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Recommending protective guidelines for whistle-blowers and victims of agency abuse.

Kay Y. Spang
The University of Montana

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RECOMMENDING PROTECTIVE GUIDELINES FOR WHISTLE-BLOWERS
AND VICTIMS OF AGENCY ABUSE

By
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B.A., University of Montana, 1984

Presented in partial fulfillment of the requirements
for the degree of
Master of Public Administration
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1989

Approved by
Chairman, Board of Examiners
Dean, Graduate School

March 30, 1989
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CHAPTER I

INTRODUCTION

This paper addresses the issue of whistle-blowing. It describes how it has evolved, presents a case study, and presents recommendations for protective guidelines for whistle-blowers and victims of agency abuse. The act of whistle-blowing produces a variety of social reactions ranging from contempt to approval. There appears to be a lack of consensus regarding the activity which creates confusion and has added to the less-than-applauded treatment of whistle-blowers. Social confusion regarding the role of the whistle-blower intensifies the risk these informants take. Emotional and physical stress, financial deprivation, damaged reputations, blacklisting, and agency reprisal are risks whistle-blowers face. Moreover, victims of agency abuse are often placed in further jeopardy once the report is filed and the situation intensifies. Thus, government needs to establish formal guidelines for the protection of whistle-blowers and victims of agency abuse.
Scholarly Treatment of Whistle-blowers

To explore the confusion surrounding the role of the whistle-blower one must pose the question: Why is the act perceived as contemptible by some people when it is met with approval by others? The answer lies in an examination of the evolving attitudes and legislative efforts that whistle-blowing has promoted.

Many people believe whistle-blowing to be a disloyal act, deserving of negative consequences, and similar to muckraking, snitching, or childish tattle-telling. Mitchell (1981) states, "I found that most people—even bystanders uninvolved in controversy of any sort—believe that the vast majority of those who challenge authority are zealots, fanatics, cranks, or finks."¹

There are two dimensions to the negative perception of whistle-blowing. One is that the act challenges authority, those who are intellectually superior and more competent to make decisions for society. The second is that only traitors or enemies attack authority, thus showing disrespect for organizational loyalty. Peters and Branch (1972) suggest that, "Whistle-blowing boils down to an attempt to suspend the rules that produce loyalty and cohesive behavior institutions."²

While many people accept whistle-blowing as a contemptible act, there have been others who perceive the act to be commendable. Peters and Branch (1972) identified the act as courageous, and state that:
The acceptance of whistle-blowing as not only correct but, in many cases, highly courageous and principled is a step toward redressing a twisted irony in the use of the word "traitor" for those who break organizational ground rules. The traitor was always hated, because he was the enemy, who . . . could shuffle back and forth between opposing camps, sniffing for the highest bidder, . . . [W]histle-blowers have actually reversed the operation of the classical traitor, as they have usually been the 'only' people in their organizations taking a stand on some kind of ideal.3

The act of whistle-blowing has brought forth other explanations, each of which presents the author's particular viewpoint. These explanations are based upon personal morality, professional ethics, guilt, revenge, and recognition. Mitchell (1981) suggests that morality is less influential than guilt in his analysis of whistle-blowing behavior and states:

Only rarely do high moral standards dictate behavior. Most of those who blow the whistle claim that they are just doing their duty. Some act not so much to uphold a promise or principle as to avoid the consequences of not acting—the guilt one would feel if worse came to worse. Others simply look for revenge or recognition.4

Peters and Branch (1972) describe whistle-blowing in terms of ethical dilemmas and suggest that, "Caught in the ethical dilemma between conflicting loyalties, the whistle-blower decides that he cannot merely leave—that he cannot remove himself from the problem while allowing it to go on."5

How does the act of whistle-blowing reflect ethical dilemmas? Americans are socialized and encouraged to perceive themselves both as free-thinking individuals and as members of a
team. If and when there becomes a conflict between one's conscience and the team's activity, one is encouraged to do the honorable thing. It is considered honorable to try to change the team's policies or to resign from the team without making accusations. A major problem arises in trying to achieve change since most team players lack influential power. Thus, the only realistic alternatives are to resign quietly or be disloyal and state one's accusations. It is clear that whistle-blowing is not an acceptable practice for a team player. Whistle-blowing is a direct violation of the cultural norms that are used to maintain the organizational team. Deference is expected from team members while dissent is rejected.

In contrast to the American cultural sense of team playing, the British have perpetuated an entirely different culture regarding dissent and/or whistle-blowing. The British have long since recognized the value of honorable dissent and have encouraged individuals to provide constructive criticism in areas of public policy. It is considered a sign of maturity and responsibility to discuss and disagree during Parliamentary sessions. It is also considered acceptable to resign under protest of policy differences. For it is through direct confrontation that policies are refined and individuals become known for their contributions.

A factor that assists in the acceptance of protest resignation is that members of Parliament tend to be actively engaged in the political arena for long periods of time and are
considered experts in policy matters, whereas Americans enter politics from diverse backgrounds. Since these diverse backgrounds imply a special interest, politicians are considered special interest team players. Whistle-blowing is thus a violation of the team's cultural norms. Consequently, special interest groups regard good policy as what is beneficial to the team.

Weisband and Franck (1975) suggest that the British Parliament has established a cultural practice that promotes resignation in protest when individuals are unable to change policy that violates their principles:

The British ritual of protest resignation is usually—but not invariably—climax by the resigner's statement in Parliament, during which he explains his reasons for quitting . . . Not only does the British system provide the resigning minister with an important public forum . . . but that forum even has special, time honored place from which the speech is made to an attentive House, Press, and Public.

Resignations in protest are not to be taken lightly. They are inspirationally principled acts that are culturally ingrained in the British political system. The British protest resignation ritual stresses principled dissent rather than personal conflict. Weisband and Franck (1975) explain:

Parliament does not forgive a member who resigns high office, except when he does so for weighty reasons of principle. Thus, whereas the American Cabinet member will deliberately overlook policy differences in stating that his resignation is for personal reasons, the British Cabinet member will tend to overlook the personal aspects of a resignation to stress policy differences.
The British system of protest resignation provides a respectful vehicle for resignation without destroying careers, allows for the public to be informed on debated issues and individual contributions, and preserves the integrity of individuals.

Weisband and Franck (1975) suggest that the irony of the American method of public protest or whistle-blowing is that Americans practice their free speech in a democracy. "But in a democracy, where the ultimate government is the people, a rigorous antitattling ethic is socially dysfunctional." Weisband and Franck (1975) assert that it is the cultural activity of team playing in America that limits constructive, principled thought and encourages inexpression and irresponsibility:

In America, the social sanctions of the team militate so strongly against going public--and the career costs are so high--that top government officials do not take advantage of that right to free speech which is so firmly protected by the Constitution.

If a democracy is to function properly, then there must be culturally appropriate methods in which dissent over public policy can be recognized, ventilated, and appreciated. Otherwise team playing will be at the expense of the whistle-blower and unprincipled policy practices.
Risks Whistle-blowers Face

In some cases where American governmental employees have blown the whistle, there have been attempts to protect informants by relocating them or assisting in name and identification changes. There have been lengthy court hearings in which, after two to three years, the whistle-blower has been reinstated to the former employment position. However, reinstatement does not ensure the worker a satisfactory return to the previous position. Workers have returned to find that the office has been relocated to a storage unit without access to other staff, fresh air, or windows. The level of work assignments can diminish, and often the worker is delegated meaningless tasks. Research indicates that for most whistle-blowers, the consequences of going public with allegations of agency abuse and corruption are an average of two or three years of unemployment, peer rejection, and physical and emotional stress. Arguments against protective guidelines for whistle-blowers have inhibited the enactment of effective legislation which would reduce agency retaliation against whistle-blowers.

The Need for Guidelines

There will continue to be mixed reactions to whistle-blowing, since the act elicits a host of preconceived notions and symbolic attachments. Whistle-blowing represents a paradoxical issue in that we desire to be loyal and respectful of authority,
while at the same time there is a desire to be ethically responsible. In the vast majority of cases, the desire to be loyal and respectful of authority does not stimulate controversy. However, not all organizations and authority figures give consideration to an individual's ethics when the goals of the organization are at stake. As Peters and Branch (1972) point out, "There is an almost inevitable tendency to accommodate the special interest or the narrow interest of the government agency involved, and that tendency produces whistle-blowers."^10

Perhaps the most valuable function of whistle-blowing is that of reforming our social institutions. Peters and Branch (1972) suggest:

> Whistle-blowing is thus both an act of reform and a part of a lengthy process of adjustment for a society that is so off balance that its major institutions are capable of contemptible fraud against the public, and of repression against the employees who try to protect the public from their own leaders."^11

The historical roots of whistle-blowing can be traced to the First Amendment of the United States Constitution. The First Amendment guarantees the right of free speech, freedom of the press, access to public documents, and the freedom of union representation. Within these freedoms an individual has the right to challenge and blow the whistle on abuses found in public employment. These First Amendment rights were given additional force in the 1978 Civil Service Reform Act in which Congress affirmed the right of public employees to expose theft, misuse of
funds, and abuse of office.

