Local Rationality and Frontline Child Welfare Workers' Decision Making

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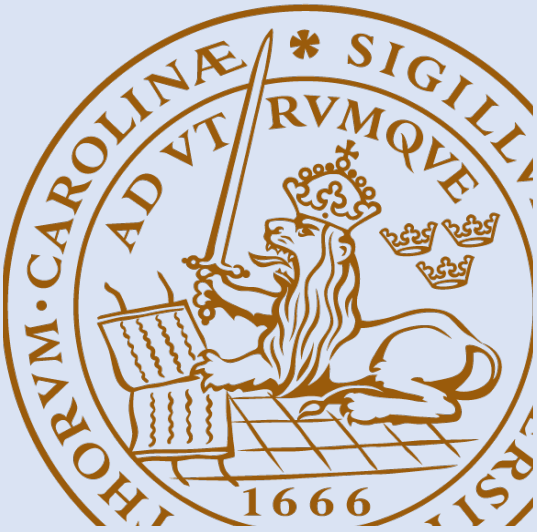

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Abstract
Decisions made by child welfare workers continue throughout the life of a case. Information is constantly being gathered and coming in from a variety of sources which can complicate the decision-making process. Child welfare agencies can benefit from understanding how child welfare workers make decisions and if certain interventions like the concepts from safety science can help increase the information gathered to support decision making. This paper studied frontline workers and supervisors from Minnesota's child welfare system to determine if the concepts that are used in safety science like that of local rationality impacted how child welfare frontline workers and supervisors made decisions and engaged with a family. Frontline child welfare workers and supervisors were interviewed about a case study to understand how they make decisions and the strategies that they use to inform decision making. The results of the interviews showed that frontline workers' and supervisors' own local rationality can play a role in supporting safety decisions and that local rationality varied amongst the participants depending on their focus of attention, knowledge and experiences and the goals that they were trying to achieve. This study also found that frontline workers' and supervisors' use their local rationality more readily when making decisions than tools and polices that are aimed to guide decision making and child welfare agencies may benefit from exploring this further.

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ABSTRACT

Decisions made by child welfare workers continue throughout the life of a case. Information is constantly being gathered and coming in from a variety of sources which can complicate the decision-making process. Child welfare agencies can benefit from understanding how child welfare workers make decisions and if certain interventions like the concepts from safety science can help increase the information gathered to support decision making. This paper studied frontline workers and supervisors from Minnesota's child welfare system to determine if the concepts that are used in safety science like that of local rationality impacted how child welfare frontline workers and supervisors made decisions and engaged with a family. Frontline child welfare workers and supervisors were interviewed about a case study to understand how they make decisions and the strategies that they use to inform decision making. The results of the interviews showed that frontline workers' and supervisors' own local rationality can play a role in supporting safety decisions and that local rationality varied amongst the participants depending on their focus of attention, knowledge and experiences and the goals that they were trying to achieve. This study also found that frontline workers' and supervisors' use their local rationality more readily when making decisions than tools and polices that are aimed to guide decision making and child welfare agencies may benefit from exploring this further.

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

INTRODUCTION

As the Minnesota Department of Human Services has been actively engaged in using safety science in their child death review, questions were raised if the components or elements of the science and new view of safety could help to explain the decisions that frontline workers make, when they interact with their families. In effect we are interested in what safety science might add to child welfare workers' notion of local rationality i.e how people make decisions given the circumstances they find themselves in, (Woods and Cook, 1999; Woods et al., 2010). While these concepts are traditionally used to understand the workplace and how incidents are examined and reviewed in those systems, these concepts could also be incorporated into understanding how a frontline child welfare worker views and investigates a family system. Frontline workers may have a different focus of attention when they are initially engaging with a client family. What knowledge was the worker using when interviewing the mother? What are the goals the worker is trying to achieve? Pushing this further, what strategies do frontline workers use to dig a bit deeper to understand the why and how things happened regarding an incident with a family and are these strategies consistent among all frontline workers. Lastly, do frontline child welfare workers' local rationality impact the decisions that they make regarding a case?

Therefore, this research study explores how frontline workers' own local rationality (the cues that captures their focus of attention, the guidance that they use and the goals that they are trying to achieve) can inform or influence the decisions that they make when engaging a family.

LITERATURE REVIEW

The practice of child welfare and/or child protection in the United States is a relatively new activity compared to other high-risk industries. State and federal governments did not oversee child welfare until the 1970's and this occurred after the 1960's saw an increased interest regarding the prevalence of child abuse identified by physicians (Myers, 2008). Therefore, the research on child welfare practice was initially very limited and continues to evolve to determine what is the best method to keep children safe while also protecting the rights of the family (English and Pecora, 1994).

As the child welfare community has grown there has been an increase in the amount of reports and investigations of child abuse (Camasso and Jagannathan, 2013). This increase has contributed to high workloads and child welfare agencies across the country have been overwhelmed (English and Pecora, 1994). Within this environment, child welfare agencies are also under intense scrutiny by the public to protect children and when they may fail the consequences become life or death. The traditional course of action and response is that the public begins to question if this error could have been prevented and who is the one that is responsible. This is usually directed towards the frontline child welfare worker and their decisions are questioned and critiqued often in public and the media (Camasso and Jagannathan, 2013; Munro, 2010).

Decisions made by child welfare workers are never ending throughout the life of a case. Information is constantly coming in from a variety of sources which can complicate the decision-making process. Some of the most major decisions in child welfare are: to take a report for investigation, to substantiate a report for maltreatment, to remove a child from their home, the decision to implement services for a family, to return a child home and when to close a case (Jones, 1993; English and Pecora, 1994; Camasso and Jagannathan, 2013). Like other industries when failures occur with such decisions, child welfare agencies over the last couple decades have

been on a quest to improve decision making with the use of procedures, policies, guides and various other tools (Munro, 2005). This comes from the belief that workers are seemingly not able to make consistent decisions and they are not able to predict harm (Munro, 2010). This has often led to an increase and standardization of control over frontline child welfare worker decisions and the birth of risk assessments in the 1980's to help guide child welfare workers to identify the level of risk associated with a family and when intervention is needed (Schwalbe, 2004; Gillingham, 2011).

Rational choice model of decision making, also known as statistical decision theory, has impacted the development of the risk assessments used in child welfare. Child welfare is often riddled with uncertainty and the theory of rational choice model attempts to establish procedures to guide decision making in uncertainty using concepts of probability theory and economics. The theory believes that a formal analysis of a decision using a mathematical equation that involves probability and utilities will provide the most "optimal decision" (Schwalbe, 2004, p. 565) given the available choices. This theory takes human judgement out of the equitation due to the inability of individuals to predict behavior and provides data that can determine expected outcomes given certain choices are available (Schwalbe, 2004).

Camasso and Jagannathan (2013) identified three different types of risk assessments that are used in child welfare which include structural clinical assessment, actuarial methods and structural decision-making method (SDM). A structural clinical assessment is a detailed assessment of risk compiled from research and clinical opinions of risk factors that are scored to determine the level of risk for maltreatment. The actuarial risk assessment is based upon the rational choice model of decision making which creates a probability assessment of choices and outcomes that produces a score of risk based upon the choices actually made (Schwalbe, 2004). This method can be very simple to implement and use, yet some of the attributes that may predict future maltreatment are not always included with the tool. The structured decision-making model is also supported by the

rational choice modelers' preference for using probability to predict risk level but does allow for a clinical assessment (Camasso and Jagannathan, 2013). Over the years the use of structured decision-making tool has increased in popularity in child welfare agencies to help guide decision making yet little research has been conducted yet to determine its validity (Gillingham, 2011).

Risk assessments in child welfare while intended to aid in decision making has received much criticism in the last years due to both its underutilization and lack of empirical evidence that it supports better decisions by child welfare workers (Gillingham and Humphreys, 2010; Schwalbe, 2004). The concern is that the assessments are not used as intended as some studies have shown that child welfare workers use the assessment after they make decisions regarding risk and safety or inflate the scores in order for families to receive services (English and Pecora, 1994; Gillingham and Humphreys, 2010; Camasso and Jagannathan, 2013). The Los Angeles Department of Children and Families Services has recently come under fire after it was found that the structured decision-making tool was not being utilized by the frontline child welfare staff because it was seen as a bureaucratic step rather than an aid to decision making (California State Auditor Report, May 2019). Gillingham (2011) concluded in his study of the structured decision-making tool in Australia that the use of risk assessment tools may actually impair the expertise developed by frontline child welfare workers. Munro (1999) found that while risk assessments can be helpful, professional judgment should not be discounted in order to prevent errors in decision making. This was also found in a study by Helm (2013) who found that "while decision tools such as assessment frameworks and predictive risk tools may contribute to effective judgement, they are a support to and not a substitute for, well-trained and well-supervised, thinking and feeling practitioners" (p. 34). Stevens and Cox (2008) found that using risk assessments to calculate risk with a family could oversimplify the decision process and applied a "linear understanding" (p. 1324) to complex problems that families may face. Additionally, this may give the frontline child welfare worker a false sense of security that if they follow every tool or procedure that it will be impossible for a child to be harmed.

