Recommendations to Legislative Task Force on Child Protection by Members of Governor's Child Protection Task Force

On September 28th, 2016, four members of the Governor's Task Force on the Protection of Children testified to the Legislative Task Force on Child protection regarding developments since the Governor's Task Force ended in March 2015. They were Dr. Mark Hudson, Medical Director of Midwest Children's Resource Center; Fairview Southdale Emergency Department physician Dr. Lisa Hollensteiner; Nicollet County Attorney Michelle Zehnder-Fischer; and Safe Passage for Children Executive Director Rich Gehrman.

The following are recommendations made by each testifier.

Dr. Lisa Hollensteiner

Transparency and Data Sharing

1. Program reports identified by the Governor's Task Force as basic to public transparency and accountability included in Recommendation #83 of the Final Report. The following are representative examples:
   a. Percent of child maltreatment reports screened in, by county
   b. Percent of cases are going to Family Assessment vs Investigation
   c. Number of cases of sexual abuse that were incorrectly assigned to FA
   d. Number of high risk cases closed with no services or court involvement
   e. Numbers of families with multiple reports and the resultant screening decisions

2. A process is underway to update child mortality review procedures. Provide information about this process including a timeline and opportunities for stakeholder input.

3. Implement a legislative review of data sharing practices among county child protection agencies, district courts, local law enforcement, and the correctional system to update practices and ensure that child safety gets priority.

Involve Members of Governor's Task Force in Implementing Recommendations

4. Include members of the Governor's Task Force in plans to implement its recommendations. No Task Force members have been included in implementation planning groups to date despite assurances that they would be.

Dr. Mark Hudson

Implement Key Practice Changes

5. Implement the major practices recommended by the Governor's Task Force that were rejected or not addressed in the final implementation plan produced by the Department of Human Services (DHS) and the Minnesota Association of County Social Services Administrators (MACSSA), including:
   a. Develop a common fact-finding protocol that all workers are trained to follow

b. End the practice of 'whole family interviews', i.e. interviewing children in the presence of their alleged abusers
c. Do fact finding before assigning cases to Family Assessment or investigation
d. Develop a single response system to make track assignment obsolete
e. Perform an outside expert review of screening
f. Put a report into the Social Services Information System (SSIS) for Family Assessments as well as investigation so there is a record of what was found

6. Develop a project plan and timeline that addresses these remaining issues.
7. Support the recommendations for clarifying definitions of Substantial Child Endangerment developed by Sen. Kathy Sheran.

Michelle Zehnder Fischer

Support the Existing Child Protection Program and Related Activities

8. Gather statewide data to determine current and estimated future workload for child protection and foster care workers, County Attorneys, and the courts.

9. Propose sufficient funds in the 2017 budget to provide for adequate staffing in these areas so front line workers have what they need to do the job we are asking them to do.

10. Increase foster care rates sufficiently to stop the exodus of foster care providers.

Rich Gehrman

Invest in a Prevention Agenda

11. Fund targeted home visiting, evidence-based parenting skills training, and early childhood opportunities for children in the system to reduce the number of families who need child protection services, and consequently reduce costs as well.

Racial Disparities

12. The Legislative Task Force or other appropriate body convene a public conversation to address racial disparities leading to a plan that is credible with communities of color.

Administrative Infrastructure

13. Provide DHS with the resources and authority it needs to carry out its oversight role of county child protection and foster care programs.
14. Provide the Department with the necessary IT resources to implement the above reports either with its own staff or by moving items higher on the MN.IT priority list.
15. Re-engineer SSIS to reduce administrative burden on staff.

Further explanation of these recommendations follows.

Transparency and Data Sharing

The Governor's Task Force recommended that data be made public in a number of areas to improve accountability and determine whether interventions are effective. To date only county performance relative to mandated federal standards has been posted to the DHS website.

Also, a state Child Mortality Review report has not been published since 2013. As a comparison, when there is a child fatality or near-fatality in Wisconsin, public notification is required within 2 days and a public summary report in 90 days. While there is reportedly a group working on this at DHS, no information has been shared about who is involved in that process, a timetable for completion of the work, or any draft recommendations.