While the right of an individual to challenge and expose organizational abuse has been upheld by the courts, the protective elements provided for whistle-blowers under the Civil Service Reform Act of 1978 are inadequate. Peters and Branch (1972) have found:

Courts generally hold that employees are not protected for public utterances that impair the "special relationship" in the office, or promote "disharmony and inefficiency" . . . the employee may not make remarks or changes that injure the atmosphere of cooperation at work.12

Mitchell (1981) contends that: "Guidelines that expand workers' rights would be helpful but setting an ethical and tolerant example at the national level to encourage dissent in the public interest would be more effective than passing laws that merely permit it."13 He thus advocates a grassroots movement and states, "Encouragement for anyone who blows the whistle in good faith will not trickle down; it will have to grow from the ground up."14

Peters and Branch (1972) understand the costs and risks whistle-blowers face; however, they argue against organized protective whistle-blowing measures:

If there is a central lesson . . . it is that public-minded purposes tend over the long haul to erode in the face of parochial interests . . . whistle-blowing loses some of its punch when organized. Because it is a necessarily unstructured, spontaneous profession, the preservation of independence is critical for the individual's readiness to take the whistle-blowing step when prudence counsels otherwise.16
Peters and Branch (1972) also state that, "This does not mean that whistle-blowing should become a riskless proposition or that the rules of loyalty and the sanctions behind them should be abolished." Rather the risks whistle-blowers take can lead to the adoption of safeguards and increase the impact of the whistle-blowing process while preserving the integrity of agency loyalty.

Conclusion

The general public must determine if the act of whistle-blowing is a disloyal or principled act. Once attitudes towards whistle-blowing have been clarified, persons who blow the whistle will have a major obstacle removed from their path, that of social isolation and rejection.

Chapter Two of this paper will provide a case study of a whistle-blowing attempt. The information presented will consist of the author's personal experience, interviews of persons involved, and documents obtained from the State of Montana Social Services Division. A brief background history involving the Mid-land Home (fictitious name of a Native American Foster Care Treatment Center), the investigation request and process, and the investigative outcome will be provided in this portion of the paper.

In April of 1985 another caseworker and I requested that the State of Montana Social Services Department conduct an investigation of a Native American foster care treatment center
called the Mid-land Home. Our charges were that the agency was providing inadequate resident treatment, was responsible for the emotional and physical abuse residents were experiencing, and was operating under questionable standards. It was our intention to report these violations to a higher authority which would review the information, correct the violations, and ultimately restore the agency to a healthy functioning level.

When the initial request for the investigation was reported, I was employed at the agency as a caseworker. However, I terminated my position fearing agency reprisal during the onset of the investigation process. The other caseworker involved in the agency report was employed through a nearby county agency and maintained contact with the agency through the referral of residents from her county to the Mid-land Home. My experience with this investigation motivated me to explore social attitudes towards whistle-blowers. I believe that these attitudes prohibit the establishment of protective guidelines that would reduce the risk informants and victims face when the whistle is blown.

Out of concern for the persons still involved with this agency and those who have provided information, the name of the agency and the persons involved have been changed. I believe that these changes will not detract from the content of this paper since it is the study of the situation itself that bears social value. I wish to express my compassion for those who have been exposed to this agency's exploitations.

Chapter Three will present an analysis of the consequences
the whistle-blowers and victims experienced and recommendations for protective guidelines. Sources for these recommendations will be the Civil Service Reform Act of 1978, interviews with social service personnel, and the author's personal opinions. It is hoped that these recommendations will serve as a base from which employees and employers will develop a common understanding of their professional roles and expectations. These guidelines will be applicable and adaptable to any public or private agency.
CHAPTER II

Background History of the Mid-land Home

The Mid-land Home is a Native American foster care treatment center located in a rural area in eastern Montana. The Home is licensed by the State of Montana Community Services Division of the Montana Welfare System. This branch is referred to as the Social and Rehabilitative Service (S.R.S.). The Mid-land Home began informally in the late 1950s when personnel from the La Junta Mission began taking in orphaned children. In 1967 the La Junta Mission provided a building for the Home which made licensing and government funding available. In 1970 the Home's first director began the Home's transformation from an orphanage to a residential child care facility. The Home's Board of Directors saw the need for further expansion of the Home in 1980 and developed the facility into a comprehensive treatment program with a capacity for 60 children.

The Home is located in a rural section of Montana, and is partially located on an Indian Reservation with an estimated local population of three thousand people. The Home is housed within the La Junta Mission campus which provides the Home with housing and educational and religious instruction. The Home serves males and females between the ages of three and seventeen. While the program is designed for Native Americans, there are no restrictions of religion, race or nationality. Residents are
admitted into the Home based on staff reviews of individual 
client capacity for learning and growth plus ability to form 
relationships with others. The structure of treatment is 
designed to assist youth who have moderate behavioral, emotional 
or character disorders, and who are abused, neglected and/or 
abandoned children. The Home maintains a philosophy that:

All children exhibit specific behavioral problems such 
as hostile and angry behavior, stealing, running away, 
or drug or alcohol abuse. In all cases the children's problems or disorders at the time of admission make it 
impossible for them to continue living in a family setting. It is the goal of the program that the children progress enough through treatment to return to 
family or community living.

Mid-land Home is designed to serve children who have severe physical disabilities, who are profoundly mentally retarded, or whose problems are so severe that they require the protection of a closed setting.

Finally, the program aims to involve the family in the child's treatment. Both the child and family receive help in adjusting to the new living situation and creating a healthy family structure. 18

Table 1 indicates the Mid-land Home's personnel and organizational structure.

The client-staff ratio at the Home is well within acceptable licensing standards which require a four-resident-per-one-staff ratio. However, when considering direct care by Mid-land Staff, indirect and direct care by La Junta staff, referring agency staff and state monitorization, the client-staff ratio distinction becomes questionable. There are over 2 staff persons per resident who monitor the resident's activities. Table 1 points out the very large number of staff and other persons involved in providing for the residents' daily needs.
<table>
<thead>
<tr>
<th>Position</th>
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<tr>
<td>Board of Directors</td>
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<tr>
<td>State Licensing Staff</td>
<td>3 persons</td>
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<tr>
<td>Mid-land Home Director</td>
<td>1 person</td>
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<tr>
<td>Budget &amp; Accounting</td>
<td>1 person</td>
</tr>
<tr>
<td>Assistant Director</td>
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<tr>
<td>Office Staff</td>
<td></td>
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<td>Education SVC</td>
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</tr>
<tr>
<td>Recreation SVC</td>
<td>1 person</td>
</tr>
<tr>
<td>Health SVC</td>
<td>1 person</td>
</tr>
<tr>
<td>Psychological SVC</td>
<td>1 person</td>
</tr>
<tr>
<td>Caseworkers</td>
<td>3 persons</td>
</tr>
<tr>
<td>Instructors</td>
<td>3 persons</td>
</tr>
<tr>
<td>Volunteers for craft workshops</td>
<td></td>
</tr>
<tr>
<td>Volunteers for field trips</td>
<td></td>
</tr>
<tr>
<td>Volunteers for martial arts</td>
<td></td>
</tr>
<tr>
<td>Volunteers for (unknown)</td>
<td></td>
</tr>
<tr>
<td>Group Home Supervisor(s)</td>
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<tr>
<td>Alternate Houseparents</td>
<td>2 persons</td>
</tr>
<tr>
<td>Houseparents</td>
<td>14 persons</td>
</tr>
<tr>
<td>La Junta School Staff</td>
<td>65 persons</td>
</tr>
<tr>
<td>Residents</td>
<td>50 persons</td>
</tr>
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</table>
Mid-land Home Funding Sources

The following funding sources for the Mid-land Home provide the financial stability the Home requires in order to administer foster care services to children.

Tribal Funding

The Mid-land Home is partially located on the Mid-land Reservation. One-half of the main office is situated on Tribal land and the other half is on county land. The Home serves mostly a Native American clientele; however, in order to receive state and federal funding the agency must not discriminate. The agency can, however, advertise itself as being "designed" to serve Native Americans. The board of directors for the agency are mostly Native Americans and the philosophy for the agency reflects a Native American culture.

The Home receives partial funding and in-kind benefits from the Mid-land Tribe. Benefits are received through police and judicial assistance, tribal welfare programs, placements for foster care, the opportunity for weekend home visits for residents, educational workshops which are conducted by the Mid-land Tribal College, and access to potentially employable staff.

State-County Funding

The state of Montana currently provides monitorization and licensing guidelines to the Home defined by the State licensing
standards found in the Montana Codes Annotated. The state authorizes funding for yearly requests for services to Indian children in the Home who reside in Montana counties. Indian children who are wards of their respective county of residence and are not formally enrolled members of a tribe and not counted in the previous year's budget request have their services paid for by their county of residence. The state rate of payment for resident care consists of $23.00 per day.

The Home recognizes that the state has the authorization to review policy statements and agency practices, and the Home develops policy geared towards fulfilling the State of Montana's requirements for licensing for sub-contract services. These licensing guidelines are found in the Montana Codes Annotated and establish minimal guidelines for agency practice; they are not considered to be a legally binding contract with the agency. The legislation states that the agency should provide minimal basic service with regard to client needs and that the agency shall not knowingly violate the ethical standards that the state presupposes the agency has previously developed.