As mentioned earlier child welfare is complex work, yet the interventions used by agencies to aid in decision making may have become overly simplistic and do not often take into consideration the contextual environment in which decisions are made (Stevens and Cox, 2008). Therefore, child welfare should look at alternative concepts used to understand decision making from other fields like safety science that have been able to shed light on decision making in high-risk environments. Naturalistic decision-making theory looked at how firefighters, nurses and military personnel made decisions given the workload, competing goals and pressure. Where the rational choice model has a prescribed set of choices that directs probability in a very structured environment, naturalistic decision-making theory understands that there is context behind decision making especially in a fast-paced pressure induced environment (Schwalbe, 2004; Klein, 2011).

However, there is limited research in how theories of safety science have been applied to child welfare. Munro, one of the few researchers to make the connection between safety science and child welfare, explained the need to have decision making concepts and models that support the naturalist approach to decisions and feedback loops of learning when things go wrong (2010). When decisions need to be made quickly, intuition, experience and training allows workers to recognize patterns through experience that can help guide decision making (Klein, 2011). In order to have risk assessments be successful, what are the skills and information that frontline workers need to access in order to input that information into the tool (Munro, 2005; Klein, 2010; Munro, 2020). Most importantly what is missing from the literature is understanding frontline decision making before failure occurs and gaining insight into the normal work that frontline workers do every day (Dekker, 2011). In order to identify what skills, supports and information frontline workers' need, agencies need to know how or what impacts how they make decisions. This highlights a gap in the literature in the practical application of the concepts of safety science that can aid in understanding decision making in child welfare, specifically using a human factors approach. Human factors in the 1970's focused on understanding decisions in the mind of an individual and interventions were targeted to changing or controlling the person, whereas the

science has since moved on to exploring the human in relation to environment around them (Dekker, 2011). Dekker (2011) notes "the unit of analysis for human factors is now the human in the context of other people, the organization, and technical artifacts associated with their work "(p. 65). Child welfare workers are not operating independent of the environment around them and in order to comprehend why they make the decisions they do; more attention is needed to be made in what informs or guides decision making and what role does the larger system have in those decisions.

One way in which child welfare agencies can understand decision making using a human factors approach is by seeing how the concept of local rationality impacts frontline decision making. The local rationality principle is that the decisions make sense to individuals given their focus of attention, knowledge and experience and the goals that they are trying to achieve at a particular time (Dekker, 2011). Dekker (2011) breaks down local rationality into three categories: attentional dynamics, knowledge factors and strategic factors to explain how these cognitive factors impact workers and their decisions. The situations in which child welfare workers find themselves in are incredibly complex and they are unable to retain or utilize all of the information necessary in order to inform the decisions that they make. Therefore, it is worth the effort of child welfare agencies to understand what cues workers are picking up on, what policies or procedures are guiding their decisions and the goal conflicts that may be presented when engaging with a family (Woods and Cook, 1999). Essentially, understanding why frontline workers do what they do on a particular case with a family and how over time knowledge and experience gained this way is applied in other cases. This will allow child welfare agencies to take a more prospective approach to see what tools, policies, metrics may be impacting case decisions before a catastrophic event occurs.

Therefore, the purpose of this thesis is to help fill in some of the gaps in the present research, in particular to determine how child welfare workers' own local rationality may impact or influence

their engagement and decision making with families under their care.

METHOD

Research Design

Using the guidance from Crotty (1998) on how to develop a research process, it is important to indicate the methods that will be used in a thesis but also clarify the ontology and epistemological approach, theoretical perspectives and methodology of a research project. This will guide how questions are asked, how data is collected, and the analysis of data. The ontological and epistemological approach guiding this research study and analysis is constructivism. Constructivism is a position that believes that knowledge can be constructed and is not independent of the individual and the interactions that they have with the environment around them. Reality is able to be constructed by those experiencing that reality and meaning is able to be created out of that perception of reality (Le Coze, 2012).

In keeping in line with wanting to gain knowledge of how frontline child welfare workers make decisions and to help fill in the gaps presented in the literature, the best way to get access to this information is by using a qualitative research strategy. Qualitative research allows for the exploration of information and does not necessarily require the same kind of certainty as quantitative research which may limit the knowledge gained (Brannen, 2004). Coinciding with qualitative research for this thesis project, I took an exploratory approach that seeks to understand and gain information that will have practical applicability for organizations or systems that utilize frontline child welfare workers decisions. The methodology that I have identified most useful in obtaining my goal to understand decision making is to draw from practice-based research. According to Williams and Salmon (2017), "practice- based research aims to produce knowledge that practitioners and others can do something with, rather than simply to further describe a problem" (p. 143). This allows us to get into the messy details of child welfare in the hopes that this thesis may guide future research in how safety science can be applied to child welfare work.

When trying to get insight into decision making, how knowledge is gained from the participants becomes an important issue for any such research project. Shadbolt and Smart (2015) defines knowledge elicitation as "a set of techniques and methods that attempt to elicit the knowledge of a domain expert typically through some form of direct interaction with the expert" (p. 163). Through the use of interviews, an informant is asked about the work that they are doing and what is informing their decisions. However, this limits the amount of tacit or otherwise knowledge that can be accessed, and the researcher may be limited by what only the expert provides. The expert's verbal knowledge may not be able to gain insight to their mental behavior or mental models of why they do what they do (Bainbridge, 1999). One way in which to address this dilemma is by using the critical decision method which helped guide how I interviewed and analyzed the information shared by my informants.

Critical decision method (CDM) is a type of knowledge elicitation technique that asks retrospective questions about an event to gain understanding about decision making (Shadbolt and Smart, 2015). Critical decision method derives from naturalistic decision making which looks to understand decision making in real life settings and is also an extension of Flanagan's critical incident technique (Klein, Calderwood and Macgregor, 1989; Klein, 1998). Naturalistic decision-making attempts to account for the context of decisions that are made in relation to the environment around the decision maker (Schwalbe, 2004).

Critical decision method has been used in a variety of high-risk settings which include interviews with firefighting commanders, tank platoon leaders and design engineers to gain knowledge around tasks when crucial decision-making occurs in short periods of time (Klein, Calderwood and Macgregor, 1989). Critical decision method looks at understanding the decisions made around nonroutine incidents. The participant is asked to discuss a particular incident and then semi structured probing questions are used to gain knowledge about the decision-making process. There are five steps in the critical decision method process according to Klein, Calderwood and

Macgregor (1989). For the purpose of this thesis proposal, the first step was that a case study of an incident was presented to each participant which was used to help elicit the models of safety that frontline workers (the participants) use when making decisions regarding a family. The case study that was created for this research study emulates a common report or referral that child welfare staff may receive about a family. The second step is obtaining an unstructured incident account, allowing the participant to provide the story of what happened around this incident. The third step is constructing a timeline of the incident which lays out the incident step by step from the participants' perspective. The fourth step is decision point identification which identifies the decisions that were made by the participant by cues that they have given throughout their account of the incident. The fifth and final step is decision point probing, which attempts to dig deeper to those decisions made by the participant that were previously identified. What was being explored throughout is how the participants' local rationality applied to a particular incident. This could be understanding the goals that the participant was trying to achieve or determining options of decisions. This helps unpack how those concepts help to inform the models of safety that frontline workers use to assess a family situation.

Participants

Participants involved in this study were frontline staff and supervisors who are part of the Minnesota child welfare system. Minnesota Department of Human Services (MN DHS) identified 14 staff who attended an Advanced Practical Training by Collaborative Safety in October 2019 and provided that information to this researcher after approval of a data sharing agreement. The Advanced Practical Training is a two-day training that teaches the concepts of safety science, forensic interviewing and behavior analysis and provides a practical application in how those concepts can be used by frontline staff in their engagement with families. All 14 were contacted through email asking if they would be interested in participating in the research study and five out of the 14 responded and agreed to be interviewed. In addition to the five interviewed, four additional staff were identified either through other training participants or with the assistance of

staff at the MN DHS that had not been participants of the Advanced Practical Training. One of the four participants had attended an orientation by Collaborative Safety, the other three were not aware of Collaborative Safety or safety science at all. All participants worked in different counties across the state. Current workloads and Covid-19 presented challenges in obtaining additional interviews of workers.

The table below provides a breakdown of the participants role (or previous roles) in Minnesota's child welfare system as well as their years of experience.