Regarding data sharing, we cannot best protect children when CPS, the police, the courts, and the correction system do not have access to timely information about a child. For example a Family Court does not have automatic access to child protection reports, so they sometimes award custody to a parent who has findings of maltreatment such as sexual or physical abuse of their child. Also, when police respond to a call about a child they do not routinely have access to information about child protection history and safety plans. Child protection workers also need better access to alleged perpetrators' criminal records, including whether there is a restraining order or other limitation on that person's access to a child. In many of these practices concerns about data privacy currently trump the safety of the child. The testifiers encouraged the legislature to implement the Governor's Task Force recommended that it review these data sharing practices and make the necessary changes to protect children.

Include Members of Governor's Task Force in Next Steps

Despite reassurances that they would be included in developing implementation plans, and even though 150 other stakeholders were asked for their input into the final report, no members of the Governor's Task Force were included in this process. The testifiers indicated that they are eager to be a resource to the Department and MACSSA, are in a position to explain the intent of the recommendations, and also can serve as a check and balance to help ensure that the implementation planning groups are true to the recommendations.

Implement Key Practice Changes Recommended by Governor's Task Force

A major concern is that DHS and MACSSA indicated in their final report ("Minnesota's Best Practices for Family Assessment and Family Investigation", May 2016) that they do not intend to follow a number of Governor's Task Force recommendations. The rejected recommendations have the common theme of not finding information needed to ensure the safety of the child.

Also, some of the changes recommended by the Governor's Task Force were incorporated into statute while others were included in the Screening Guidelines developed by DHS. It is not known whether counties are all following the new requirements, which include doing collateral contacts, checking for past maltreatment reports in other counties, and implementing Multi-Disciplinary Teams (MDTs) that include local law enforcement and County Attorneys. DHS and MACSSA should provide an update on implementation of these practices.

Support the Existing Child Protection Program and Related Activities

Anecdotal information and data from a few counties indicates that there has been a sharp increase in the number of total child maltreatment reports, the percentage screened in to receive an investigation or Family Assessment, the number of cases opened for ongoing child protection services, and the number of children placed in foster care.

This indicates that the system needs more child protection workers, foster homes and Assistant County Attorneys. In addition, due to unintended consequences of the NorthStar legislation, many foster care homes are reportedly closing due to a *de facto* rate cut, particularly those that serve the highest needs children.

Invest in a Prevention Agenda

The state should invest in prevention and early intervention so fewer children experience maltreatment, and demands on the system are reduced. The recommended priority is to fund services with a record of reducing the actual incidence of child maltreatment, including quality child care placements, evidence-based parenting skills training, and targeted home visiting.

Disparities

Racial disparities in Minnesota's child protection system are more than two times the national average for African Americans, and four times for Native Americans. Past efforts to address this situation have not made significant progress on reducing this gap. A public conversation that includes representatives of communities of color is needed to address this issue effectively.

Administrative Infrastructure

Minnesota has relatively weak state oversight of county operations compared to similarly-organized states. This is partly due to a lack for funding of state positions to do training and quality assurance. The legislature addressed this issue in 2015 relative to screening child maltreatment calls by requiring that counties follow the screening guidelines developed by DHS. This requirement needs to be extended to other parts of the child protection and foster care service continuum, including guidelines for assigning screened in cases to investigative or family assessment track, ongoing open child protection cases, and foster care.

Overall, DHS does not have adequate IT resources to implement a number of recommendations from the Governor's Task Force. This includes programming the transparency- related reports described above. In addition, limitations in SSIS are hampering access to data from other counties, or workers' ability to identify repeat reports (for example see recommendations 7-9 in the Final Report). This is in part because of state policies whereby MN.IT sets priorities for operating departments.

Direct service workers in child protection reportedly spend 50% or more of their time entering data into the Social Services Information System (SSIS). In theory workers should be spending no more than 15% of their time in this type of activity. DHS should address this issue by hiring a reengineering consultant or engaging state staff who implement LEAN projects. This would at minimum identify easily implemented changes that reduce the amount of time workers spend on this administrative area. Every hour of time not spent on SSIS goes to direct service.