Each year the state Community Services Division of the Montana Welfare System reviews the budgetary request of the Home, allows for incremental adjustments in the budget, and authorizes the sub-contract funds. The state licensing authority visits the agency, reviews the agency's files, interviews staff and residents, and renews the agency license. If the agency is viewed in violation of the licensing requirements, then the
licensing personnel recommend that these areas receive attention by the agency in accordance with licensing standards.

The role of county funding is minimal. When a child is referred to the Home by a county, they are requested to provide the child's background data which includes family history, court referral, birth certificate, social security number, medical records, and a legal mandate for the director of the Home to be the child's legal guardian. The county retains financial responsibility for the child's services and they are billed monthly at a fixed fee rate.

Federal Funding

Mid-land Home receives funding from the federal government through entitlements administered through the Bureau of Indian Affairs. These entitlements are for social services to Native Americans who are one-fourth degree Indian blood, or who have interest in trust land. These entitlements are largely funded through the Indian Child Welfare Act. The Home collects service fees from each child's home reservation, then the home reservation requests the fee amount from the Bureau of Indian Affairs. In some cases the home reservation general assistance program pays the fee from money that has been received previously from the BIA for foster care or treatment care.

There is a monetary as well as a definitional difference between the terms "foster care" and "treatment care." The fee payment for treatment care is larger than the payment for foster
care. Treatment care is considered more costly because it infers that a child's needs exceed general foster care service. In 1980 the Home became more complex and expanded its service to meet the needs of children who were delinquent and those who had minimal emotional disorders. The Home continued to admit children who were neglected and abused and in need of foster care while expanding services to meet the needs of emotionally troubled youth. The Home now provides services beyond foster care services to encompass the therapeutic needs of troubled youth and the effect of expanding these services was reflected in the increased service fees for child care at the Home.

Private Funding

The Home receives a considerable amount of funding from the La Junta Mission. The Mission provides the area with a combined spiritual and academic campus. The land for the campus was entrusted to the La Junta Pastors by the Mid-land Tribe, while the land adjacent to the campus was purchased by the parish.

The La Junta campus affords these services:

1) a church
2) a rectory
3) a high school and dorms
4) a gymnasium
5) maintenance shops for buses, grounds maintenance and storage
6) football and track fields
7) rental housing units
8) an alternative school
9) administrative buildings and museum gift shop (Mid-land Home office located here)
10) a print shop for advertising, newsletters and donations
11) a private airfield
12) a lunch room
The Home receives a large part of its funding through public solicitation. Newsletters are printed and mailed through the services provided by the Mission in an attempt to collect funding from across the nation. The Mission pays for professional writers to come to the Home and, using the residents' files, create solicitation stories which are later printed and mailed out. The donors receive professionally written thank you notes describing how their donation has helped the residents achieve their potential, and how they have now stopped their self-destructive and violent behaviors (see Appendix).

These solicitations are quite successful, and the moneys received pay for the services of the professional writing staff, printing and advertising staff, and the Home and La Junta offices' maintenance. To manage the incoming donations the Mission maintains a lock-up office in which the accountants are locked in for their shift and camera monitors are focused on them at all times. There is also a warehouse for in-kind donations of clothing, food, and toys. Once a year the Home provides a picnic for administration staff and "special" guests. This event has been referred to as the "Million Dollar Picnic" since the special guests are those who have contributed this million dollar sum to the charity functions of the Home and La Junta Mission.

The Mid-land Home cannot be considered a private or public agency because of the multiple-source funding it receives. The Home is a public agency because it maintains state licensing and state and federal funding; however, the Home's involvement with
Tribal governments and the La Junta Mission are considered to be private business relationships. The multiple-source funding practice of the Home allows for agency continuance of service and at the same time creates concern over complex issues in internal and external agency accountability and management. Is the agency accountable as a public or private agency and what regulations govern its service practices? The agency is public in the sense that it must comply with minimal state regulations regarding services; and private agency regulations or the right to profit from services rendered are not addressed in state contracts for services. The state focuses only on the contractual agreement held with a public not-for-profit service. The Home is both a public agency and a private agency and state contracts for service only regulate the public portion of the Home's activities, leaving the private agency functions unrestricted and unobserved.

**Investigation Request and Process**

I began my case manager responsibilities at the Mid-land Home in February of 1985. In this position I was responsible for twenty-one residents within three group homes. My duties included: providing one-to-one counseling, group counseling, record maintenance, crisis intervention, academic monitorization, conducting client progress staffings, encouraging family participation, case planning, and providing information to
houseparents regarding resident progress and care, conveying houseparent concerns to the administration, informing referring agencies of resident progress, and promoting "team" concepts. In April of 1985, while still employed at the Home, I requested the State of Montana to conduct an investigation of the Mid-land Home. I was aided in this request by Kelly (fictitious name), a caseworker from a nearby county social service agency. The following is a summary of the charges and events that led to the investigation request.

**Investigation Charges**

(A) Inadequate Resident Treatment

Residents of the Home were isolated through a controlled environment. Daily schedules provided residents with eight hours of school, one hour of study hall after school, a dinner hour, clean-up and chores, and two to three hours of mandatory recreation or activities. Weekend schedules required recreational activities, cultural and art classes, chores, and church. Residents were supervised and monitored at all times.

The residents received between two and four dollars weekly. This money was to be accounted for with receipts and itemized lists. Each resident had a savings account with the local bank in which requests for withdrawals could be made by the resident, provided staff signatures were collected and the referring agency was contacted for approval.
The rigid structure and financial control of the residents brought rebellion and other acting-out problems. The weekend before I resigned, sixteen residents ran away from the Home, and in the period of my employment an average of six to ten residents ran away on weekends. Other acting-out behavior included abusing drugs and alcohol, gasoline and glue sniffing, failing classes, and youth pregnancy.

The question arises as to the appropriateness of structure and control with regard to foster care or treatment care. Most of the residents and staff believed the Home to be a foster care unit; however, the structure and controls used were more applicable to treatment centers. The structures and policies guiding the efforts of the Home were developed by directors who were trained in managing residential treatment centers for juvenile delinquents.

The physical location of the Home provided residents and staff with an isolation barrier. Residents and staff were isolated physically within the institution and geographically from outside influences due to the Home's rural location. The Home and surrounding population is approximately three thousand and the local township is approximately one hundred miles away from the nearest city of any considerable size (50,000). The Home employs heavily from the local population and provides for in-service training with the assistance of a nearby Tribal community college.

The Mid-land Home is situated on the La Junta Mission campus
and is separated from the local township by a river and a bridge. The campus is virtually self-contained with the exception of food and commodity deliveries. The residents are monitored at all times and, to a large degree, so are the staff. The housing areas are located in the outer areas of the campus and are quite congested. The campus is provided security patrols by the La Junta Mission; however, there are jurisdictional problems that inhibit the authority of any protective service in the area whether they are Tribal, private, county, or federal. These jurisdiction problems will be addressed later on in the paper.

The local township includes between fifteen and twenty businesses. One individual conducts the tasks of Postmaster and owns and operates a gas station and grocery store. This individual also conveyed information to the Home's director regarding resident and staff mailings. Through this practice the director had knowledge of staff and resident communications with ex-staff and other persons. The director on one occasion returned one of my client's letters which had been opened and not yet postmarked. The director stated that residents were not allowed to correspond with ex-residents and that the necklace which had been mailed with the letter would not be returned to my client.

The director's practice of retrieving mail is a definite factor in the continued isolation of residents and staff at the Home. Letters that I have written to staff during the investigation have never been received and they have not been
returned to me. I recently made arrangements with a staff member to correspond with me under an assumed name and address, and this practice has been successful. These arrangements were made when the staff member visited my area of residence. The area of the Mid-land Home is well known for severe drug and alcohol problems. The Native American population in the area has a long history of drinking Lysol products to receive the alcohol benefit and this situation has prompted store owners to only sell one can of Lysol spray at a time in an attempt to prevent misuse of the product. During my employment residents and staff at the Home repeatedly reported the practice of glue and gasoline sniffing to me, and it was common knowledge that the sale of drugs was a regular practice within the classroom and hallways of the La Junta Mission School. Consequently, living in the area would provide exposure to the behaviors associated with chemical addiction. These behaviors are denial, manipulation, and dysfunctional relationships. Even if individuals are not directly involved with a chemical addiction, they carry the intercultural symptoms of the exposure, and the behaviors of denial and manipulation are carried on through each generation and become a "normal" method of relating with others. The staff, residents and local community of the La Junta mission were all subjected to the destructive behaviors found in chemical addiction through the generational transmission of addictive behavior. Thus, the potential for developing healthy relationships was limited for residents as well as staff and no
one was untouched by the leftover effects of generations of alcohol and drug influence.

The following cases reflect concern for resident treatment and the appropriateness of resident placement in the Mid-land Home. One of my residents was an 11-year-old female who had previously resided with an aunt and uncle. In reviewing her progress and contacting her aunt and uncle, I found that she did not have emotional or behavioral problems. This child's family placed her in the Home thinking that the Home was a boarding school. Their family history showed a well above-average income and education; however, it is a Native American tradition to send one's children to boarding school to receive educational and religious instruction. This practice began with the establishment of reservations and government attempts to assimilate the Indian into the American culture. This child did not belong in foster care nor did she require treatment. Screening for admittance into the Home was fraudulent and the child's family was not told that the Home was not a boarding school.

