Comparison of Structure, Purpose, and Policies of Child Protection Systems in Colorado and the Netherlands

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Agenda for this session

- Introduction and rationale for the study – Krugman
- Methods and findings – Schwab-Reese
- A Dutch perspective on these observations and the current child protection system in the Netherlands – Lamers-Winkelman
- Discussion questions – Audience
- Wrap up – what are we missing?

Rationale for the study: 1990

- The US Child Protection System has for the last 50+ years relied on mandatory reporting of suspected cases to county and/or state child welfare agencies who had responsibility to investigate these reports.
  - By 1990, the system was struggling and called "a national emergency".
- Child protection in Belgium and the Netherlands had been health based since 1973 . "Confidential Doctors" had multidisciplinary teams of professionals who received reports and invited the families reported to come for evaluation and treatment, if necessary.
  - There was no mandatory reporting.
  - The Confidential Doctors believed that their approach was superior to ours.

Intervening history

- Study could not be started in 1990, but did commence in 2015.
- In the interim, the Confidential Doctor System in Netherlands and Belgium was modified.
    - The change occurred ~2005, and followed changes in law that occurred after scandalous cases in Belgium and the Netherlands.
    - In the Netherlands, the teams were merged with the teams dealing with domestic violence.
    - In Belgium, the Centers became “Confidential Centers”.
    - Most, but not all of them, had physicians working with them.
    - In both countries, responsibility was taken by the Ministries of Welfare.

Other considerations

- The privacy laws in Netherlands and Belgium prevented access to data that could shed light on whether the former system was effective.
- We decided that the first step was to understand how the current systems in the US and Europe actually were working.
- We designed, with our European colleagues, a 19 question interview to conduct with administrators and front line child protection workers.

Key questions

(1) How and why are child protection systems different in purpose, structure and practice?

(2) How and why do child protection systems change over time?

(3) How do child protection systems measure their effectiveness?

Methods: Study Design

- Comparative case design using qualitative data
- In-depth, semi-structured interviews (n = 74)
  - Colorado (n = 27)
  - The Netherlands (n = 37)
  - Belgium (n = 10)
- Interviewees at each site include:
  - Front line employees with deep knowledge of daily mechanics and processes (e.g., agency directors, social workers)
  - Experts and thought-leaders who possess historical memory and perspective about their site's child protection system
- Sample selection both purposive and snowball
  - At each site, selection began with professional contacts at each level, then expanded through recommendations until thematic saturation was achieved
- Study approved by Colorado Multiple Institutional Review Board (COMIRB)

Methods: Data Collection

- Interview guide design led by experienced qualitative researcher
  - Designed to elicit data on the structure, history, evolution, and central purpose of each site's CPS; perceived benefits and costs of CPS; perceptions of mandatory reporting; measures of system effectiveness; and methods of post-case follow-up
- All interviews conducted in person and on location by an interviewer trained in qualitative methods
  - RK = senior investigator, received training in interviewing techniques prior to study, conducted interviews in English, focused primarily on interviews with experts and thought-leaders
  - LSR = experienced interviewer, conducted interviews in English in Belgium and Colorado with front line CPS professionals
  - LS = experienced interviewer, conducted interviews in Dutch, primarily with front line system employees in The Netherlands.
- Interviewees received no financial incentives for participation

Methods: Analysis

- All interviews digitally recorded and transcribed verbatim
  - Dutch transcripts were translated into English following transcription.
- Data were formally analyzed using established qualitative content analysis methods
  - Initial code list generated by 3 members of the research team
  - Codes independently applied to 10% of transcripts to establish inter-coder reliability across 2 coders
  - After inter-coder reliability was established, we applied codes to remaining transcripts using qualitative software package ATLAS.ti
  - Focus on the Netherlands and Colorado today

Results: Impact on workers

- Burden on employees
  - CO: substantial administrative & case load burden
    - process-related data entry was overwhelming
    - inadequate administrative support for this burden
  - NL: substantial case loan burden
    - substantial influx of cases leads to waiting lists
- Support for workers
  - CO: supervisors provide support; constrained by resources
  - NL: access to other consulting personnel is limited

