Removing Children from Home -The Legislative Auditor Weighs In

The Minnesota Office of the Legislative Auditor (OLA) just issued a report on removing children from their families. Read their study or the Star Tribune editorial and summary of the report.

OLA discovered that practices vary widely among counties, including the rate of removals, social services/law enforcement cooperation, and the availability of preventive services. This finding echoes other studies showing variability in related service areas. The result is that children and families are being treated differently depending on where they live.

OLA recommendations include standardizing protocols between local child welfare agencies and law enforcement, expanding the courts' performance measures to include child well-being metrics, and making prevention services available consistently statewide.

These findings cry out once again for the Department of Human Services to assert a stronger role in developing statewide standards across all steps in the child welfare process.

Narrative for Safe Passage podcast on Office of the Legislative Auditor report on removals of children from their bio family to foster care

Our overall reaction to this Minnesota Office of the Legislative Auditor (OLA) report is that there is a lot to like. This is largely because the Legislative Auditor is able to get information that is ordinarily unavailable. This happens sometimes because the Department of Human Services and the counties are required to give information to OLA that they might not give to an advocacy organization or the media, but also because due to the county-based nature of the Minnesota system, a lot of information that you would think would normally just be there has to be obtained by a special project or study, for example whether services are available to populate case plans or the extent to which children are removed through by court orders versus emergency holds by the police.

The fact that I am generally impressed by this report is good news because I have not always been a big fan of OLA. This began in about 2013 when we were able to get OLA to do a report on child protection intake. At that time they came up with very similar findings to what they discovered in this report regarding removals. However their findings and recommendations generally glossed over the problems that they had discovered and they issued summary comments indicating that the system overall was working well. I want here to give a shout out to Senator John Marty because in the hearing on the Legislative Auditor report, he pointed out this cognitive dissonance between their detailed findings and their summary recommendations, which helped get us back on track. In comparison the findings and recommendations in this report seem to be consistent with the details of what they discovered.

We expect that not everyone will be satisfied with this product. In particular, I have heard, although I was not part of these discussions, that the impetus for this report was concerns by activists particularly in the African-American community about the disproportionate number of BIPOC children being removed from their bio families. The OLA report did address this in some ways. For example they noted that state laws are very broad about when to remove children

which contributes to the wide variation in local standards and practices, and of course this would open the door for decisions to be made that were affected by racial bias. Overall, as result, there are significant differences in whether families are preserved or the children removed.

It is important to recognize that the Legislative Auditor is a generalist group which is not really equipped to look in depth at the reasons for the disproportionate number of children of color in foster care. Again as we have said many times before, getting at an issue of this nature would require statewide standards for when to remove children and when to reunite them with their families. This in turn would have to be supported by a robust quality review system that would be sufficiently detailed to identify any disparities due to unequal treatment as opposed to other factors such as poverty. This would involve case reviews based on those standards, leading to reliable and credible results and most importantly results that are actionable. Being actionable includes training on the areas to be improved and further follow-up with additional quality reviews to see if the changes are being implemented. These and other elements of a continuously improving organization, such as regular team meetings to review recent case decisions, are some of the steps that are needed to actually identify where disparities are related to racial bias versus other factors and to correct them. Short of having these components of a what is sometimes called a learning organization we won't be able to actually get at the issues that the activists were hoping this report would address.

But we can get some valuable insights from this report which could lead to significant improvements in the program if the Department of Human Services and the counties will take them to heart and take action.

Just the fact that the Legislative Auditor highlighted that state laws are very broad about when to remove children with the result that local officials make very different decisions about child protection from county to county.

In addition OLA surfaced the fact that case plans written by caseworkers in child protection are often very long, they said typically 30 pages, and include both legal and social services jargon that laypeople are unlikely to understand. The recommendation that case plans be simplified and written in non-technical language could by itself remove a major headache for parents who are doing their best to comply with what the court expects them to do.

One finding that we were especially grateful to see was that the relationships and protocols between county and tribal social services agencies on the one hand and local law enforcement on the other vary widely across the state. The auditor juxtaposed two adjacent counties, one in which 80% of removals were precipitated by a law enforcement emergency hold compared to 2% in the neighboring county. A more specific finding for example was that when child protection services are working with local law enforcement they are more likely to issue an emergency hold and remove the children until the courts can get involved. The implication of this is that children are more likely to be considered unsafe and removed from situations when social workers are involved. The importance of this was illustrated by last year's case of Autumn Hallow where the Elk River police were called to her home 31 times over a period of 6 to 8 months without ever seeing the child except waving from a balcony. Neighbors produced recordings of the child screaming but the police did not exercise their authority to ask to either

see the child voluntarily or that failing ask the courts to intervene. During this time there were, as best as can be determined from the case records, only a handful of cross reports to child protection services, which did not take action despite the frantic pleading of the bio mother. As a result Autumn was slowly starved to death during that half year or more. That included locking her in a sleeping bag and throwing her in the bathroom or closet for long periods of time and finally ending her life by suffocating her to death.

The OLA recommendation here is for DHS to convene a workgroup that would sort out common protocols and training between local law enforcement and county and tribal child protection agencies. We applaud this recommendation and hope that such a workgroup is initiated quickly.

A further helpful observation was that Juvenile Courts, which handle child protection in Minnesota, are focused pretty narrowly on meeting federal standards for timely resolution of cases and aren't looking at other important measures such as whether safety plans are in place, service plans are appropriate and being implemented, and if reasonable efforts were made to prevent the removal of the children. The discussion of "reasonable efforts" surfaced the complexities of this issue. Often children are not known to child protection until circumstances require them to intervene and remove the children. Secondly the availability of prevention services varies widely statewide because of the fact that they are largely paid for from local property taxes which themselves vary significantly statewide. Overall however, the recommendation that the courts put some effort into looking at the metrics that they track could lead to some important changes in their role in child protection in foster care.

We commend the remaining findings and recommendations in the report to your reading. In some however I would say that if the Department of Human Services and counties, the courts, and local law enforcement follow through on just the major findings of this report, that could go a long way toward making some significant improvements in the quality of services delivered to children and families.

And one last thought. Just as I was about to send this podcast into production the Star Tribune published their lead editorial for July 5 2022 on the OLA report. They made many of the same points as I did in this blog but of course their readership is very large, so this message will get to many of the thought leaders of our community. As many of you know, in 2015 the Trib published a brilliant Pulitzer Prize-nominated investigative reporting series on Eric Dean and 52 other children killed by their caregivers. Since then their coverage of child welfare issues has been on-again, off-again, so we are relieved and grateful to see them weigh in on this important issue and hopefully give some momentum to reform efforts.

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