Another case example, and a major impetus for the investigation request, involved a resident named Marsha. Marsha was a 17-year-old female about to graduate from La Junta High School. Her file showed a two-year absence from the Home from ages twelve through fourteen and a re-admission when she turned fifteen. Prior to her leaving and into the early part of her return she was an A and B student. Her grades began to
deteriorate at La Junta when she returned at age fifteen. There were several attempts to run away and reported drug involvements listed in Marsha's file, and her last four report cards were not present in her file.

In our sessions Marsha spoke of her career plans and the assistance of a La Junta guidance counselor in her preparations to attend a fashion design school after graduation. The counselor had assisted her in communicating with three ex-staff members regarding her career plans. Marsha was not allowed to contact or receive mail from ex-staff; however, through her counselor she had made arrangements for their assistance after she left the Home. When I discussed Marsha's career plans with her houseparents, I was given Marsha's failing and absent slips from La Junta High School. She had not attended several of her classes for months and appeared to be flunking all of her senior level classes. The houseparents had been called to the school and had discussed Marsha's involvement with the guidance counselor. They discovered that the La Junta teaching staff were concerned about Marsha's spending two hours a day in her counselor's office while not attending classes.

I confronted Marsha with the information, and she refused to discuss the situation and insisted that her counselor said that she would graduate and that she needed to plan her career. She also said that the rumors at the Home about the ex-staff she had befriended and was in contact with were not true. When I asked her to explain she said that the rumors indicated that her friend
in New York was a prostitute, and that the couple in western Montana were molesters and drug users. She stated that the Montana couple were more like parents to her.

I discussed Marsha's situation with my supervisor and found that the rumors regarding the ex-staff were considered true by the Home's administration. My supervisor said that the three ex-staff persons resigned from the Home at the same time and she believed that the three were drug users. She recommended that I discuss the situation with our director. The director listened to what I had to say, became outraged, and said he would talk with the guidance counselor's supervisor and would let me know what he found out in this discussion. He never discussed this situation with me after this point.

I spent the next four days commuting to the Tribal jail to see Marsha. The director had filed charges against her for trying to stab another resident. Her report was that she was peeling an apple with a knife and made a joke about stabbing another resident. Marsha became very detached and quiet during this period. Her response to the whole situation was that she didn't think that they would do this to her and that she did not want to be put in a mental institution. The director did threaten to have her committed to a mental hospital since he believed that she had had a psychotic episode and felt that this was an ideal time to have her committed before she turned eighteen. The commitment subject was dropped because Marsha's referring agency did not want to authorize funds for the action.
When I drove Marsha home from the jail, she expressed her concern about what was happening. She felt that if she did not quit causing trouble she was going to be physically hurt. She stated that she was going to stay out of trouble, not talk to anyone, and leave as soon as possible. She then suggested that I be careful. Marsha refused to explain her comments any further.

A week after Marsha returned from jail she was found by houseparents at 3:00 AM on the campus grounds with a security guard. The guard said that he had found her and was about to return her to her unit. Marsha was very high on drugs and had four large bruises (hickeys) on her neck. Later the houseparents received information from La Junta staff that Marsha had been seen two hours earlier with the same security guard.

The evening after I resigned and left the area to distance myself from the investigation I had requested, Marsha and two female residents ran away. When they were returned they stated that they ran fearing that they were going to be killed and that they were sure I would be found dead. The young women refused to identify the potential killers or explain why I could be killed. Marsha was definitely a candidate for a treatment center; however, the Home did not have the ability to treat mental health and drug and alcohol addiction. Moreover, the influence of the school counselor was abusive and inappropriate.
(B) Emotional and Physical Abuse

My first exposure to resident abuses came from a discussion with my supervisor. She asked me if I had heard any of the residents talking about six residents who were still at the Home. She told me that I would probably hear about what had happened at the Home and that I should know about the situation. She stated that a previous counselor had implemented a wilderness program that had involved nine males and included their living in a wooded area away from the Home. They attended school by being transported to and from classes and were not to have any contact with staff or residents throughout the project period. On a few occasions the Home's nurse met the wilderness staff and some residents to give medications and first aid, but this occurred on a road leading to the camp.

About a month after the program began, a staff member from the camp came to the director and reported resident abuses. He stated that residents were being physically abused. They were being beaten, forced to eat roots and berries, and had to sleep on the ground. The residents were being sexually abused by being subjected to fondling, intercourse, and filming during baths. Residents were experiencing emotional abuse by being shot at with a pistol to instill control and fear by the counselor in charge of the project. The director confirmed the information and the project counselor resigned. I was told (by Kelly) that this person is now the director of the Big Brothers and Sisters program in an eastern Montana city, and that he is intimately
involved with a state licensing official who is responsible for renewing the Mid-land Home's license.

Upon leaving my position with the Home I came upon the brochure used to solicit funding for the wilderness project. The funding request showed a picture of a group of males riding on a raft with lifejackets and floating down a river. The brochure requested a $2,000 tax-free contribution per child. The money would be used to provide sleeping gear, camping equipment, and food. At the end of the brochure was a note that a female wilderness program would be implemented in the future.

In the process of asking questions regarding the wilderness program I came across other questionable situations. These situations ranged from counselors molesting children on overnight trips to a young female being drugged and sexually abused by a state judge in a nearby city. The young woman described was brought back to the Home by a houseparent (Jenny) who was summoned to pick up the resident at 2:00 AM by the director. When the houseparent arrived to pick up the resident, her staff counselor and the judge were not conscious.

I began reviewing resident files for information on abuses, but what I found was that each file had a psychological profile that was generic. Each resident was typically below average intelligence, not honest, a thief, and could not be trusted. All were in need of therapy. All evaluations were signed by our in-house psychologist. This information is critical since it significantly limits the credibility of any resident who comes
forward concerning abuse.

On two occasions three male houseparents from the intake unit group home were reported to have taken medications from the locked nurses' station and had given residents some of these drugs. Within this same period these residents were also seen dating the houseparents who gave them the drugs. The residents during this incident were reportedly missing from the Home and a police report was filed to assist in locating the children. After these staff-resident violations were reported and confirmed by the director, two of the houseparents were suspended for two days and the third houseparent was taken to a drug and alcohol treatment center after he threatened to commit suicide.

(C) Questionable Standards

In the Mid-land Home policy manual for 1985 is a policy regarding the Home's goal to involve the families of residents in the treatment process. Obstacles to carrying out this policy became evident when families contacted, or were contacted by staff regarding the progress of residents. There were rigid guidelines for any visit to the Home by family members or other agency personnel. The director required advance notice for visitations, usually two or three days, with completed visitation forms, appropriate signatures, and close supervision of the visitor at all times. Caseworkers from county or Tribal agencies were not authorized for visits without advance
notification and supervision. Unauthorized visits from outside agency personnel resulted in staff reprimands of verbal censures and personnel reports of the incidents were kept on file. The effects of this unwritten policy encouraged caseworkers to visit the Home less and inhibited inter-agency contacts. Family members were equally discouraged in visitation attempts.

The director's professional behavior is a direct factor which contributed to the agency's ability to provide services. I perceived the director to be exceptionally intelligent and articulate. There were no confrontations between the director and me; however, I witnessed several outbursts of rage from the director with regard to staff and residents. His behavior was predictable in that he would listen to a situation, become raging with anger, and then calm down but remain stern. Following this behavior he typically stated that he should be trusted in his decisions since he knew more about the agency's objectives, and that he needed to be informed about any future problems.

Staff members were isolated or confined to the area through the scheduling of shifts. Most direct care givers received one day off on the weekend with an additional day off during the week. Any requests for trading shifts required signatures, advance notice, and questioning from the director. In most cases the spouse of a staff member was also employed with the Home or with La Junta. This situation made requests for leave equally difficult. All staff were on twenty-four-hour call and had to be available for emergencies. What this means is that the staff was
physically and professionally isolated from traveling, recreation, and personal and professional relationships outside of the immediate area. This isolation factor contributed to staff burnout, employee turnover rates, and staff-to-staff communications of personal and professional problems which may not have been productive.

The jurisdictional ambiguity with respect to police and protective services in the Home's area were a major problem. On two occasions staff members were assaulted and charges were dropped on the grounds that jurisdictional authority could not be determined. The Home and La Junta services are located on both Tribal and county property, and in the case of assault or other crimes, none of the protective services has clear authority to arrest suspects for prosecution.

An example of this problem can be viewed in the following situation. A female staff member of the Home was assaulted by three male staff persons. The female was Caucasian and resided on Tribal land, and two of the three males who assaulted her were Caucasian and resided on Tribal land; however, the third male was Native American and resided on Tribal land. The incident occurred on Tribal land. The problem was that county police and La Junta security could not arrest Caucasians on Tribal land, or arrest and prosecute Native Americans who assault Caucasians. In another case, a female Caucasian staff member was assaulted by a Tribal resident who was a male. The incident occurred on Tribal property; however, the police could not arrest the suspect since
the court would not recognize a complaint filed by a Caucasian. Complaints were filed in both cases; however, the cases were not accepted in Tribal court and were dismissed. A federal police officer was called by the Home's director when the assaults occurred. The officer's reply was that he did not have the authority to intervene since federal jurisdictional authority had not been established in the area. Given these jurisdictional problems, it is not clear to me how the director of the Home was able to have residents who ran away located, detained, questioned, and returned by Tribal and county police.