Table 1: Participants

Participant Identifier	Role/Previous Roles	Years of Experience
Participant 1	Ongoing Case Management	7 Years
Participant 2	Investigator/Family Assessment	8 Years
Participant 3	Family Assessment	6 Years
Participant 4	Family Assessment	6 Years
Participant 5	Supervisor Investigation/Family Assessment	20 Years (1 Year of Supervision)
Participant 6	Supervisor Family Assessment	18 Years (8 Years of Supervision)
Participant 7	Family Assessment (Investigator for 21 Years)	28 Years (6 Years in current role)
Participant 8	Family Assessment	16 Years
Participant 9	Ongoing Case Management	5 Years

Data Collection

As previously mentioned, to support the method selected to gain more knowledge and understanding semi-structured interviews inspired by the critical decision method were used (Klein, Calderwood and Macgregor, 1989). The semi structured interviews were conducted with the identified (above) nine frontline staff and supervisors and all were given and signed consents prior to the interviews (See Appendices A for Consent Form). Considering the current circumstances with COVID 19, the interviews with the participants were conducted through Zoom and recorded using that platform. The recordings were then transcribed by Zoom and reviewed by

this researcher multiple times for any inaccuracies in transcription and for further analysis. In the interviews, participants were provided with the following case study:

> David Warner is the father to Timothy (age 5) and Neveah (age 2) who lives on the first floor of an apartment building. It is unknown who the mother of the children is, and David is the primary caretaker for the children. On November 30th, Timothy and Neveah were found alone walking around the apartment complex at 10pm by some residents of the apartment complex. Neveah presented with a large bruise on her forehead and when Timothy was asked by a neighbor what had happened, he reported that "Daddy did it." The children were reported to have on clean clothing but were not appropriately dressed for the weather that day. The children did not appear to be in any distress. The local police department was contacted as the apartment residents were unable to locate where the children resided. Soon after the police arrived David was located. When the police arrived at the family's apartment, there were open beer cans in the living room. The home appeared dirty, with clothes strewn about and dirty dishes in the sink. When David was questioned about the bruising on Neveah's forehead, he stated that he did not know what happened and was evasive in his replies to police. The police took pictures of the bruising and will be referring the case to a detective to investigate further.

After participants reviewed the case study the following questions were asked of the participants.

- What are your initial perceptions of this event?
- Tell me about the strategies that you may use to gain information about the event indicated in the case study?
- What may be the goals that you will want to achieve approaching this event?
- Tell me some of the questions you may ask when interviewing with this father?

For participants that also had exposure to Collaborative Safety or safety science, the following questions were asked.

- How do you see the concepts that you have learned from your trainings with Collaborative Safety apply to your response to this event?
- How have these concepts from safety science helped or not helped when first interacting with a family?

Data Analysis

This research is to understand local rationality's influence on frontline decision making in a child welfare setting. In order to answer the question posed above, it is important to use this analytical

position to analyze the data that has been collected by the participants. There are various methods that can aid in this analysis, one of which includes coding.

There are a variety of coding processes identified by Klein, Calderwood and Macgregor (1989) that can be used to make sense and analyze the information that had been provided by the participant. For the purpose of this research project, I have chosen descriptive decision model to help my coding process. Descriptive decision model codes the different decision points made by the informants at different junctures that are obtained in the interviews. These decision points can then be categorized and indicate the different themes that arise within those decisions. Another coding process that was used to support the analysis in this research project is thematic analysis. Thematic analysis also uses coding to guide the researcher to identify patterns that may present themselves while reviewing the interview data (Lapadat, 2012). With this type of analysis, the coding was not restricted to just decision points made by the participants but allows for additional data and viewpoints to be interpreted from the interviews.

Ethical Considerations

According to Lund University's Research ethics website (https://www.researchethics.lu.se), my research project, given that it is a student project, does not require formal ethical approval. Additionally, my research project did not collect any sensitive personal data indicated by the University that would require such an ethical review. With that said, there are still ethical considerations that needed to be made in order to protect the information gained from the informants in the research study.

In order to proceed, I gained the approval of the Minnesota Department of Human Services (MN DHS) and signed a data sharing agreement in order to interview and protect participants (See Appendices B for Agreement). While participant selection was on the basis of whether or not they took part in a Collaborative Safety training event, this research is not intended to comment negatively or positively on Collaborative Safety work or activities with MN DHS. Rather it was to

explore the changes in local rationality which set the stage for child welfare workers that occurred with the introduction of safety science into the workplace. In other words, the presence or absence of participant training is simply a way to enroll and analytically sort participants for this study. Further, this researcher abided by the requirements and protections set forth by MN DHS in the agreement.

It was important for the participants in the research study to understand what that research they were asked to participate entails (McLaughlin, 2014). Therefore, I developed a written informed consent for the informants to sign prior to their interviews which highlighted the following issues as required by the Ethical Review Act (https://www.researchethics.lu.se):

- the overall plan for the research,
- the purpose of the research,
- the methods that will be used,
- the consequences and risks that the research may entail,
- the person responsible for the research,
- that participation in the research is voluntary, and
- that the research volunteer has the right to terminate his or her participation at any time.

For this research project, participation was voluntary and was imperative to emphasize this given that there may be a power differential between the Department of Human Services and the county in which the participant is employed and the participant feeling an obligation to participate. Moreover, in order to meet the ethical requirements, all participant information remained confidential through the use of coding informants by a number and title and any information in the written thesis cannot be linked to the informant (McLaughlin, 2014).

Lastly, this researcher is an employee of Collaborative Safety and has trained staff in Minnesota about concepts and theories of safety science and in order to avoid bias, participants were not

interviewed that this researcher trained. Further, Collaborative Safety has a consulting role with Minnesota Department of Health Services, however it does not have a direct consulting role with any of the informant's employers with the exception of Hennepin County Children and Family Services (whose employees were not interviewed). Additionally, I have experience in frontline child welfare work may impact the lens in which I view all this.

RESULTS

This research study attempted to understand how local rationality impacted how frontline child welfare staff made decisions and engaged with families. In order to gain this knowledge a case study was used to elicit how a group of participants would respond to this incident and the decisions that they may make and demonstrated how local rationality played a role.

Local Rationality

While presented with a case study involving an incident with a family, frontline workers and supervisors showed that they use their own local rationality at the present moment when making decisions given their focus of attention, knowledge and experience that they have and the goals they are trying to achieve. This case study did not appear out of line of what frontline workers and supervisors would be exposed to in the workplace with one worker (participant 8) noting, "my initial perceptions is that it's a very typical case for FA case management" and the decisions that would need to be made on a day-to-day basis. The local rationality of the participants and how this impacted decisions was broken down into the three categories noted in the research; attentional dynamics, knowledge factors and strategic factors. These different categories surfaced often all at once in discovering the workers' local rationality and were interwoven in how this influenced worker decision making. Specifically, this study showed how the local rationality of the participants impacted the decisions that they made regarding safety in this case study, participants shared the strategies that they do use to inform their local rationality and in general how they approach the work that they do and the decisions that they make.

Attentional Dynamics

The case study presented a number of concerns and the participants' initial focus of attention in the assessment varied on what they were most concerned about or what they needed to address with the family. A third of the respondents initially focused on the bruising to the child's head, another

third was concerned about the supervision of the children and the last third were attentive to the father's drinking. This was evident in the statements that were made which indicated where participants saw the biggest issues after reading the case study. Participant 3 noted "I am concerned about the bruising." Participant 5 stated "we're talking about them (the children) being out alone at 10 o'clock at night" and participant 4 replied "first and foremost is making sure that the kids are watched by a sober adult." Another theme that surfaced by the participants that captured their attention was the location of the mother when this incident happened with the family. Six of the nine respondents made some mention of the mother and wanting to know her whereabouts and involvement with the children. Participant 2 stated "Initially, I mean, I want to find out where's mom, is mom living, you know just where is she, what's going on with her" and Participant 9 and 7 expressed confusion on the case study indicating that the mother was unknown, as they believed that someone must know who the mother is. This focus on finding out information about the mother gives some indication of the importance of mothers in a child welfare case and cultural implications of mothers and their caregiving role for children have for these workers and where and how frontline workers may focus their efforts in investigating a child welfare incident.

Further, the issues presented dominated the participants' initial perceptions of the event, the strategies that they used and the questions that they may have asked the father to garner more information. Six of the respondents expressed wanting additional information to understand the situation with this family and some expressed wanting to reserve any type of judgement before making a decision. Participant 6 noted that "I feel like we need way more information" and Participant 5 stated:

"before I jump to any conclusions as a supervisor, I would want the workers to go out and actually find out the full situation because sometimes things are reported to us and we may not get all of the information or some of the information might be skewed a bit."

Moreover, the participants' focus of attention guided the types of interventions that they would use for the family. Participant 9 reported that they would want an evaluation to determine if the father had a chemical dependency issue or participant 2 noted that they would want to use a Family Safety Meeting (an intervention used by this particular county) to talk about the safety issues that were present. Participant 3 wanted to help the father saying, "How can we be of support to him, what does, what does that look like for him." Overall, there was no correlation found of differences or similarities of each group of participants, which in of itself may demonstrate that not all frontline workers' and supervisors' foci of investigation are the same and what counts as local rationality varies among individuals.

