago where were talking about some of the challenges in providing services that are appropriate with Indian children and their families. One of the Indian representatives at the meeting very eloquently talked about the necessity of a healing process. In the Indian culture, that is really the focus—healing, and yet we have families who are in a court process that is viewed and perceived as very destructive. That has caused me to question what we should be doing, from a system perspective, to really look at healing with all families who come before us, but particularly those families with the most challenges. Thank you. [Applause]

Professor Wattenberg's Questions

How much does ideology guide the system and does this contribute to errors? Are permanency directives—the policy response to the negative consequences of children drifting through the system without a stable, permanent family—inadvertently leading to the source of errors?

Does decision-making, within brief time lines (guidance for permanency), take into account the uncertainty and unpredictability of parents' progress in treatment . . . and are these considerations before termination of parental rights is ordered?

This rush toward permanency was described to us by advocates for the family in this way: the system throws out a rope to the family, i.e. the case plan. The parents know that this is really a test of their compliance with a case plan. Whenever there is non-attendance in a parent improvement program; a relapse in steps toward substance abuse sobriety; or non-attendance at a counseling session, child protection cuts a piece out of that rope, until it hangs them. Should this embittered version of parent's perspective be assigned any credibility? In this perspective, compliance is measured in attendance, but attention to the condition of the children is not recorded. At the end, parents face termination of parental rights, with little regard for the condition of the children. Does the need for speed compound the possibility of error? Actually, we have very few studies on the role ideology plays in shaping practice behaviors. Does the UK have anything to tell us about ideology as a source of human error?

Professor Munro's Response

We have the same problem of ideology driving discussions. It starts with the sensible element that research provides a direction, like the desirability for children having stable environments. But in a desperate and childish attempt to get certainty, we turn it into an absolute mantra . . . looking at it in the cold light of day, we would see that people are just so scared of getting it wrong that they veer off track, and they stick to very rigid rules that just don't apply. If you're really looking at how to help children, then you recognize that children are unique. Of course, you want some general principles and you want some general guidance, but you want a system that has the flexibility to treat every child as just themselves and not a type. We had a judge in one of our inquiries who came up with a statement which has been quoted a lot, because it is a very good reminder that the child is a person and not just an object of concern. I think we veer very much toward treating children as objects of concern, when we don't let them talk to us—when we don't let them participate in the decision- making. I was very struck by your comments on the voice of the child, because another part of the work I do is a course on child rights. Every year I am becoming more ideologically committed to the rights of the child—the voice of the child being heard and listened to with respect, in the ways that we try to help them. The trend at the moment is towards paying lip service to that, but not putting space for it in the actual services.

Audience Comment

. . . in terms of the ideology . . . we are being directed, fairly clearly, by Federal and State guidelines. Local agencies do not have the flexibility that you attribute to them . . . The courts, themselves, have, in this State, embraced permanency. Our departing Chief Justice, Kathleen Blatz, when she was a legislator, was arguing strenuously that youngsters should be given three months before making a fateful decision on permanency. . . . I think part of what we struggle

with is how to have an ongoing conversation so that the Feds, the State and the agencies are in it together. . . . I am absolutely delighted that Anita [Judge Fineday] and others are moving toward courts of competency, so that many of these youngsters from the Indian community can be treated in the way that they should be treated. [Applause]

Audience Question

Creating a space for thoughtful supervision is almost impossible, because supervisor and managers have to make sure that every "t" is crossed and every "i" is dotted. Are there any examples of agencies that try to create a space for thoughtful supervision?

Professor Munro's Response

I do know of some places that have tried to make it a firm procedure that you have one hour of supervision: thirty minutes is devoted to managerial work and thirty minutes to clinical issues. I know of another place that was going to experiment with having a day a month when the team got together. They had two teams in the office, and they were going to have one team covering duty for the other—to give them the entire day to look at group supervision and to use the team as a resource, rather than just the one-to-one of supervision The hope was that this would maximize the creativity of the team and build the team and that people could share the anxiety of the difficult cases more with each other. . . . I thought that was a very creative idea.

Audience Comment/Shannon Smith

I am the director of the Indian Child Welfare office in Minneapolis. We have a system that has placed a lot of emphasis on permanency. I understand these mandates are both federal and state. I think in many ways it is a very fictional goal. For example, we talk about permanency in the light of terminating parental rights, and at the same time, we talk about initiatives "through the eyes of a child." It has been my experience, working with families and working with children, that [termination of parental rights] gives no sense of permanency to that child. . . . It is premised on a system that believes that transfer of legal custody and adoption is permanent, and therefore everyone can step out and say "we've done our job." . . . the reality is that the child may be a part of the very same system, and at this time, may be facing a second round of termination of parental rights. This is obviously devastating for everyone involved. If you recognize that returning a child to the family through a transfer of legal custody—maybe through a court process or maybe it is something everyone agrees upon at that time—is in the child's best interest, or it may simply be that the transfer of legal custody is disruptive and that child returns to the family that that child knows and loves. I think there is certainly a push for permanency and I think oftentimes it is misguided. Again, I understand that there is Federal policy and that there is State policy, but is it really looking "through the eyes of a child." . . .