**Investigation Request and Process**

In assessing the overall situation at the Home I discussed my concerns with a social work professor from the University of Montana who was conducting a workshop in the area. His advice to me was to leave the area within a week and contact him after I was safely out of the area. At this point we would request a state investigation of the Home's activities. After the professor left, I was contacted by a caseworker named Kelly from a nearby Tribal agency. The director of the Home was attending a three-day workshop when the caseworker arrived, and we discussed her concerns about the residents her agency had placed with us. She began discussing a lot of concerns about the area's isolation, drug problems, and the care the residents were receiving. She also said that she had made previous complaints to her supervisor and nothing had ever come of her reports except
that visitations to our agency were harder to conduct. We began discussing information regarding reported abuses and agreed that an investigation was necessary. Kelly was to contact a county attorney and a high level state official, and I was to finish out the week and return to the University of Montana and provide information to a state investigations team. These arrangements were made by Kelly and the state official she had contacted.

I received a phone call from Kelly the next evening after our initial discussion. She had made her contacts and she was concerned that I might be in some danger since she had found out that the director of the Home was leaving his workshop early and would be returning the next day. Kelly insisted that I go to my office with assistance and collect any documents that I needed and try to leave the area that evening. She stated her concern about the director's outbursts of anger and reported that he kept a gun in his office. She stated that I should lock any important papers in the trunk of my car and that I was to check in with her at her office when I drove through her county. I was to meet with the investigations team as soon as I returned to Missoula, Montana.

Investigation Process

In April of 1985 I returned to Missoula, following a two-month period of employment with the Mid-land Home. Shortly after my arrival in Missoula I was contacted by a staff member from the
Missoula County Welfare Department. This person's name was Alan (fictitious name). He arranged for a meeting between the state investigators and me. During this meeting I provided information to the five-member team for approximately three hours. The taped information from this interview was to be reviewed by the state prosecuting attorney and the Community Services Division Administrator prior to the actual field investigation of the Mid-land Home.

I was told by the team to maintain phone contact with Alan at all times, and I was to provide them with phone numbers where I could be reached. I was to reside at various locations, not to conduct routine activities or be alone for long periods of time. I was to be alert and careful at all times. The team leader, Alan, and the Community Services Administrator assured me that I was receiving adequate police protection, and that the persons and residents who had provided information to me regarding the Home's abuses would be protected. The state team left Missoula after the interview and conducted strategy meetings with state Welfare Department officials in Helena for the next two weeks.

The state team functions in conjunction with the State Welfare Department Community Services Division which licenses sub-service or contract agencies. These contract agencies provide general health and welfare care to adolescents and the adult public. The Montana Welfare Department has the authority to develop and implement provisions for the investigation of reported cases of child abuse and neglect. It is under the State
Welfare Department statutory provisions that the state team receives authority to investigate reported cases of child abuse and neglect in private homes as well as in public and private agencies. Thus, the state team is a specially assembled unit empowered by statute to investigate reported cases of child abuse and neglect. The origination of the state team began in November 1984 in Helena, Montana, following a training session provided by Cornell University staff. It was determined by state welfare staff that a special team was necessary to enhance the state's investigatory ability. The administrator of the Community Services Division selected the four-person team from various state welfare departments. A fifth person (Alan) was assigned to coordinate and lead the team efforts in conducting investigations and developing intervention strategies. There were no formal guidelines or policies to guide the state team. However, it was assumed that the team would be assembled by the Administrator of Community Services after a written request for team intervention was received by her office. The team would receive either an assessment-needed assignment, or an immediate protection-needed assignment. An assignment for an assessment would require assembly for planning and investigation, proposal of the team's recommendations following the investigation, and team disassembly. An assignment of immediate intervention would call for protective investigation and required immediate intervention in the designated area with protective intervention prior to planning, a proposal of team recommendations, and team
disassembly.

After receiving the team's summary and recommendations from the investigation, the county involved would send a child protective service worker, licensing worker, social work service III's administrator, and assistant administrator who would decide the State Welfare Department course of action. Their action consists of these alternatives or combined options: (1) use of a corrective plan to ensure future compliance with the existing state licensing requirements; (2) revoke agency license, or not revoke agency license; and (3) monitor the agency actions for a determined period and/or strengthen licensing requirements.

The state team received an assessment-needed assignment for the Mid-land Home investigation. Following two weeks of information-gathering and strategy development, the state team conducted their investigation. The director of the Home was cooperative in allowing interviews, record reviews, and agency exploration. Alan reported that the investigation supported Kelly's and my information entirely, and that the residents and staff were indeed victims of agency abuse. In discussing these findings with the director, Alan informed the director that I had been interviewed and the director stated that he was confused by my resignation but stated that I had been a very competent case manager. Alan informed the director that the investigation request was initiated by several anonymous ex-staff and that the results of the investigation were pending. The director was very compliant at that time and was eager to assist the team's
Soon after this discussion I requested that Alan contact the agency and request that the director release and forward my last two paychecks. During the telephone discussion between Alan and the director regarding my paychecks, the director lost control of his anger and stated that I was trying to ruin him and that I would have to call him to discuss getting my paychecks. The result of this conversation gave Alan a clearer understanding of my situation and increased his concern for the residents and staff that had been interviewed. For a period of two months I continued to try to collect my paychecks. I contacted various agencies for assistance and finally a United States Federal Attorney agreed to check into my situation. The attorney stated that he was tired of hearing complaints against this agency and indicated that there were several complaints against the Home. He stated that my checks would be mailed to me within two days. He told me to call him if I had not received the checks within this time frame. I did not have to call him again.

In my discussions with staff persons at the Home during the investigation process, I found that the interviews were considered threatening to some of the residents and staff. The investigators asked residents and staff if they thought the Home should be closed or left open. When residents thought that they might lose their place to live they were reluctant to see the Home closed. Staff members feared the loss of their employment. Another factor that influenced the interviews was the location.
The interviews were held in the Home's main office next to a room where the director's assistant was stationed during the interviews. This was very intimidating to residents and staff. I discussed these issues with Alan and he confirmed that there were several errors in the investigation process. However, he considered the director's behavior and the information collected to be enough to revoke the agency's license.

**Investigative Outcome**

In May of 1986, one year after the investigation, I discussed the outcome with Alan. At that time the continuance of the state team was in question and officials from the state were to decide whether to continue the special team. Alan had resigned due to the Mid-land Home situation. The team had recommended closing the Home and/or replacing the director. However, state officials dropped their charges when the Home's attorneys threatened to sue the State of Montana Welfare Department.

Alan cited the following problems as factors in his resignation: (1) Team recommendations which do not receive appropriate remedial action by the State Administrative staff promote employee frustration and indifference. (2) The non-existent guidelines for the team to conduct investigations and lack of state support for the investigations render the team unable to protect victims and informants from agency retaliation. (3) The contractual binders between state welfare systems and
agencies pose serious questions regarding the practice of licensing sub-service agencies within the minimal guidelines established by law for licensing an agency. The licenses are awarded to the agencies without specific contractual agreement of expectations, and provisions for authority over the agency have minimal impact. Thus, licensing awards are inadequate and are not specific contractual binders enforceable by law. (4) There are questions regarding the legality of the investigations without a binding contract as well as concerns for investigator liability. After discussing with S.R.S. officials the legal concerns of operating without legally binding contracts, Alan believed that this practice of licensing would be allowed to continue. (5) Alan believed that the legal basis for effective investigation is non-existent, and that this situation would render the function of the team objectives impossible, or limit the impact of the team's efforts.

In closing this discussion with Alan he stated that neither the residents nor I had been adequately protected during the investigation. He felt that there was cause for our protection and that the State does not have the ability to provide this service. He said that Kelly had been protected since she was protected by the Civil Service Reform Act that governs state employees. I asked Alan if there was a possibility that I could be blacklisted. He did not believe that I could be formally blacklisted; however, since the director attends a lot of workshops he believed I could be informally discredited in
conversations. Alan stated that the director believed that I had requested the investigation. Alan suggested that both of us continue to inform as many people as possible regarding this situation.

In collecting information for this paper I contacted the present state team leader and requested a copy of the taped interview that I had provided to the state team, copies of the Mid-land Home's licensing proposals for years 1984 through 1986, and copies of state legislation which regulates the state team. The letter on the following page conveys the Community Services Administrator's response to my request.

The Administrator's response is significant in that my request was denied based on policy that usually upholds public disclosure of records.

(1) Section 41-3-205 of the Montana Code Annotated does not specifically address my request for Public Statistical Information System information, or release of the taped interview. The law generally relates to natural parents, custodial parents, health care professionals currently involved with abused or neglected children, and the non-custodial parents of an abused child (see Appendix).
August 8, 1986

Kay Spang
420 E. Front
Missoula MT 59801

Dear Ms. Spang:

I am responding to your request of July 18, 1986 regarding Home, etc.

I have attached a copy of the laws regarding the confidentiality of CA/N information, as well as an Attorney General's Opinion of those laws. The response in this letter is based a large part on those laws and AG Opinion.

Attached is a copy of the Home licensing file with the confidential information removed.