Knowledge Factors

Participants shared their education and experience that helped to guide them regarding the strategies that they would use with this family. Participant 7 talked about their advisor in college over 25 years ago and how that mentorship shaped how they ask questions of families. Another participant (8) indicated the experience that they have gained has come from families, "you know I would say I have learned the most from my clients over the 20 years of doing this kind of work." Another participant (6) discussed how they gained experience over the years in how not to ask certain questions to get information from families based on the guidance from supervisors and their own experience. Overall, participants viewed that having more experience is influential when doing assessments with families and achieving better outcomes. Participants noted experience played a role in how they viewed an incident and a family member. Participant 3 believed that within the first year of child protection work, that because of what they may have seen, that this has made novice workers judgmental and that overtime workers start to pull out the strengths of families and not come to judgement when making decisions. Participant 6 provided an example:

There can be dishes in the sink and [this is] not the way I live [but] doesn't need to be the way a client lives they, you know, as long as their kids are safe and they're caring for them…I tried to do

[that] for newer social workers, try to remind them of that. And I feel like after a while they, they, after they've been in enough homes, they kind of pick up on that to…"

Some participants referenced trainings that they have attended that have informed how they engage with families. These included motivational interviewing, forensic interviewing, signs of safety and even exposure to safety science. In the responses received by the participants when questioned specifically about the concepts in safety science, the participants who had supervisory roles not only were able to remember the concepts more readily but also to discuss how they believed the concepts positively impacting their work and/or able to identify the barriers that they find in being able to use the concepts. Specifically, one participant (5) noted that they had learned these concepts just starting in their supervisory role:

"I think it helped a lot because like I said it's kind of a new way of looking at things and it helps for the clients to be more cooperative when they don't have to worry about, you know, was somebody accusing me… we actually can work with them a little bit easier and can make some changes that might need to be made."

This may be the case because participants in supervisory roles may have a relatively more sophisticated understanding of these concepts and/or how they can be applied to their work with families. For example, supervisors were often able to provide a more global view of how these concepts impact the larger system and how workers feel about the work that they do. In general, participants viewed that having more experiences is influential when doing assessments with families.

Another theme that arose from the group of participants is how their own experience of being a parent impacts how they interact with families. Participant 8 stated

"I've been doing this for a long time, but I also parented kids and know how challenging parenting is. And a lot of times, as I described, doing my always kind of joke and say, I made it through a teenage daughter, like you will make it too."

Participant 9 stated that her experience as a parent helps her to put herself in the position of the parent that she is working with, noting "I tried to use, you know, transpection, put myself in their shoes right. I think that would be. I'm a parent myself. I think it would be terrifying." This shared experience of parenting has helped guide frontline staff or supervisors in how they see incidents taking place with families and therefore informs the information that they may gather and/or the interventions that they use when interacting with a family.

Overall in this study, every participant noted different ways in which they have gained information or knowledge over the years and how they used that knowledge in making a decision when approaching this case study.

Strategic Factors

As expected, the majority of participants in this study saw the safety of the children as the overall goal of this case study even when how they would try to achieve safety looked different. This case study presented the issue of one of the most crucial decisions that is made in child welfare which is to leave a child in the family's home or to remove the child and place them into out of home care. Interestingly, all but two of the participants (two out of seven participants) did not advocate an immediate removal of the children from the home. A majority of those participants indicated that while they had concerns, they indicated a need to gain more information before making any safety decisions with statements of "I feel like we need way more information (participant 6)," and "I guess my perceptions are kind of worries, are things I would want to look into more (participant 1)." One supervisor (participant 5) expanded on their initial reactions:

"I think before I jump to any conclusions as a supervisor, I would want the workers to go out and actually find out the full situation because sometimes things are reported to us and we may not get all of the information or some of the information might be skewed a little bit."

Further, one participant's (3) initial perception around the incident was about the father, "my initial assessment would be that we have a single dad with two small children who seem to be, he may be overwhelmed with taking care of the two children." This appeared to be a common theme among the participants who did not advocate for removal. They initially wanted to gain information in order to assess the situation and then moved to wanting to see how they could assist the family, much like what guided their focus of attention on the investigation

In examining the responses by one participant (2) who indicated removal, they made statements about wanting to place the children with family, court intervention and interviewing the father after the children have been placed in the care of relatives as they did not believe the father was a safe caregiver. The other participant (7) who advocated for removal of the children stated, "I'm concerned that these kids are still in this home." This participant was currently working within family assessment but had 21 years of experience as an investigative worker which was the same role that the other participant had whom advocated for removal. This investigation role indicates that perhaps the role and/or experience that a frontline worker has, can impact how they may approach or assess a family and they may be more conservative in their assessment of safety for children than others.

When looking at other features that may play a role in the local rationality of the goals that a worker is trying to achieve with a family, remarkably, only one participant commented on their workload. This has impacted their work and given the limited time and high caseload they have to focus on the high-risk cases rather than those that may appear to be more low risk. Participant 2 reported:

"I have a case sitting right here that I went and saw the kid and I haven't touched it since. I know the kid is safe because the perpetrator is gone…so it's, it's not a high priority for me, but should I have contacted this person by now, absolutely."

Strategies of Engagement

Lastly, it is worth mentioning that when elaborating on their initial perceptions of the incident and strategizing how the participants would proceed with the family, all but one of the participants said they used a tool, checklist or formal assessment to guide their decision making. Participant 2 who noted using a checklist, did not indicate that this was a formal checklist given by her county or oversight agency but a checklist that indicates the areas of which needs to cover in an investigation (i.e. Native American heritage, mental health issues). The majority of participants in the interviews relied on their experience, knowledge, skills and intuition to make a determination on how they would approach this family and the possible interventions that they would use. An overarching theme among the participants was the importance on the strategies they used to gain information from the family which then impacted the actions that they would take on a case. Open ended questions, refraining from judgement or blame and hearing the father's story were tools that the participants indicated using to help guide decisions. Moreover, getting the story from the father is very similar to a concept used in safety science called second stories. Some used the term explicitly like referring to finding the second story or indicating that second stories fits in well with their philosophy of social work practice. However, others referred to the concept in much indirect ways. Statements were made like from participant 1 who said, "looking for alternative solutions or reasons," or participant 3 stating "really dig. I think dig deeper" or participant 4 expressing a need at "getting his (father) side of the story" and participant 8 expanding "listen to them, hear their stories, understand where they're coming from." Of the three participants who did not use this type of discourse, two of the three were also the only two that advocated for a removal of the children. This suggests an interesting connection between using second stories and impact local rationality has on the decisions that are made.

DISCUSSION

Local Rationality and Decision Making

This research aimed to discover how local rationality, a concept used in safety science, informs the decisions that frontline child welfare workers make when engaging a client family. The findings of this research study suggests that the cues that workers focus their attention on, the knowledge and experience and goals do impact the decisions that frontline child welfare workers make, and that local rationality varies for each participant. This finding is supported by much of the literature on local rationality that normal decisions of workers are impacted by the "locality of their knowledge, their mindset, and the multiple goals that they are trying to balance" (Woods, Dekker, Cook, Johannesen and Sarter, 2010). A surprising finding of the research is that the participants' focus of the investigation or assessment, even though presented with the same case study, was different and the interventions they would use to support the family were dependent on their focus. This indicates that frontline workers' and supervisors' local rationality informed what they wanted to address with a family, the interventions they would use to address safety concerns and the ability to implement the interventions that they identified a family needing were diverse despite policies, procedures or tools that are intended to guide them towards standardized decision making.

Local Rationality and Strategies

Another unanticipated finding of this study was that all but one of the participants did not mention using a tool, guide or risk assessment while making their decision about this case study or the choice of strategies used to guide decisions but instead relied on their education, experience and goals to inform how they made decisions. This supports much of the research on decision making and how decision making impacts the use and usefulness of tools and guides created for child welfare workers to assess risk and harm. Munro (2019) suggests child welfare professionals will make different decisions based on their knowledge, experience, skills and that efforts needs to be

made to understand how those decisions are made in the context of work. For instance, in this study, participants shared that their experiences as parents was a tool they used to engage and develop a rapport with a client parent that ultimately helps them gain information to make more informed decisions. They also used their experience as a parent to understand the difficulties in parenting and what they see as a problem within a client family and what may constitute as acceptable or unacceptable behaviors of parenting. Additionally, this study highlighted that the differences in roles and experience impacted how frontline workers made decisions. For this study there were no participants with less than five years of experience in this field and these years of experience helped to shape what strategies they have found more useful in engaging with families and have learned from previous mistakes. Their experience supports their ability to recognize potential risks quickly and to take actions which are necessary to ensure safety. There were two participants in this study that had strong experience in investigative roles and these two participants were the only participants to quickly determine from the case study that the children should be removed from the home to ensure safety. This suggests perhaps that investigative experience of a frontline worker or supervisor informs local rationality differently when making safety decisions than those who do not have this experience. Munro (2020) found "experience, both of life in general and child protection work in particular, helps develop background knowledge about how people tend to behave and why" (p. 131).

Another strategy that supported the local rationality of the participants and how they make decisions was the use of second stories. While traditionally second stories have been used to explain the context and complexity of decision making by workers when human error occurs in attempts to improve the system (Woods, Dekker, Cook, Johannesen and Sarter, 2010). Second stories were also found here to be useful in understanding incidents that can also happen in family systems as well by the participants. Second stories were not always explicitly identified by staff but surfaced in discourse that supported getting a deeper contextual picture of how incidents were unfolding within a family before decisions were made regarding a child removal. If the overall

goal of obtaining second stories, as Woods and Cook (2002) argue, was to improve learning and create safety after accidents, it is hard not to see the same goals applying in a child welfare environment while assessing a family.

