

# **Minnesota Legislative Task Force on Child Protection**

**December 4, 2023**



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# Department of Human Services

## October 2023 screening guidelines

Regardless of path (Family Assessment – Family Investigation), all child protection responses have things in common:

- Timeline to complete assessment (45 days) is the same.
- Risk and assessment tools are the same.
- Interview requirements are the same.
- Focus is on child safety and strengthening families to create child safety when/if possible.
- Child In Need of Protection or Services (CHIPS) petition can be filed from data in either path.
- Both paths are non-voluntary responses.



# DHS screening guidelines - County perspective

## Pathways

### Some facts on path assignment (Family Assessment – Family Investigation)

- Assignment determines timeliness of first contact.

Since statutory change to say that time of contact starts with receipt of report, it is nearly impossible for counties to meet the 24-hour deadline if all directed steps are taken.

- Path assignment can change.

A case in FA can move to FI if there is not cooperation or county learns that the original reported issue is more significant.



# DHS screening guidelines – County perspective

## Common misperceptions about pathways

***If FI path is chosen and child protective services are needed, a family must engage and accept services. This is not true.***

- Families may decline services (and often do).
- The only option may be to file a CHIPS petition – something determined by individual county attorney's offices.

***While there were changes made to the screening guidelines resulting from the Child Protection Legislative Task Force, there were not substantive changes to the CHIPS statute that would have counties filing more cases in court. This leads to counties conducting more FA but not necessarily doing more ongoing case management.***



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# DHS screening guidelines – County perspective

## Common misperceptions about pathways

***FA is chosen often because it is more cost effective.*** This is not true.

- It is not consistent with practice.
- FA requires the same tools, meetings, and assessments.
- If a family can be engaged, counties may spend more time with families, resulting in higher cost.



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# DHS screening guidelines - County perspective

## Pathways

**Minnesota's use of FA vs. FI is consistent with national data: 60% of substantiated child protection responses involve neglect only.**

- Neglect can lead to tragic ends.
- Definition of neglect varies state to state, making it difficult to compare generally.
- It is difficult to determine what types of neglect most often lead to tragedy.

***Poverty is the leading reason that families are reported into the child protection system:***

- ***Inadequate food/shelter***
- ***Inadequate supervision***
- ***Inadequate clothing***
- ***Educational neglect and truancy are often a result of inadequate resources***



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# Center for the Study of Social Policy findings

## Protective factors for families:

- Parental resilience
- Social connections
- Knowledge of parenting and child development
- Concrete supports in times of need
  - Food assistance
  - Specialized medical care
  - Legal services
  - Housing assistance
- Social and emotional competence of children

## Reliable predictors of child welfare involvement:

- Income loss
- Housing hardship
- Cumulative material hardship



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# DHS screening guidelines - County perspective final thoughts

## Role of bias in reporting and rigidity of screening guidelines

- Families of color and those living in poverty may be moved into FI when it should be FA.

These families tend to be reported on more. When counties are required to also look at screened out reports, there tends to be more volume of reports for these families; therefore, they are screened into FI.

These guidelines were moved into statute, which limits professional discretion.

# County perspectives on child welfare changes



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# Child welfare changes counties are eager to collaborate on

## **Increased funding and build-out of an infrastructure of services.**

- Family resource centers
- Robust parenting programs
- Expanding Parent Support Outreach Program (PSOP) to older kids
- Expanding current preventative programs to be used with older children
- Access to appropriate, timely chemical dependency treatment
- Embedding successful models, like Collaborative Safety, within counties



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# County perspective on child welfare changes

**Building a sustainable work force: the more experienced, diverse staff we have, the better we will be able to practice.**

- Incentives for people to pursue social work careers (and appropriate schooling)
- Partnerships with higher education to recruit candidates and promote career path
- Funding to reduce staff caseloads
- Embed self-care and second-hand trauma training in ongoing training

***Estimated national average turnover rate for child welfare workers was approximately 30%. A Casey Family Program report suggests that pre-pandemic, those rates were even higher. No organization can sustain that type of turnover.***



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# Child welfare changes counties are eager to collaborate on

**Technology investments: real time, accurate information and tracking will allow us to gather better data and show us where gaps and needs are.**

- Impact of multiple reports of the same incident
- Dated technology and SSIS limitations
- Reporter bias, stigma with racial/economic disparities

***Having better data may help us more thoroughly understand family situations. Poverty isn't cured by child protection – it is a bandage of an immediate issue. Incomplete data means that a family may be more likely to come back which does not address larger, more negative issues.***



# Child welfare changes counties are eager to collaborate on

## More funding for preventative care. We know it works.

- Chapin Hall research shows that families with screened-in reports who are sent to FA are more likely to receive concrete supports.
- Families with open child welfare cases who receive home-based services are less likely to experience a child maltreatment report.
- Children experiencing housing insecurity that receive supportive housing programs experience fewer removals, lower prevalence of substantiated maltreatment, and increased reunification.
- Access to affordable childcare decreases child welfare encounters.



# Some final data – national statistics

**Any child fatality is tragic.**

Minnesota's child fatality rates (per 100,000 children) are not abnormally high.

- National average is 2.46/100,000 – Minnesota is 1.67/100,000

	Minnesota	Wisconsin	Colorado	South Carolina
2017	24	31	35	28
2018	30	24	40	39
2019	17	34	25	60
2020	21	32	24	36
2021	22	22	31	41

(MN compared to states closest in population, child fatalities 2017-2021)



# Final thoughts

- It's difficult to make true comparisons based on data – each state records, reports differently.
- Data is only as good as its consistent gathering and documentation (MN and nationally).
- Need to look through collaborative safety lens.
- Recognize that majority of people in the system are doing the best they can.
- Accountability does not equate to blame.

***Minnesota counties stand committed to working collaboratively to create a stronger child welfare system with an eye on continuous improvement.***



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# Questions?

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