The PSIS reports cannot be released due to 41-3-205.

The tape interview cannot be released without a court order.

Home policy statements, as we have them, are part of licensing file are attached.

The general information regarding state CA/N team is attached.

Legislation regarding state authority to subcontract 41-3-1101-41-3-1102 41-3-1103 and 41-3-1105 MCA is attached.

Legislation regarding the State CA/N Team's function and authority as such - there is none. It is a tool used by the Department to fulfill its statutory obligation to investigate CA/N Reports. See 41-3-202(5) MCA.

Sincerely,

...
Mr. Lewis's opinion does imply that any release of information by the Department concerning allegations of abuse and neglect has the potential to lead to civil liability. I believe that it is this factor that prompted the Administrator to deny my request absent a court order.

(2) The letter indicates that all confidential information was removed prior to my receipt of the materials. This decision was based on the Attorney-General's interpretation of confidentiality laws. The information that I received with this letter consisted of hundreds of pages of the Home's policies and licensing proposals. However, any relevant information regarding agency reported violations of abuse was absent. Information regarding group home violations with respect to inadequate window screens, fire alarm violations, garbage disposal concerns, and inappropriately sized fire extinguishers was left intact. From the information regarding the 1985 period during the investigation, the Home was placed on a provisional license and corrections were outlined. There were eleven areas of deficiencies and four of these areas were blacked out. Of the remaining areas needing correction, the following corrections were recommended:

(A) Program descriptions and types of children accepted needed to be established.
(B) Injuries to residents must be reported within 24 hours.
(C) Written plans must address steps necessary to reduce the number of runaways.

(D) Telephone numbers must be posted in the units.

(E) Personnel files must be complete and brought into compliance.

(F) Residents must be involved in their case plan developments.

(G) Policies must be developed to insure that medications are not accessible to residents.

In the 1985 licensing policy the wilderness program is described as being an "immediate concern." Listed as concerns were an inadequate school program, lack of program definition, inadequate clarification of authoritative persons, and lack of responsibility descriptions for case managers and living supervisors. There was concern for a check-and-balance measure so that one person would not be totally in charge of the program or residents. As a result of these findings the Home wilderness program was not licensed. The program was not mentioned in the materials after this point.

(3) The administrator substantiates Alan's concern for the authority and activities of the state team in the last paragraph of the letter. The team is a tool to fulfill a statutory obligation, and it does not have qualified staff for conducting investigations. The purpose of the team is to review and recommend only. The state team did not have the authority to protect victims of agency abuse or persons
who requested the investigation, and the team could not grant investigative immunity from potential agency retaliation. Thus, the State of Montana abandoned their investigation when the Mid-land Home's attorneys responded.

Conclusion

A clear definition of the role of whistle-blowing and specific guidelines for protecting whistle-blowers and victims of agency abuse would reduce informant risk while lessening civil liability. Without protective guidelines for whistle-blowers and victims of agency abuse, principled dissent will be an underutilized means to provide balanced checks on an agency's power, whether these agencies are public, private, or both. There are no guarantees that an agency will develop internal checks that inhibit unethical agency abuses. Thus, the development of protective guidelines to protect whistle-blowers and victims of agency abuse would assist agencies in establishing appropriate internal and external checks on agency practices.

Chapter Three will list the risks and consequences the victims and I faced in blowing the whistle on the Mid-land Home, and the agency's reactions to the investigation. Recommendations found in this chapter will serve to assist agencies in recognizing the benefits of whistle-blowing in terms of agency accountability and the equal importance of 'all' team players, from residents to administrative staff, to state team
investigators and concerned citizens.

Agencies who respond negatively to whistle-blowing have failed to recognize that all participants within an agency are 'team' players including clients, direct care staff, administrative staff, team investigators, and the Attorney-General. These participants must not be divided into groups that oppose each other and create battle lines with which to destroy the perceived enemy.
CHAPTER III

Risks and Consequences Victims and Whistle-blowers Faced

Blowing the whistle on the Mid-land Home created risks and consequences for the residents, staff, investigators, and myself. The risks and consequences for each group of participants were as follows:

Residents:
Residents were called in to discuss the investigation with the director. They were asked to disclose what they had said to the interviewers, and if they wanted to continue residing at the Home. They were also told that they would be heavily monitored and that the director would punish anyone involved with the investigation request. Residents told staff that they were afraid that the Home would be closed and that they would not have a place to live. They were also fearful of receiving increased tasks in their units and several believed they would be punished by the director for having talked to the interviewers during the investigation.

Staff:
Staff were verbally reprimanded by the director for talking with the interviewers and were told that any disclosures that were found to be anti-agency would bring about employee termination.
Some staff member teams were split up and placed in Home units that they had not worked in before. All staff were informed by the director that staff were not to talk to each other about the investigation and that one individual (Darla) was viewed as an informant to the investigators. Staff did not talk to Darla professionally or otherwise for approximately one year after the investigation. Darla was not informed prior to scheduled staff conferences regarding children in care or organizational meetings, although other staff were informed by office memos which were delivered to individual staff mailboxes. Darla was assigned to a new unit with a new co-worker and assigned a live-in night shift. This schedule consisted of working three nights, having one night off, and did not allow for having a weekend off. Staff were told that shifts could not be traded among workers and that changes could be arranged for time off if emergency leave was needed. Darla requested emergency leave when her mother suffered a heart attack, and her request was denied by the director based on an unwillingness of staff to cover her shift.

**Investigators:**

The investigators were displeased with the outcome of their efforts and, as stated earlier, the team leader resigned from the investigation unit. These individuals felt that they were unable to effectively provide remedial functions and informant protections. The team's recommendations were ignored and the
persons interviewed were later traumatized by the Home's administrator. The investigators felt responsible for the trauma the residents and staff experienced because of the interviews. The long-term effect of this investigation will no doubt be reflected in future investigations where team members will be less enthused about conducting an intervention since their recommendations are not upheld.

Personal Consequences:

Following the investigation, I faced the risks and consequences of financial loss, reputation assassination, and physical harm. Other problems surfaced during the two years following the investigation and included employment and geographical limitations. As an example, I am a member of the Mid-land Tribe; however, I do not feel safe to travel to the eastern Montana area and seek employment opportunities or visit relatives. Future employment limitations include being unable to use my employment record at the Home for employment references. I list my experience at the Home on my résumé, however, I provide Alan's phone number as a reference for questions concerning my qualifications and experience.

The crisis for me was lessened much sooner than for the residents and staff who resided at the Home. However, I still carry feelings of responsibility for the pain that was endured by others during the investigation, and until the agency is stabilized my overall concern goes beyond any measurable effects found in the defined risks and consequences of blowing the whistle.
This concern focuses on the underlying messages that repressed speaking out against agency abuse. These messages were clear to the whistle-blowers. Don't talk to outsiders, don't think for yourself, and don't trust non-agency persons. The agency's administration knew what was best for everyone and was sanctioned by a state license to manage the lives of all persons involved with the Home. This type of agency control deteriorates personal integrity and self-determination while promoting dependency and lack of responsibility for one's living conditions.

Agency Reactions to the Investigation

The initial reaction of the Home was to tighten up the group home units. All residents in the independent living unit were confined to the group home except when they were attending school. Staff members were to increase their monitorization and journal writings on resident behavior and all units were closed to visitors and family. Staff members from the main units that I worked in were transferred to different units and no longer worked together with previous staff and residents. These staff members' shifts were also changed.

After the state team conducted the investigation and the Community Service Division of the Montana Social Service Welfare Department put the Home on a provisional license, the Home changed its name, moved the main office to the intake unit, which
is situated on Tribal land, began resident work training in a
tree plant experiment, and closed the alternative school. The
Home also attempted to receive a Tribal license as opposed to a
state license for agency operations. This would have removed
state monitoring of the Home.

The agency continued in a state of chaos until the fall of
1986 at which time the director of the Home was relieved of his
duties by the board of directors at the La Junta Mission. The
board requested the director’s resignation and the assistant
administrator (Ted) and the group home supervisor (Cindy) became
the co-directors of the newly named La Junta Home, formerly the
Mid-land Home.

In April of 1987, I met my previous supervisor, who is now
the co-director of the Home, at a national conference on child
abuse. The conference was held in Wisconsin and the new co-
director and I had ample time to discuss the investigation and
the outcome. The co-director stated that the Home had been in a
constant state of crisis since the investigation and that the
director became very violent with residents and staff. Cindy was
pleased that the director was gone and felt worried about his
current occupation. The Home’s director had been hired to
develop a new adolescent group home in another eastern Montana
town.

Cindy thanked me for requesting the investigation and
helping to create the changes that arose from the intervention.
She cited changes in the agency’s policies that geared the
program towards more effective resident treatment care and more restrictive resident admittance standards. The Home now follows a screening technique that only accepts youth from the immediate geographical area. This change allows the staff to provide outreach to the families of residents which promotes the goal of family reunification as opposed to ongoing institutionalized care.

Recommendations for Protective Guidelines

Based on my experiences at the Mid-land Home, I propose that the following measures be implemented by private and public agencies to establish protective guidelines for whistle-blowers:

1) Agency operations manuals which define policy and procedure should be updated to reflect the agency’s attitude toward principled dissent of employees and clients. An example of an agency statement that reflects this position would state: "This agency encourages principled dissent among employees and clients served in an effort to preserve the integrity of conscientious individuals. Retribution for principled acts will not be tolerated."