Local Rationality and the Goal of Safety

Moreover, safety was found to be the main goal and at the forefront of each of the participants' minds when presented with the case study, however, the ways in which they saw safety or the actions that were required to ensure safety varied amongst the participants. The local rationality of the frontline workers' and supervisors constructed a lens in how they each see a family which directed the inventions that may be used to ensure safety for children. This finding is consistent with the study by Keddell (2011) of social workers' decision making that found that "the constructions that workers rely on to explain the causes of clients behavior, their views of clients' moral culpability and the capacity to change are important, as they affect the trajectory and the focus of practice interventions" (p. 1264). Two of the nine participants in the study, believed that safety was ensured by removing the children from their home at initial contact while others believed that safety could be maintained while allowing the children to remain home with their family. Furthermore, what was found in this study based on participants responses, is that safety was not created by the tools, checklist, policies or procedures that is implemented by an agency but by initial perceptions and the discourse that a frontline worker has with a family and the strategies they use that they believe are successful in supporting that discourse. This finding is consistent with the literature from Turnell, Munro and Murphy (2013) who found that more attention is needed towards understanding the "soft skills" that a worker may have in order for child welfare agencies to prevent maltreatment of children.

Overall, the findings of this study demonstrate how crucial it is to understand local rationality if child welfare agencies want to reduce unfavorable outcomes especially since at the present moment little attention is paid to understanding why and how workers make decisions at certain

junctures of engagement with a family. The research suggests that when a system is constrained and there is pressure to be efficient, like that of the child welfare system, workers will rely on strategies that are familiar to them, and these may or may not be necessarily what the agency has prescribed (Dekker, 2010). Independent of policies, procedures, tools and checklists frontline workers' and supervisors are using a multitude of knowledge and experience when making decisions in a complex environment and efforts are needed to understand this process in order to prevent adverse events and ultimately for staff to learn and improve.

Limitations of Research and Next Steps

While conducting this study in an attempt to answer my research questions, there were a few difficulties that need to be noted. The Covid 19 pandemic presented some challenges in terms of interviewing participants. All interviews were conducted through Zoom and much attention was given to the time dedicated to the interview given workload tasks. Additionally, this study was conducted on a very small sampling of child welfare staff in the state of Minnesota and more research would need to be conducted in other jurisdictions to determine how local rationality of frontline child welfare workers impacts decisions overall. Additionally, more research may need to be conducted on child welfare systems that have more constraints and pressure as not all child welfare agencies are the same and these different dynamics may have alternative effects in how frontline workers and supervisors use local rationality to inform decisions. Lastly, more research is needed on if local rationality and the strategies used to make decisions is impacted by years of experience in the field of child welfare. As noted, all the participants in this study had more than five years of experience and more information would be needed to analyze how the local rationality of frontline child welfare workers changes over time. To conclude, there is little to no research in the child welfare field that discuss the use of local rationality and decision making and further research is needed to understand the various impacts that this may have on child welfare organizations and their clients.

CONCLUSION

This thesis sought to understand how local rationality impacted the way in which frontline workers engaged with the families that they serve and help to fill in a gap in the research on child welfare practice and safety science. The findings of this study suggest that frontline workers and supervisors use varying local rationality when assessing a client family and this variation influences the strategies that they use and the decisions that they make regarding clients. This study explored how knowledge and both professional and personal experiences contributed to how frontline workers and supervisors made decisions - more so than on any tools, guides or polices that a child welfare agency may require. More research is needed though to explore the connections between child welfare frontline workers' and supervisors' decisions and local rationality. In particular we need to better understand how local rationality may differ rank by rank and novice to expert. Future studies may want to see if certain types of family incidents create environments where local rationality differs or is more similar amongst child welfare frontline workers and supervisors.

REFERENCES

Bainbridge, L. (1999). Verbal reports as evidence of the process operator's knowledge. *International Journal Human-Computer Studies*, 51, 213-238.

Brannen, J (2004) In C.Seale, G. Gobo, J.F. Gubrium, & D. Silverman. (Eds) *Qualitative Research Practice*. London. Sage.

California State Auditor Report. (2019). Los Angeles County Department of Children and Family Services. Retrieved from https://www.bsa.ca.gov/pdfs/reports/2018-126.pdf

Camasso, M.J. & Jagannathan, R. (2013). Decision making in child protective services: a risky business? *Risk Analysis*, 22(9), 1636-1649.

Crotty, M. (1998). *The foundations of social research: meaning and perspective in the research process.* London: SAGE Publications Ltd.

Dekker, S. (2011). *Patient safety: A human factors approach*. Baca Raton, Fl: CRC Press.

English, D. & Pecora, P. (1994). Risk assessment as a practice method in child protective services. *Child Welfare*, 73(5), 451-473.

Gillingham, P. & Humphreys, C. (2010). Child protection practitioners and decision-making tools: observations and reflections from the front line. *British Journal of Social Work*, 40, 2598-2616.

Gillingham, P. (2011). Decision-making tools and the development of expertise in child protection practitioners: are we 'just breeding' workers who are good at ticking boxes'? *Child and Family Social Work*, 16, 412-421.

Helm, D. (2013). Sense-making in a social work office: an ethnographic study of safeguarding judgements. *Child and Family Social Work* 26-35.

Jones DSW, L. (1993). Decision making in child welfare: a critical review of the literature. *Child and Adolescent Social Work Journal,* 10(3), 241- 262.

Keddell, E. (2011). Reasoning processes in child protection decision making: negotiating moral minefields and risky relationships. *British Journal of Social Work*, 41, 1251-1270.

Keddell, E. (2014). Theorizing the signs of safety approach to child protection social work: positioning, codes and power. *Children and Youth Services Review*, 47, 70-77.

Klein, G.A., Calderwood, R. & Macgregor, D. (1989). Critical decision method for eliciting knowledge IEE Transaction on Systems, Man and Cybernetics, 19(3) 462-472.

Klein, G. (1998). *Sources of Power: How people make decisions*. Cambridge, MA: The MIT Press.

Klein, G. (2011). *Streetlights and shadows: searching for the keys to adaptive decision making*. Cambridge, MA: The MIT Press.

Lapadat, J. C. (2012). Thematic Analysis. In Mills, A.J, Durepos, G. & Wiebe, E. (Ed), *Encyclopedia of Case Study Research* (926-927). Thousand Oaks: SAGE Publications Ltd.

Le Coze, J. C. (2012). Towards a constructivist program in safety. *Safety Science* 50, 1873-1887.

McLaughlin, H. (2014). *Understanding social work research*. London: Sage Publications Ltd.

Munro, E. (2005). Improving practice: child protection as a systems problem. *Children and Youth Services Review*, 27, 375-391.

Munro, E. (2010). Learning to reduce risk in child protection. *British Journal of Social Work*, 40, 1135-1151.

Munro, E. (2019). Decision-making under uncertainty in child protection: creating a just and learning culture. *Child & Family Social Work*, 24, 123-130.

Munro, E. (2020). *Effective Child Protection* (3ed). London: SAGE Publications

Myers, J.E.B. (2008). A short history of child protection in america. *Family Law Quarterly*, 42(3), 449-463.

Olsen, W. (2014). *Data collection: key debates and methods in social research*. London: SAGE Publications Ltd. Research Ethics Information (n.d.).
Retrieved from https://www.researchethics.lu.se/research-ethics-information

Schwalbe, C. (2004). Re-visioning risk assessment for human service decision making. *Children and Youth Services Review*, 26, 561-576.
Stevens, I & Cox, P. (2008). Complexity theory: developing new understandings of child protection in field settings and in residential child care. *British Journal of Social Work*, 38, 1320-1336.
Shadbolt, N. R. & Smart, P. R. (2015) In Wilson, J.R. & Sharples, S. (Ed) *Evolution of Work*, Florida, CRC Press.
Turnell, A., Munro, E., & Murphy, T. (2013). Soft is hardest: leading for learning in child protection services following a child fatality. *Child Welfare*, 92 (2), 199-216.
Williams, C. & Salmon, S. M. (2017) In Shorrock, S. & Williams C. (Ed) Human Factors and Ergonomics in Practice, Florida, CRC Press
Woods, D. D., & Cook, R. I. (1999). Perspectives on human error: hindsight biases and local rationality. In *Handbook of applied cognition* (pp. 141-171). John Wiley & Sons, New York, NY.
Woods, D. D., Dekker, S., Cook, R., Johannesen, L., & Sarter, N. (2010). *Behind human error (2 ed).* Surrey, UK: Ashgate Publishing Limited.

APPENDICES

Appendix A: Consent Form

Consent for Participation in Interview for Research

Lund University
Master's Program: Human Factors and System Safety

Research Study/Thesis Topic: Safety science theories and concepts and their influence on frontline child welfare workers decision making

Researcher:

Casey Melsek
Email: cm@collaborative-safety.com
Phone: 1-602-639-0118

Purpose of Study:
You have been asked to participate in a research study which is looking to understand how the theories or concepts in safety science may have impacted child welfare frontline decision making when interacting with families at initial contact.