Results: Impact on workers

- System structural change
  - CO: Executive director is appointed
    - Regular change with governor change
    - Shifting priorities, ways to operate, measures, etc.
  - NL: System structure occasionally changes
    - Confidential doctor system → AMK → Veilig Thuis
    - Disruptive to employees; unsure how to function within system
- System worker change
  - CO: burnout contributes to frequent turnover
  - NL: temporary contracts cause frequent turnover

Results: Impact on Families

- Initiation of the referral
  - CO: majority are authority/other system driven
    - Adversarial beginning to relations
    - Involuntary process
  - NL: community drive
    - Less adversarial
    - Voluntary process
- Orientation towards family engagement
  - CO: historical punitive focus; newly evolving focus on family engagement
  - NL: long-standing tradition of family engagement; emphasis on therapeutic process

Results: Impact on Families

- Services for families
  - Both: Insufficient resources for mental and behavioral health treatment
    - CO: Some organizations hired professionals to provide services within the agency

  - Child welfare system can’t address the systemic issues underlying the abuse/neglect so these services are key to future prevention.

Results: Mandatory Reporting Practice

- CO: Mandatory Reporting
- NL: No Mandatory Reporting

Results: Perceived Positive Aspects of Mandatory Reporting

- CO:
  - System enables CPS to "be the bad guys"
  - Difficulty of public response is reduced because reporting is their only role
  - Has a limited paperwork burden
- Both:
  - Encourages people to be aware of child abuse and neglect
  - Perceived to be a straight-forward system
  - Forces people to report (In CO: 30% increase in reports after adult protective services mandate)

Results: Perceived Negative Aspects of Mandatory Reporting

- NL:
  - No evidence to support
  - Negatively influences referrals
    - Too many referrals immediately following implementation
    - Referrals will eventually stop because "reporting every little thing" undermines reporter confidence
  - Eliminates social responsibility
  - False positive reporting will reduce the time available for other cases
  - Limited feasibility of punishment/enforcement
- CO:
  - Better education needed for mandatory reporters
  - Variations in reporting between experts/professionals and lay reporters
- Both:
  - Stressful for professional working with the families

Results: System Effectiveness for Outcomes

- Data on system effectiveness
  - CO: A lot of process data are collected; with little purpose except legal compliance
    - Unclear how these data are related to a coherent set of larger goals/purposes
    - Not necessarily continuity in the collection, analysis and use of the data across administrations
    - Overwhelmed by data collection requirement
  - NL: No indication of systematic data collection
    - Parental permission is a barrier to systematic collection

Results: System Effectiveness for Outcomes

- The effectiveness of these systems is unclear.
  - Insufficient outcome data in both places, except some measurement of recidivism
  - No post-case follow-up

Interviewer: “How do you know if your system is doing a good job?”

Respondent: “Well, I mean, theoretically if they don’t come back into the system, and people move on with their lives. I mean, that is the only way we can know.”

Perspective from The Netherlands

Meanwhile, a possible lesson from the health system.

- In 1999, physicians, nurses, pharmacists and other health professionals were thought to be responsible for at least 100,000 deaths annually in our hospitals.
  - And there are many more hospital acquired complications that do not lead to death but do prolong hospitalization and add significantly more cost.