This statement suggests to agency policy developers that employees, themselves included, and clients, have reasoning ability and are valuable to the agency in guiding agency progress and direction. This statement carries the message to all participants in an agency that integrity and human dignity are respected values.
A component of the agency statement should address a principled dissent remedy. This remedy should involve all participants in the conflict and a neutral mediator. The mediator should be a highly trained individual who can identify the mutual interests and value systems that are present in the conflicting parties. The mediation service should be financed within the agency budget and be a routine line item expense. This service could be included in the agency's consultant line item if a new category was unacceptable to agency funding sources.

2) Agency operations manuals should be updated to carry provisions that allow for documentation of client satisfaction and agency service review. Policy would need to address a mechanism that collects client satisfaction data and agency response to remedy dissatisfaction. The dissatisfaction and the remedy should be documented and reviewed by agency staff and non-agency participants who are assembled every three months for this internal review audit. Non-agency participants could include interested community members or professionals. The entire documentation process should then be reported to the agency's funding or licensing authority annually and remain open for public review. Any principled dissent, agency service dissatisfaction and agency response would be documented and reviewed by the described internal audit mechanism and a final document would be delivered to the agency's ultimate authority.
Conclusion

These recommendations provide for agency recognition of employee dissent, remedy for conflict, review of agency operation with regard to conflict and remedy, and documentation of client dissent and service remedy.

Overall the proposed recommendations provide the agency with an internal control mechanism which sanctions dissent while providing a legitimate forum for expression of value differences. The agency achieves a higher level of accountability and a reduction of stress while enacting controls over crisis situations.

Whistle-blowers achieve a respected and safe environment in which to describe their dissent and are assured that accountability is the agency's goal. The advantages of the policy recommendations described above allow for the preservation of integrity for all individuals concerned.

Moreover, these measures alter the adversarial role between employees, clients and agency authority when whistle-blowing occurs, and transfer the focus to a remedial outcome. This option holds the potential to create a productive exchange of ideas rather than organizing strategies for war and collecting allies for battles. The recommendations proposed in this paper attempt to redefine conflict as a productive element rather than a destructive force among the power relationships found in organizational structures.
I hope that the proposed recommendations will be given serious consideration by agency directors and policy developers, and that the recommendations will be made available to clients and employees who come forward to create change based on integrity and ethical conscientiousness.
Footnotes


3Ibid., p. 288.


7Ibid., p. 113.

8Ibid., p. 186.

9Ibid., p. 119.


11Ibid., p. 297.

12Ibid., p. 280.


14Ibid., p. 320.

16 Ibid., p. 249.

17 Ibid., p. 298.

18 University of Montana, Division of Documents, Monthly Checklist of State Publications (Helena, Montana: Published by the Montana Legislative Council, Montana Codes Annotated, Section 46.5.671, March 31, 1985).

19 Ibid., Sec. 46.5.671, 3-31-85.


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APPENDIXES
July 1986

Dear Friend and Benefactor:

Tommy arrived at eight weeks ago -- a tragic child who has suffered more in his 10 years than most of us experience in a lifetime. He has been beaten, neglected and emotionally abused. It is safe to say that he has never experienced love.

Tommy never even looked up when he was spoken to. He was filled with anger and distrust. He couldn't comprehend anyone caring for him or being interested in what happened to him.

Yesterday, I heard Tommy laugh. It was like music to my ears. The houseparents tell me that he is rapidly adapting to the new surroundings. He now sleeps through the night without screaming or crying out in his sleep. He has made new friends and even enjoys taking a bath.

Tommy is one of the 35 children at Home who have found not only hope for the future, but also a safe haven for the present.

These children do not return to their families on weekends like the other children at our school. They have no home to go to. Some dream of the day when family life is restored. It takes months, and more often, years to bring families together.

The underlying causes are poverty, unemployment and in many cases, alcoholism. Until the parents are ready to face the problem of alcoholism, there is no hope.

Tommy's father and mother have not yet accepted the fact that they are sick and need help in combating alcoholism. They haven't yet hit bottom. Their suffering continues in Tommy's life.

Providing a home, food and shelter for the children at Home is very costly. But a child's life can not be measured in dollars and cents. The hundreds of dollars we spend each month to provide this special care is a work of love.

KEEP THE MIRACLE ALIVE
Please help me to provide not only a home for the children, but also the love these children yearn for, giving them the assurance that we care and are willing to go to any length to provide for their basic needs.

Your grateful beggar friend,

Director
Dear

I want to help you to bring love and hope to Tommy and all the children at Home. It takes hundreds of dollars to provide for their needs. I want to do my part. Enclosed is my gift in the amount of $__________.

NAME ____________________________________________________________

ADDRESS ___________________________________________________________________

CITY __________________________ STATE _________ ZIP __________

Contributions to _________________ are tax deductible.
CHILD ABUSE - Confidentiality of records;

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES - Confidentiality of records kept in connection with abused and neglected children;

PRIVACY - Confidentiality of records kept in connection with abused and neglected children;

MONTANA CODE ANNOTATED - Section 41-3-205.

HELD: Absent a court order, section 41-3-205, MCA, prohibits the Department of Social and Rehabilitation Services from disclosing case records and reports of child abuse and neglect to: (1) the natural parents or parent, or other person having legal custody of a child who is the subject of a dependency and neglect action filed under section 41-3-401, MCA; (2) health care professionals who are treating a child suspected of being abused or neglected; (3) the noncustodial parent of a child who has been removed from the custodial parent following an incident of abuse or neglect; and (4) the natural parents or parent, or other person having legal custody of a child who has been abused or neglected while in the care of foster parents.

27 February 1986

David M. Lewis, Director
Department of Social and Rehabilitation Services
111 Sanders
Helena MT 59620

Dear Mr. Lewis:

You have asked my opinion on the following questions:
1. Does section 41-3-205, MCA, prohibit the Department of Social and Rehabilitation Services from disclosing information contained in departmental files to the natural parents and/or their attorneys in connection with a dependence and neglect action filed under section 41-3-401, MCA?

2. Does section 41-3-205, MCA, prohibit the Department of Social and Rehabilitation Services from disclosing information concerning the circumstances of abuse or neglect to professionals such as psychologists, physicians, treatment centers, etc., who provide treatment to the child who has been injured or damaged by the abuse or neglect of the child's parent or custodian?

3. Does section 41-3-205, MCA, prohibit the Department from disclosing information concerning allegations of abuse or neglect to the noncustodial parent when the child has been removed from the custodial parent because of a substantiated incident of abuse or neglect?

4. Does section 41-3-205, MCA, prohibit the Department from notifying the natural parent of a child who has been placed in foster care that the child has been abused by the foster parents while in foster care?

My conclusion that section 41-3-205, MCA, prohibits disclosure in each of these situations is based on the plain language of the statute, Montana case law, and decisions from other states interpreting similar statutory language.

Section 41-3-205, incorporated within the child abuse, neglect, and dependency chapter of the Montana Code Annotated, states:

Confidentiality. (1) The case records of the department of social and rehabilitation services and its local affiliate, the county welfare department, the county attorney, and the court concerning actions taken under this chapter and all records concerning reports of
child abuse and neglect shall be kept confidential except as provided by this section. Any person who permits or encourages the unauthorized dissemination of their contents is guilty of a misdemeanor.

(2) Records may be used by interagency interdisciplinary child protective teams as authorized under 41-3-108 for the purposes of assessing the needs of the child and family, formulating a treatment plan, and monitoring the plan. Members of the team are required to keep information about the subject individuals confidential.

(3) Records may be disclosed to a court for in camera inspection if relevant to an issue before it. The court may permit public disclosure if it finds such disclosure to be necessary for the fair resolution of an issue before it.

(4) Nothing in this section is intended to affect the confidentiality of criminal court records or records of law enforcement agencies.

The language is clear and unambiguous. It expressly limits disclosure of abuse and neglect records to an interagency interdisciplinary child protective team and to a court when relevant to an issue before it.

Strict disclosure limitations are enacted for a variety of reasons. Reports of child abuse often contain information about the most private aspects of personal and family life. The information may or may not be corroborated and can be very damaging to the integrity of the family unit if released indiscriminately. Confidentiality also encourages the public to report incidents of child abuse. Case workers and those providing information rely on the confidential nature of the case records. A further reason disclosure is limited is to alleviate the potential stigma to the abused or neglected child.

As you have noted in your legal memorandum, indiscriminate disclosure may additionally lead to civil liability. In Colorado a social worker acting on an anonymous tip of sexual abuse confronted the alleged perpetrator and victim, a father and daughter. The Department of Social Services after its investigation
concluded that the allegations were unfounded and proceeded no further. A complaint was then filed by the family against the Department for slander, outrageous conduct, and negligence. On appeal the Colorado Court of Appeals held that summary judgment was improper where the Department may not have acted in good faith and remanded the case for trial on the defamation issues. Martin v. County of Weld, 43 Colo. App. 49, 598 P.2d 532 (1979). The Colorado confidentiality statutes at issue are similar in relevant part to their Montana counterparts. See § 41-3-203, MCA (persons investigating or reporting any incident of abuse or neglect are not immune from liability if acting in bad faith or with malicious purpose).