Judge Stoneburner's Response

I'd just like to second what you are saying. We are starting to see, in the Court of Appeals now, a lot of placements that took place early on—when permanency timelines came in and people were placing children with relatives—and now that hasn't worked, because there wasn't enough groundwork done . . . you place a grandchild with fetal alcohol syndrome with a grandmother, and she just doesn't have [the necessary] skills. Then later, her rights are terminated, and it is on appeal. Appeals, I have to confess, are taking an average of 242 days, which is longer than the parents have to clean up their act to keep their children. We are working to cut down that

timeline, but every time you have a placement and an appeal, there is a lag, and that is just the Court of Appeals. The Supreme Court has its own time schedules . . . another 240 days for *that* appeal. This whole issue is really vitally important.

Audience Question

What are your thoughts about disability and the multiple systems that are involved in responding to a child with a disability?

Professor Munro's Response

I had a colleague whose doctoral thesis was studying the experience of parents who had a child with cerebral palsy. She called her publication, "Parents as Care Managers." There was, at the grassroots level, no real coordination between the systems, and it was actually the parents who did all the linkages, although officially they are all meant to be linked up. We have cases in which parents, with a child with disabilities, are saying, "this situation is so difficult— the physical and emotional demands are very hard—can I have more support?" And they are told "no, we haven't got any more money. You can't have any more."
But then, somebody at the child's school sees a bruise, and it comes in as a child protection issue. "It is physical abuse. We are going to remove this child, unless you stop hitting the child. What can we do to help you stop hitting the child?" Well, now, we'll give them what they asked for six months ago. I just find it so painful that these parents and child have to go through that experience—that our system cannot respect the parents' need for help; it can only respect its own need to respond to an allegation of abuse. We seriously fail children with disabilities and parents who are looking after them, despite the fact that we have more skill and resources, and more ideas of how to help them than we've ever had.

Esther Wattenberg's Question

Do case records provide evidence for the courts that is "clear and convincing"? Those of us who have read cases, as the source of information for studies, will tell you it is very difficult to construct the narrative that embraces the experiences of a child. Case recordings are very sparse; very often incoherent. Constructing some reality of the experiences is very difficult.

Judge Stoneburner's Response

In a typical case, social workers on the witness stand will testify to what has been done to provide reasonable evidence for the decision on permanency issues. Often, they find themselves testifying from records derived from people who provide psychology evaluations, CD evaluations, etc. The question is whether the social worker can testify to that or whether the person who wrote that report should testify. This is one of those issues about whether the evidence should come in from a report, without the author on the witness stand to testify about their experiences with the family. A lot of hearsay comes into termination of parental rights cases. Hearsay is something that was said outside the court, not under oath, not by the person who is testifying. . . . You get a lot of layers of evidence and layers of reliability of evidence, and then the District Court Judge has to sort out what is the clear and convincing evidence from the hearsay. Parents testify often, of course. They bring in their relatives to testify about what they've seen, and sometimes they have hired experts who have done other evaluations, and they testify as well. There are many ways that evidence comes in. A lot of these cases are more than one day long—sometimes three days, four days long —solid testimony and many documents. A

psychology report, a chemical dependency assessment, a risk assessment tool may all be introduced. The court is actually flooded with evidence in these cases. That is why I would say 99% of them are affirmed at the Court of Appeals . . . That doesn't mean that in the long run the parents feel they have had due process, even though we've gone through these long proceedings. Much of it is "he said; she said," and no communication occurs.

Concluding Remarks Wattenberg

It has occurred to many critics of the child welfare system that the sources of grievances from parents may be lodged in the fact that a high proportion of families in child protection, especially those described as "chronically neglecting," i.e., families coping with multiple problems and high stress, do not receive services. Findings from research provide this picture: low compliance with case plans that require attendance and participation. And transportation in rural counties is a major issue.

In searching for the sources of error in child welfare, we have yet to confront the phenomenon of low compliance with case plans.

Professor Munro's work directs us to distinguish between avoidable and unavoidable errors: the environment within an agency impacts on the quality of decision-making. Supervision and the quality of record-keeping are key items in faulty decision-making.

In a broad context, according to Professor Munro, public sector services in all developed economies have had to face new demands for accountability and transparency leading to the creation of complex audit systems. Professor Munro reminds us that while the audit system in public sector services is concerned with efficiency, our professional commitment must be focused on effectiveness.

Our objective is to ensure that children are securely attached to persons who are capable of providing safety and well-being for the duration of childhood. We hope today's forum has made a contribution to our commitment to the continuing improvement of all aspects of child protection.

We thank all of you for your attendance, and of course, a special note of appreciation for the presenters and the audience participants.