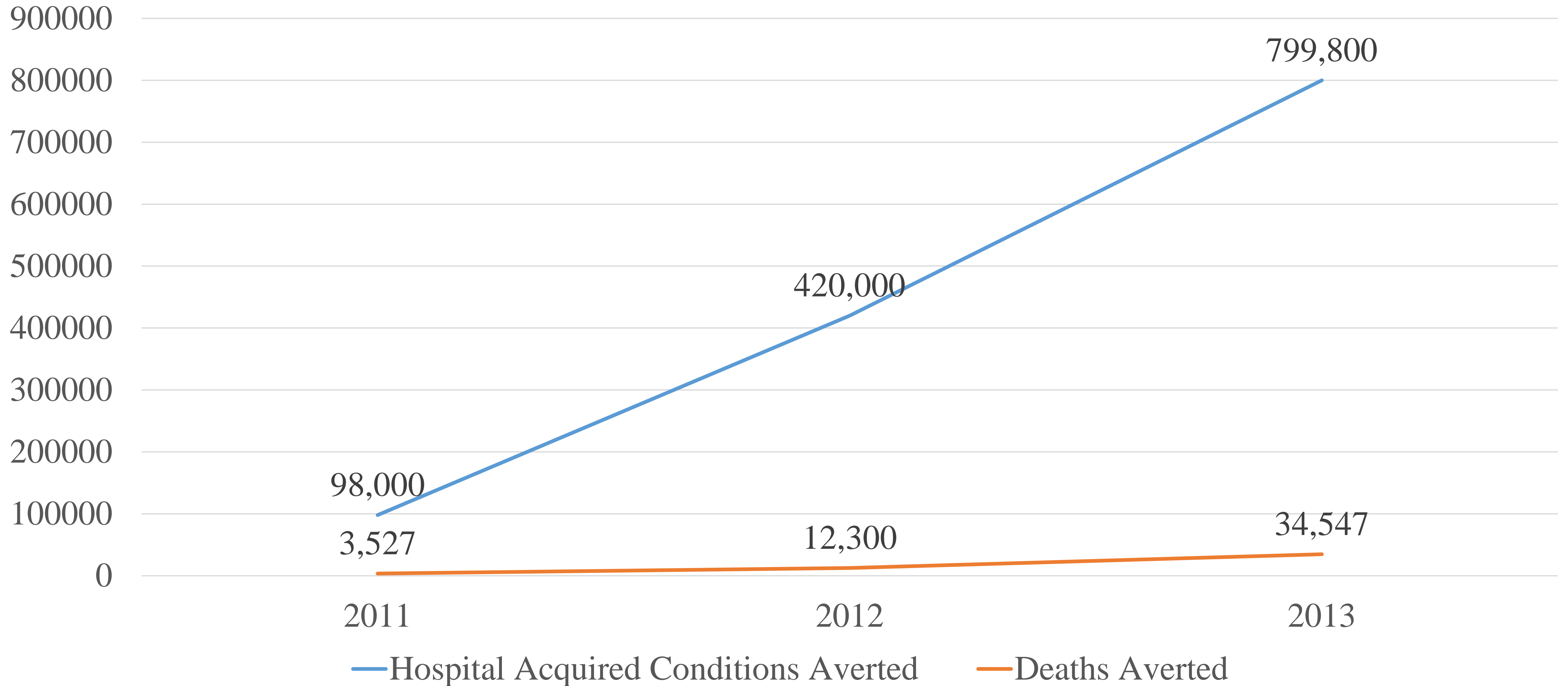
To Err Is Human: Building a Safer Health System 1999

- "Humans, in all lines of work, make errors. Errors can be prevented by designing systems that make it hard for people to do the wrong thing and easy for people to do the right thing."

- Recommendations:
  - National focus on leadership, research, tools, and protocols to understand safety;
  - Identify and learn from errors through mandatory reporting efforts;
  - Raising standards and expectations through oversight organizations, group purchasers, professional groups;
  - Create a safety system inside health care organizations.

Crossing the Quality Chasm: A New Health System for the 21st Century 2001

- Six aims to reduce medical errors:
  - Safe
  - Effective
  - Patient-centered
  - Timely
  - Efficient
  - Equitable


Number of Hospital Acquired Conditions and Deaths Averted since 2010
900000
800000
700000
600000
500000
400000
300000
200000
100000
0
799,800
420,000
98,000
3,527
12,300
34,547
2011
2012
2013
Hospital Acquired Conditions Averted
Deaths Averted

There has been progress

- Last year, there were ~83,000 deaths in US hospitals.
- Taken alone, that statistic is frightening.
- In context, it is significant progress.

- Child Protective Service Systems need to how quality and outcome data to resist policy making by scandal and assure that there are data to support our work and the positive outcomes we want for children and families.

Questions, comments, suggestions:

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Discussion Question 1

- 1) In your Child Protection System, what are the "top three" benefits and costs of mandatory reporting to children, their families, the communities, and the system?
  - How are or should these benefits and costs be measured?

Discussion Question 2

- 2) What is the central purpose of your child protection system, and how should success be measured in your system?