The Montana confidentiality statute was recently interpreted in two related Montana Supreme Court decisions. In Wyse v. District Court of Fourth Jud. Dist., 195 Mont. 434, 636 P.2d 865 (1981), an attorney petitioned the Court for a writ of review of a district court order finding him guilty of contempt for the unauthorized release of information contained in a dependent and neglected child file. The writ of review was denied and the Court strictly interpreted the language of section 41-3-205, MCA. The Court stated:

The statute is clear that information relating to dependent and neglected children will not be released unless a court order is obtained.

Wyse v. District Court of Fourth Jud. Dist., 195 Mont. at 438, 636 P.2d at 867. This decision underscores the principle that anyone seeking confidential information must first obtain a court order for a determination of relevancy before the information may be released.

The second Montana Supreme Court decision arising out of the same factual circumstance was a disciplinary action taken against the petitioner in Wyse by the Commission on Practice. Matter of Wyse, 41 St. Rptr. 1780, 688 P.2d 758 (1984). In this case the Court elaborated on its prior holding and discussed the statutory terms "public disclosure" and "unauthorized dissemination":

The provisions relating to "public disclosure" are not synonymous with nor intended to be synonymous with the term "unauthorized dissemination." Any unauthorized dissemination, public or private, is prohibited under section 41-3-205(1). The term "public disclosure" comes into play if request is made.
to the court to permit the same and the court finds such public disclosure necessary for the fair resolution of an issue before it.

41 St. Rptr. at 1786, 688 P.2d at 763 (emphasis added).

The two Wyse decisions do not address any of the factual situations presented in your opinion request. The Court was faced only with an attorney in Montana who surreptitiously gained case records for unrelated litigation in another state. The questions you have asked arguably present situations where the child's best interests would be furthered by immediate disclosure by the Department of Social and Rehabilitation Services (hereinafter Department), e.g., the release of a case record to a physician treating a child suspected to be the victim of abuse or neglect. However, the words of the statute and the Wyse decisions are clear: Any disclosure absent a court order is prohibited.

Challenges concerning the confidentiality statutes of other states have typically arisen following the judicial denial of a petition for discovery in a termination of parental rights proceeding. These cases can be roughly analogized to the first question you have asked concerning the Department's disclosure to natural parents in a dependency and neglect action filed under section 41-3-401, MCA. Ray v. Department of Human Resources, 155 Ga. App. 81, 270 S.E.2d 303 (1980) (right of discovery exists in a juvenile court proceeding for termination of parental rights subject to relevancy determination following in camera inspection); Nunn v. Morrison, 227 Kan. 730, 608 P.2d (1980) (where adversaries allowed full access to "social file" and Kansas law permitted disclosure to "parties," defendant natural mother in a deprived child proceeding had right to examine a report in the file); Matter of Damon A. R., 112 Misc. 2d 520, 447 N.Y.S.2d 237 (1982) (attorney of child who was the subject of a delinquency proceeding allowed full access to abuse and neglect reports on statutory grounds and for the purpose of allowing the attorney to prepare a thorough defense). These cases are more instructive to a district court faced with a petition for disclosure than they are to the Department faced with a request for information. Disclosure occurs under the authority of the district court, and the Department is prohibited by the plain language of the statute from independently disseminating any information.
A Montana district court in any proceeding affecting the parent-child relationship must ensure that the parties are afforded due process. As our Supreme Court noted in an early abuse and neglect appeal:

There are ... few invasions by the state into the privacy of the individual that are more extreme than that of depriving a natural parent of the custody of his children.

In Matter of Guardianship of Doney, 174 Mont. 282, 285, 570 P.2d 575, 577 (1977). The due process clause of the Fourteenth Amendment of the United States Constitution requires that parents be permitted a fair hearing on their fitness before children may be taken away from them in a dependency proceeding. Stanley v. Illinois, 405 U.S. 645 (1972). A hearing in which a parent was denied access to abuse and neglect reports that were used to terminate parental rights would not comport with basic notions of due process including the rights of representation, confrontation of witnesses, and introduction of evidence.

Section 41-3-205(3), MCA, establishes a procedure whereby a party may petition a district court for release of records, thereby invoking the in camera review process. The petitioning party could be inter alia a parent, a physician, or the Department. This procedure provides a process for recognition of the basic due process rights of the parent, guardian, or other person having legal custody of a child subject to a dependency and neglect action. When case records are relevant to an issue before a court they must be released.

Attorneys acting on behalf of parents are similarly barred from receiving information directly from the Department. The Montana Supreme Court addressed this issue in the second Wyse decision:

No application was made here to the court for the right to disseminate, privately or publicly, the information in the juvenile proceedings. The zeal of a lawyer to protect his client is not a sufficient excuse for the abuse of the confidentiality provisions of section 41-3-205, MCA, without application to the court for permission to disseminate the information.
Matter of Wyse, 41 St. Rptr. at 1786, 688 P.2d at 765. This admonition would apply equally to attorneys representing any of the individuals or parties discussed in this opinion.

The second question you have asked is whether the Department may disclose information to health professionals treating an abused or neglected child. The Montana statute is silent on this point. Research indicates that most state statutes expressly provide for dissemination to a physician treating a suspected victim of abuse or neglect. Our Legislature chose not to provide such an exemption from confidentiality. A doctor is included on interagency interdisciplinary child protective teams as described in section 41-3-108, MCA. These teams are allowed access to records for assessing needs, formulating a treatment plan, and monitoring the plan. § 41-3-205(2), MCA. However, in communication submitted with your opinion request you have indicated that in practice the doctor on the protective team is not always the treating doctor of the abused child.

Where a youth has been abused or neglected or is in danger of being abused or neglected the Department may petition for temporary investigative authority and protective care (commonly known as a TIA petition). See §§ 41-3-401, 41-3-402, MCA. After such a filing the court may direct the child or parents to undergo medical and psychological evaluation or counseling as part of an "order for immediate protection of youth." § 41-3-403(2), MCA. The TIA petition can be used as a vehicle to carry the Department's request for disclosure of confidential records. Upon petition by the Department the court could order disclosure of confidential case records to the examining health professionals as part of its order for immediate protection. Regardless of the confidentiality inherent in all doctor-patient relationships, the Department is barred by the terms of section 41-3-205, MCA, from physician disclosure absent a court order.

Your third question addresses disclosure to a noncustodial parent when the child has been removed from a custodial parent because of a substantiated incident of abuse or neglect. As the above discussion has indicated, the confidentiality statute contains no special exemptions. Where the Department determines that it is essential that a noncustodial parent receive confidential information, a petition for disclosure must be filed. This request could accompany a petition filed
Your final question asks whether the Department may inform the natural parents of a child who has been placed in foster care that the child has been abused by the foster parents. Section 41-3-205, MCA, prohibits such notification to the same extent it bars disclosure in other situations. The Department's duty lies primarily with providing protective services for the abused child, encouraging reports of abuse and neglect, ensuring the confidentiality of case records, and otherwise arranging for the youth's well-being. Nowhere in chapter 3 of Title 41 is the Department given a duty to notify natural parents of difficulties their children experience.

This primary duty to the abused child was highlighted in a recent appellate opinion of the Oregon Court of Appeals, Brasel v. Children's Services Division, 56 Or. App. 559, 642 P.2d 696 (1982). Brasel was a wrongful death action brought by the parents of an 18-month-old girl who died as a result of injuries suffered in a day care center certified by the Children's Services Division (CSD) of the State. The plaintiffs alleged that the defendant agency was negligent in failing to inform them of a prior incident of child abuse. CSD argued that it was forbidden to disclose the existence of the child abuse report by Oregon's confidentiality statute. The appellate court agreed:

[The confidentiality statute] forbids public access to reports and records of child abuse. We take it to forbid as well publication to prospective users of a certified day care facility the fact that a report involving the facility had been made. CSD's duty, in regard to reports of child abuse, is to investigate and to take appropriate action to protect the children; it is not authorized to advise parents of reports of child abuse. It follows that CSD had no duty to disclose the report.

Brasel v. Children's Services Division, 642 P.2d at 699-700. The Oregon confidentiality statute is similar in relevant part to section 41-3-205, MCA. Brasel is instructive because it highlights the Department's duty to the abused child and strictly construes the confidentiality statute. In Montana the Wyse decisions have similarly construed section 41-3-205, MCA. For
this reason the Department is prohibited from making disclosures of continuing abuse to parents and, under the reasoning of Brasel, may be protected from alleged negligence for such a refusal to disclose.

THEREFORE, IT IS MY OPINION:

Absent a court order, section 41-3-205, MCA, prohibits the Department of Social and Rehabilitation Services from disclosing case records and reports of child abuse and neglect to: (1) the natural parents or parent, or other person having legal custody of a child who is the subject of a dependency and neglect action filed under section 41-3-401, MCA; (2) health care professionals who are treating a child suspected of being abused or neglected; (3) the noncustodial parent of a child who has been removed from the custodial parent following an incident of abuse or neglect; and (4) the natural parents or parent, or other person having legal custody of a child who has been abused or neglected while in the care of foster parents.

Very truly yours,

MIKE GREELY
Attorney General