Consent:

- Your participation in this research study is completely voluntary. You may refuse to participate or withdraw from the study at any time.
- If any questions make you feel uncomfortable throughout the interview process, you may decline to answer the question or end the interview
- Your privacy will be protected, and any identifying information will not be used in any report that is published.
- The interview will take approximately 60 minutes. The interview will be digitally recorded and transcribed.

By signing below, the participant understands the purpose of this interview, the intent of this consent form and agrees to participate as outlined above.

Participants Signature:_____
Date: _____

Researchers Signature:_____
Date:_____

Appendix B: Data Agreement

DEPARTMENT OF HUMAN SERVICES

DATA SHARING AGREEMENT
TERMS AND CONDITIONS

This Data Sharing Agreement, and amendments and supplements thereto ("Agreement"), is between the State of Minnesota, acting through its Department of Human Services, Child Safety and Permanency Division, ("STATE") and Collaborative Safety ("DATA SHARING PARTNER").

RECITALS

This Agreement sets forth the terms and conditions in which STATE will share data with and permit DATA SHARING PARTNER to Use or Disclose Protected Information that the parties are legally required to safeguard pursuant to the Minnesota Government Data Practices Act ("MGDPA") under Minnesota Statutes, chapter 13, and other Applicable Safeguards.

The parties agree to comply with all applicable provisions of the MGDPA, and any other Applicable Safeguard that applies to the Protected Information.

General Description of Protected Information That Will Be Shared: Case notes for county child protection cases where the primary case worker participated in an advanced practicum training by Collaborative Safety.

Purpose for Sharing Protected Information and Expected Outcomes: For purposes of a master's thesis, understand whether skills learned by case workers in the Collaborative Safety advanced practicum training are applied by the case workers in their work with families and children.

STATE is permitted to share the Protected Information with DATA SHARING PARTNER pursuant to:

Minn. Stat. § 13.46, subd. 2(a)(5), permits STATE to release private data on individuals to personnel of the welfare system who require the data to evaluate the effectiveness of programs and Minn. Stat. § 13.05, subd. 7, allows the STATE to delegate the preparation of summary data to others under contract.

This Agreement neither creates a business associate relationship nor constitutes a business associate agreement as defined in the Health Insurance Portability and Accountability Act (HIPAA).

DEFINITIONS

A. "Agent" means DATA SHARING PARTNER'S employees, contractors, subcontractors, and other non-employees and representatives.

B. "Applicable Safeguards" means the state and federal safeguards listed in subsection 2.1.A of this Agreement.

C. "Breach" means the acquisition, access, Use, or Disclosure of unsecured Protected Health Information in a manner not permitted by HIPAA, which compromises the security or privacy of Protected Health Information.

D. "Disclose" or "Disclosure" means the release, transfer, provision of access to, or divulging in any manner of information by the entity in possession of the Protected Information.

E. "Individual" means the person who is the subject of protected information.

F. "Privacy Incident" means a violation of an information privacy provision of any applicable state and federal law, statute, regulation, rule, or standard, including those listed in this Agreement.

G. "Protected Information" means any information, regardless of form or format, which is or will be Used by STATE or DATA SHARING PARTNER under the Agreement that is protected by federal or state privacy laws, statutes, regulations, policies, or standards, including those listed in this Agreement. This includes, but is not limited to, individually identifiable information about a State, county or tribal human services agency client or a client's family member. Protected Information also includes, but is not limited to, Protected Health Information, as defined below, and Protected Information maintained within or accessed via a State information management system, including a State "legacy system" and other State application.

H. "Security Incident" means the attempted or successful unauthorized accessing, Use, or interference with system operations in an information management system or application. "Security Incident" does not include pings and other broadcast attacks on a system's firewall, port scans, unsuccessful log-on attempts, denials of service, and any combination of the above, provided that such activities do not result in the unauthorized exposure, viewing, obtaining, accessing, or Use of Protected Information.

I. "Use" or "Used" means any activity involving Protected Information including its creation, collection, access, acquisition, modification, employment, application, utilization, examination, analysis, manipulation, maintenance, dissemination, sharing, Disclosure, transmission, or destruction. "Use" includes any of these activities whether conducted manually or by electronic or computerized means.

1. TERM OF AGREEMENT.

1.1 Effective date. The effective date of this Agreement is **September 1, 2020**, or the date this Agreement is signed by both parties, whichever is later.

1.2 Expiration date. The expiration date of this Agreement is **December 31, 2021**, or until all obligations set forth in this Agreement have been satisfactorily fulfilled, whichever occurs first.

2. DUTIES.

2.1 STATE will disclose the following information to DATA SHARING PARTNER: The case notes from the Social Service Information System for cases in which the identified worker was listed as the primary worker. Additionally, contact information will be shared for supervisors of the workers who have attended the training for the DATA SHARING PARTNER to contact.

A. The data exchanged under the Agreement is provided to DATA SHARING PARTNER for DATA SHARING PARTNER to: conduct a study for a master's thesis to understand whether skills learned in an advanced practicum training through Collaborative Safety are applied to work with families and children.

B. STATE is permitted to share the Protected Information with DATA SHARING PARTNER pursuant to: Minn. Stat. § 13.46, subd. 2(a)(5) and Minn. Stat. § 13.05, subd. 7.

C. STATE will share the Protected Information by providing an email with contact information for supervisors of identified case workers, and copies of case notes sent via encrypted email pursuant to sections 6.2.B.C.4. and 6.3.A. for identified cases.

2.2 DATA SHARING PARTNER shall: Contact the supervisors of the case workers identified by the STATE and ask if the identified case workers would be willing to participate in this study. This request would be given to the identified workers as well. The study is voluntary, and participants will be provided informed consent before participating and are able to withdraw participation at any time. In the interview, participants will be given a generic case study for reflection and interview questions will explore if the skills learned in the Advanced Practicum Training has been incorporated into engagement and decision making by the identified workers. Interviews will be video recorded, transcribed, analyzed and will not use any identifying information of the workers. All records will be kept confidential and protected by the DATA SHARING PARTNER. Copies of case notes for identified cases will be used to establish a baseline data for understanding if documentation also reflects the skills learned in the Advanced Practicum Training. Any case identifying information will be remain confidential and no specific information regarding a particular case will be shared in the study. Documents will be analyzed, and themes will or will not be identified in how the identified worker's input or document an engagement with a family. The research is focused on frontline case worker decision making rather than the characteristics or identity of a family. At the conclusion of the study, all copies of case notes will be handled according to section 6.5.

3. TIME.

The parties will perform their duties within the time limits established in this Agreement unless prior written approval is obtained from the other party.

4. CONSIDERATION AND PAYMENT.

There will be no funds obligated by either party under this Agreement. Each party will be responsible for its own costs in performing its stated duties.

5. AUTHORIZED REPRESENTATIVES AND RESPONSIBLE AUTHORITY.

5.1 State. STATE's authorized representative is **Nikki Kovan, Acting Deputy Director of Operations, CQI, and Safety and Prevention, nikki.kovan@state.mn.us, 651-431-3873,** or successor. DATA SHARING PARTNER shall make any notice or contact to STATE required by this Agreement to STATE's authorized representative.

5.2 Data Sharing Partner. DATA SHARING PARTNER's Authorized Representative is **Casey Melsek, Senior Consultant with Collaborative Safety LLC, 8161 Hwy 100 #206 Nashville, TN 37221 Telephone Number 602-639-0118** or successor.

5.3 Information Privacy and Security. STATE's responsible party for the purposes of complying with the Applicable Safeguards in this Agreement is STATE's authorized representative. DATA SHARING PARTNER's responsible party for the purposes of complying with the Applicable Safeguards in this Agreement is **Casey Melsek, Senior Consultant with Collaborative Safety LLC, 8161 Hwy 100 #206 Nashville, TN 37221 Telephone Number 602-639-0118** or successor.

6. INFORMATION PRIVACY AND SECURITY

DATA SHARING PARTNER and STATE must comply with the MGDPA and all other Applicable Safeguards as they apply to all data provided by STATE under the Agreement, and as they apply to all data created, collected, received, stored, Used, maintained, or disseminated by DATA SHARING PARTNER under the Agreement. The civil remedies of Minn. Stat. § 13.08, "Civil Remedies," apply to DATA SHARING PARTNER and STATE.

6.1 Compliance with Applicable Safeguards.

A. State and Federal Safeguards. The parties acknowledge that the Protected Information to be shared under the terms of the Agreement may be subject to one or more of the laws, statutes, regulations, rules, policies, and standards, as applicable and as amended or revised ("Applicable Safeguards"), listed below, and agree to abide by the same.

1. Minnesota Government Data Practices Act (Minn. Stat. Chapter 13);
2. Confidentiality of Alcohol and Drug Abuse Patient Records (42 U.S.C. § 290dd-2, "Confidentiality of Records," and 42 C.F.R. Part 2, "Confidentiality of Substance Use Disorder Patient Records");
3. Tax Information Security Guidelines for Federal, State and Local Agencies (26 U.S.C. § 6103, "Confidentiality and Disclosure of Returns and Return Information," and Internal Revenue Service Publication 1075;
4. U.S. Privacy Act of 1974;
5. Computer Matching Requirements (5 U.S.C. § 552a, "Records Maintained on Individuals");
6. Social Security Data Disclosure (section 1106 of the Social Security Act: 42 USC § 1306, "Disclosure of information in Possession of Social Security Administration or Department of Health and Human Services");
7. Disclosure of Information to Federal, State and Local Agencies (DIFSLA Handbook, Internal Revenue Service Publication 3373);
8. Final Exchange Privacy Rule of the Affordable Care Act (45 C.F.R. § 155.260,

"Privacy and Security of Personally Identifiable Information,");

9. NIST Special Publication 800-53, "Security and Privacy Controls for Federal Information Systems and Organizations," Revision 4 (NIST.SP.800-53r4); and,
10. All state of Minnesota "Enterprise Information Security Policies and Standards."[1]

The parties further agree to comply with all other laws, statutes, regulations, rules, and standards, as amended or revised, applicable to the exchange, Use and Disclosure of data under the Agreement.

B. Statutory Amendments and Other Changes to Applicable Safeguards. The Parties agree to take such action as is necessary to amend the Agreement from time to time as is necessary to ensure, current, ongoing compliance with the requirements of the laws listed in this Section or in any other applicable law.

6.2 DATA SHARING PARTNER Data Responsibilities

A. Use Limitation.

1. Restrictions on Use and Disclosure of Protected Information. Except as otherwise authorized in the Agreement, DATA SHARING PARTNER may only Use or Disclose Protected Information as minimally necessary to provide the services to STATE as described in this Agreement, or as otherwise required by law, provided that such Use or Disclosure of Protected Information, if performed by STATE, would not violate the Agreement or state and federal statutes or regulations that apply to the Protected Information.

2. Federal tax information. To the extent that Protected Information Used under the Agreement constitutes "federal tax information" (FTI), DATA SHARING PARTNER shall ensure that this data only be Used as authorized under the Patient Protection and Affordable Care Act, the Internal Revenue Code, 26 U.S.C. § 6103(C), and IRS Publication 1075.

B. Individual Privacy Rights. DATA SHARING PARTNER shall ensure Individuals are able to exercise their privacy rights regarding Protected Information, including but not limited to the following:

1. Complaints. DATA SHARING PARTNER shall work cooperatively and proactively with STATE to resolve complaints received from an Individual; from an authorized representative; or from a state, federal, or other oversight agency.

2. Amendments to Protected Information Requested by Data Subject Generally. Within three (3) business days, DATA SHARING PARTNER must forward to STATE any request to make any amendment(s) to Protected Information in order for STATE to satisfy its obligations under Minn. Stat. § 13.04, "Rights of Subjects of Data," subd. 4. DATA SHARING PARTNER must promptly make any amendments

[1] *See* https://mn.gov/mnit/government/policies/security/

to Protected Information as directed by STATE.

C. **Ongoing Responsibilities to Safeguard Protected Information.**

1. **Privacy and Security Safeguards.** DATA SHARING PARTNER shall develop, maintain, and enforce policies, procedures, and administrative, technical, and physical safeguards that comply with the Applicable Safeguards to ensure the privacy and security of the Protected Information, and to prevent the Use or Disclosure of Protected Information, except as expressly permitted by the Agreement.

2 **Electronic Protected Information.** DATA SHARING PARTNER shall implement and maintain appropriate safeguards with respect to electronic Protected Information, and comply with Subpart C of 45 C.F.R. Part 164 (HIPAA Security Rule) with respect to prevent the Use or Disclosure other than as provided for by the Agreement.

3. **Monitoring Agents.** DATA SHARING PARTNER shall ensure that any Agent to whom DATA SHARING PARTNER Discloses Protected Information on behalf of STATE, or whom DATA SHARING PARTNER employs or retains to create, receive, Use, store, Disclose, or transmit Protected Information on behalf of STATE, agrees in writing to the same restrictions and conditions that apply to DATA SHARING PARTNER under the Agreement respect to such Protected Information.

4. **Encryption**. According to the state of Minnesota's "Enterprise Information Security Policies and Standards,"[2] DATA SHARING PARTNER must use encryption to store, transport, or transmit Protected Information and must not use unencrypted email to transmit Protected Information.

5. **Minimum Necessary Access to Protected Information.** DATA SHARING PARTNER shall ensure that its Agents acquire, access, Use, and Disclose only the minimum necessary Protected Information needed to complete an authorized and legally permitted activity.

6. **Training and Oversight.** DATA SHARING PARTNER shall ensure that Agents are properly trained and comply with all Applicable Safeguards and the terms of the Agreement.

D. **Responding to Privacy Incidents, Security Incidents, and Breaches.** DATA SHARING PARTNER will comply with this Section for all Protected Information shared under the Agreement. Additional obligations for specific kinds of Protected Information shared under the Agreement are addressed in subsection 6.2.F, "Reporting Privacy Incidents, Security Incidents, and Breaches."

1. **Mitigation of harmful effects.** Upon discovery of any actual or suspected Privacy Incident, Security Incident, and/or Breach, DATA SHARING PARTNER will mitigate, to the extent practicable, any harmful effect of the Privacy Incident, Security Incident, and/or Breach. Mitigation may include, but is not limited to, notifying

[2] https://mn.gov/mnit/government/policies/security/

and providing credit monitoring to affected Individuals.

2. **Investigation.** Upon discovery of any actual or suspected Privacy Incident, Security Incident, and/or Breach, DATA SHARING PARTNER will investigate to (1) determine the root cause of the incident, (2) identify Individuals affected, (3) determine the specific Protected Information impacted, and (4) comply with notification and reporting provisions of the Agreement and applicable law.

3. **Corrective action.** Upon identifying the root cause of any Privacy Incident, Security Incident, and/or Breach, DATA SHARING PARTNER will take corrective action to prevent, or reduce to the extent practicable, any possibility of recurrence. Corrective action may include, but is not limited to, patching information system security vulnerabilities, sanctioning Agents, and/or revising policies and procedures.

4. **Notification to Individuals and others; costs incurred.**

   a. **Protected Information.** DATA SHARING PARTNER will determine whether notice to data subjects and/or any other external parties regarding any Privacy Incident or Security Incident is required by law. If such notice is required, DATA SHARING PARTNER will fulfill the STATE's and DATA SHARING PARTNER's obligations under any applicable law requiring notification, including, but not limited to, Minn. Stat. §§ 13.05, "Duties of Responsible Authority," and 13.055, "Disclosure of Breach in Security."

   b. **Failure to notify.** If DATA SHARING PARTNER fails to timely and appropriately notify Individual data subjects or other external parties under subparagraph (a), then DATA SHARING PARTNER will reimburse STATE for any costs, fines, or penalties incurred as a result of DATA SHARING PARTNER's failure to timely provide appropriate notification.

5. **Obligation to report to STATE.** Upon discovery of a Privacy Incident, Security Incident, and/or Breach, DATA SHARING PARTNER will report to STATE in writing as further specified in subsection 6.2.F.

   a. **Communication with authorized representative.** DATA SHARING PARTNER will send any written reports to, and communicate and coordinate as necessary with, STATE's authorized representative or designee.

   b. **Cooperation of response.** DATA SHARING PARTNER will cooperate with requests and instructions received from STATE regarding activities related to investigation, containment, mitigation, and eradication of conditions that led to, or resulted from, the Security Incident, Privacy Incident, and/or Breach, and all matters pertaining to reporting and notification of a Security Incident, Privacy Incident, and/or Breach.

   c. **Information to respond to inquiries about an investigation.** DATA SHARING PARTNER will, as soon as possible, but not later than forty-eight (48) hours after a request from STATE, provide STATE with any reports or information requested by STATE related to an investigation of a Security Incident,

Privacy Incident, and/or Breach.

6. **Documentation.** DATA SHARING PARTNER will document actions taken under paragraphs 1 through 5 of this Section, and retain this documentation for a minimum of six (6) years from the date it discovered the Privacy Incident, Security Incident, and/or Breach or the time period required by subsection 6.2.H, whichever is longer. DATA SHARING PARTNER shall provide such documentation to STATE upon request.

E. **Reporting Privacy Incidents, Security Incidents, and Breaches.** DATA SHARING PARTNER will comply with the reporting obligations of this Section as they apply to the kind of Protected Information involved. DATA SHARING PARTNER will also comply with subsection 6.2.E, "Responding to Privacy Incidents, Security Incidents, and Breaches," above in responding to any Privacy Incident, Security Incident, and/or Breach.

1. **Other Protected Information.** DATA SHARING PARTNER will report all other Privacy Incidents, Security Incidents, and/or Breaches to STATE.

   a. **Initial report.** DATA SHARING PARTNER will report all other Privacy Incidents, Security Incidents, and/or Breaches to STATE, in writing, within five (5) calendar days of discovery. If DATA SHARING PARTNER is unable to complete its investigation of, and response to, a Privacy Incident, Security Incident, and/or Breach within five (5) calendar days of discovery, then DATA SHARING PARTNER will provide STATE with all information under subsections 6.2.E(1)–(4), of this Agreement that are available to DATA SHARING PARTNER at the time of the initial report, and provide updated reports as additional information becomes available.

   b. **Final report.** DATA SHARING PARTNER will, upon completion of its investigation of and response to a Privacy Incident, Security Incident, and/or Breach, or upon STATE's request in accordance with subsection 6.2.E(5) submit in writing a report to STATE documenting all actions taken under subsections 6.2.E(1)–(4), of the Agreement.

F. **Access to Books and Records, Security Audits, and Remediation.** DATA SHARING PARTNER shall conduct and submit to audits and necessary remediation as required by this Section to ensure compliance with all Applicable Safeguards and the terms of the Agreement.

1. DATA SHARING PARTNER represents that it has audited and will continue to regularly audit the security of the systems and processes used to provide services under the Agreement, including, as applicable, all data centers and cloud computing or hosting services under contract with DATA SHARING PARTNER. DATA SHARING PARTNER will conduct such audits in a manner sufficient to ensure compliance with the security standards referenced in this Agreement.

2. This security audit required above will be documented in a written audit report which will, to the extent permitted by applicable law, be deemed confidential security information and not public data under the Minnesota Government Data

Practices Act, Minn. Stat. § 13.37, "General Nonpublic Data," subd. 1(a) and 2(a).

3. DATA SHARING PARTNER agrees to make its internal practices, books, audits, and records related to its obligations under the Agreement available to STATE or a STATE designee upon STATE's request for purposes of conducting a financial or security audit, investigation, or assessment, or to determine DATA SHARING PARTNER's or STATE's compliance with Applicable Safeguards, the terms of this Agreement and accounting standards.

4. DATA SHARING PARTNER will make and document best efforts to remediate any control deficiencies identified during the course of its own audit(s), or upon request by STATE or other authorized government official(s), in a commercially reasonable timeframe.

G. Documentation Required. Any documentation required by this Agreement, or by applicable laws, standards, or policies, of activities including the fulfillment of requirements by DATA SHARING PARTNER, or of other matters pertinent to the execution of the Agreement, must be securely maintained and retained by DATA SHARING PARTNER for a period of six years from the date of expiration or termination of the Agreement, or longer if required by applicable law, after which the documentation must be disposed of consistent with subsection 6.6 of this Agreement.

H. Requests for Disclosure of Protected Information. If DATA SHARING PARTNER or one of its Agents receives a request to Disclose Protected Information, DATA SHARING PARTNER shall inform STATE of the request and coordinate the appropriate response with STATE. If DATA SHARING PARTNER Discloses Protected Information after coordination of a response with STATE, it shall document the authority used to authorize the Disclosure, the information Disclosed, the name of the receiving party, and the date of Disclosure. All such documentation shall be maintained for the term of the Agreement or six years after the date of the Disclosure, whichever is later, and shall be produced upon demand by STATE.

I. Conflicting Provisions. DATA SHARING PARTNER shall comply with all applicable provisions of HIPAA and with the Agreement. To extent that the parties determine, following consultation, that the terms of the Agreement are less stringent than the Applicable Safeguards, DATA SHARING PARTNER must comply with the Applicable Safeguards. In the event of any conflict in the requirements of the Applicable Safeguards, DATA SHARING PARTNER must comply with the most stringent Applicable Safeguard.

J. Data Availability. DATA SHARING PARTNER, or any entity with legal control of any Protected Information provided by STATE, shall make any and all Protected Information under the Agreement available to STATE upon request within a reasonable time as is necessary for STATE to comply with applicable law.

6.3 Data Security.

A. STATE Information Management System Access. If STATE grants DATA SHARING PARTNER access to Protected Information maintained in a STATE information

management system (including a STATE "legacy" system) or in any other STATE application, computer, or storage device of any kind, then DATA SHARING PARTNER agrees to comply with any additional system- or application-specific requirements as directed by STATE.

B. **Electronic Transmission.** The parties agree to encrypt electronically transmitted Protected Information in a manner that complies with NIST Special Publications 800-52, "Guidelines for the Selection and Use of Transport Layer Security (TLS) Implementations"; 800-77, "Guide to IPsec VPNs"; 800-113, "Guide to SSL VPNs," or other methods validated under Federal Information Processing Standards (FIPS) 140-2, "Security Requirements for Cryptographic Modules." As part of its compliance with the NIST publications, and the State of Minnesota's "Enterprise Information Security Policies and Standards," DATA SHARING PARTNER must use encryption to store, transport, or transmit any Protected Information. DATA SHARING PARTNER must not use unencrypted email to send any Protected Information to anyone, including STATE.

C. **Portable Media and Devices.** The parties agree to encrypt Protected Information written to or stored on portable electronic media or computing devices in a manner that complies with NIST SP 800-111, "Guide to Storage Encryption Technologies for End User Devices."

6.4 STATE Data Responsibilities

A. STATE shall Disclose Protected Information to DATA SHARING PARTNER only as authorized by law to DATA SHARING PARTNER.

B. STATE shall obtain any consents or authorizations that may be necessary for it to Disclose Protected Information with DATA SHARING PARTNER.

6.5 Obligations of DATA SHARING PARTNER Upon Expiration or Cancellation of the Agreement. Upon expiration or termination of the Agreement for any reason:

A. In compliance with the procedures found in the Applicable Safeguards listed in subsection 6.1.A, or as otherwise required by applicable industry standards, or directed by STATE, DATA SHARING PARTNER shall immediately destroy or sanitize (permanently de-identify without the possibility of re-identification), or return in a secure manner to STATE all Protected Information that it still maintains.

B. DATA SHARING PARTNER shall ensure and document that the same action is taken for all Protected Information shared by STATE that may be in the possession of its Agents. DATA SHARING PARTNER and its Agents shall not retain copies of any Protected Information.

C. In the event that DATA SHARING PARTNER determines that returning or destroying the Protected Information is not feasible or would interfere with its ability to carry out its legal responsibilities, maintain appropriate safeguards, and/or comply with Subpart C of 45 C.F.R. Part 164, it shall notify STATE of the specific laws, rules, policies, or other circumstances that make return or destruction not feasible or otherwise inadvisable. Upon mutual agreement of the Parties that return or destruction of Protected Information is not feasible or otherwise inadvisable, DATA SHARING PARTNER will

continue to extend the protections of the Agreement to the Protected Information and take all measures possible to limit further Uses and Disclosures of the Protected Information for so long as it is maintained by DATA SHARING PARTNER or its Agents.

D. DATA SHARING PARTNER shall document and verify in a written report to STATE the disposition of Protected Information. The report shall include at a minimum the following information:

1. A description of all Protected Information that has been sanitized or destroyed, whether performed internally or by a service provider;

2. The method by which, and the date when, the Protected Data were destroyed, sanitized, or securely returned to STATE; and

3. The identity of organization name (if different than DATA SHARING PARTNER), and name, address, and phone number, and signature of Individual, that performed the activities required by this Section.

E. Documentation required by this Section shall be made available upon demand by STATE.

F. Any costs incurred by DATA SHARING PARTNER in fulfilling its obligations under this Section will be the sole responsibility of DATA SHARING PARTNER.

7. INSURANCE REQUIREMENTS

7.1 **Network Security and Privacy Liability Insurance.** DATA SHARING PARTNER shall, at all times during the term of the Agreement, keep in force a network security and privacy liability insurance policy. The coverage may be endorsed on another form of liability coverage or written on a standalone policy.

DATA SHARING PARTNER shall maintain insurance to cover claims which may arise from failure of DATA SHARING PARTNER's security or privacy practices resulting in, but not limited to, computer attacks, unauthorized access, Disclosure of not public data including but not limited to confidential or private information or Protected Health Information, transmission of a computer virus, or denial of service. DATA SHARING PARTNER is required to carry the following **minimum** limits:

$2,000,000 per occurrence

$2,000,000 annual aggregate

8. INTERPRETATION

8.1 Any ambiguity in this Agreement shall be interpreted to permit compliance with all Applicable Safeguards.

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By signing below, the parties agree to the terms and conditions contained in this Agreement.
APPROVED:

1. **DATA SHARING PARTNER**

DATA SHARING PARTNER certifies that the appropriate person(s) have executed the Agreement on behalf of DATA SHARING PARTNER as required by applicable articles, by-laws resolutions or ordinances.

By: DocuSigned by: 65122ACE02E84EE...
Printed Name: Casey Melsek
Title: Senior Consultant with Collaborative Safety, LLC
Date: 9/1/2020

2. **STATE AGENCY**
By (with delegated authority): DocuSigned by: Jamie Sorenson 597452F00A1E416...
Printed Name: Jamie Sorenson
Title: CSP Director
Date: 9/1/2020

Distribution: (copy of fully executed contract to each)
Contracting and Legal Compliance Division
Data Sharing Partner
State Authorized Representative