Implementation Planning Document – Updated Jan. 2018
Governor's Task Force on the Protection of Children

☒ = Recommendation implemented/completed
☐ = The Department is currently allocating funds, staffing and/or resources towards implementation

	Recommendation	Status Notes
1	Revise the Public Policy statement which begins Minnesota's Reporting of Maltreatment of Minors Act to include child safety as the paramount consideration for decision making.	• 2015 changes to M.S. 626.556, subd. 1(a) revised the public policy statement
2	The Minnesota Legislature should repeal the statutory provision barring consideration of screened out reports. The use of prior screened out reports when considering a new referral should be permitted and encouraged. The screening guidelines should be updated to reflect this change. It is recognized that prior history is an essential element in screening and assessing maltreatment reports. Records of screened out reports should be maintained for five years to make this change in practice effective.	• 2015: Legislature repealed the referenced statutory provision. M.S. 626.556, subd. 7(b) requires an agency to consider, when relevant, all previous reports, including screened out reports. • Changes are reflected in Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines
3	Make intake/screening decisions, whether a report is screened in or out, in consultation with a Multi-Disciplinary Team (MDT) or, minimally with a supervisor.	• Policy for MDT screening decisions is reflected in Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines • Version 17.3 of SSIS includes a screen for specifically documenting if screening decision was made by a team or an individual; and, if by an individual, the supervisor who was consulted and/or reviewed the screening decision
4	Review, revise and establish clear Child Protection Intake, Screening, and Track Assignment Guidelines a) Review and revise the Guidelines on an annual basis. The Guidelines should also include best practices for the treatment of reports from intake through track assignment. This process should include input from a cross-section of professionals involved with children and families, including law enforcement, mental health professionals and physicians. The screening review committee must seek significant input from counties, tribes and county attorneys. The reviewing committee, should at minimum, refer the Guidelines to the Minnesota County Attorney's Association for review and comment as county attorneys are responsible for providing legal advice to social services during the screening and assessment process. Collaboration up front will help reduce conflicting interpretation. b) Require counties and tribes to use the Minnesota Guidelines for receiving and screening reports of children maltreatment as a baseline. The Guidelines should not be modified without written authority from DHS. c) Rewrite the Guidelines to supplement references to Minnesota statutes with plain and understandable language.	• Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines were most recently updated in December 2017 and released in January 2018. The Guidelines are viewed and updated annually. • M.S. 626.556, subd. 7a requires agencies to follow the guidelines provided by the department and requires any modifications to be preapproved by the commissioner
5	DHS should provide additional guidance on screening as set forth below: a) Establish a required information standard for reports received at child protection services intake. This standard would specifically describe information that must be gathered, if obtainable, and documented in all cases. However, the inability of the reporter to provide this minimal	• Items a through e are included in Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines • 5 b) Work is currently being done with MN.IT to address specific documentation of referrals and services in SSIS; currently occurs in narrative format.

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information should not be decisive to whether a report is screened in. This information should minimally include: • Description of allegations • Child's injury/condition as a result of the alleged maltreatment • Information that the child may be of American Indian heritage • Description of the child's current location, functioning, special needs and vulnerability • Description of threats to child safety • Name, age, gender, race, ethnicity of all members of the household and their relationships to each other, address, phone numbers, places of employment, child's school, daycare, or child care • Presence of domestic violence • How the family may respond to intervention • Reporter's name, if given, relationship to the family, and source of information • Consideration of the safety of all children in the household and all children of the alleged offender, whether the offender's children reside in the household or elsewhere.	
b) Ensure county and tribal agencies are recording reports received, reports screened in, and reports screened out. This will permit future evaluation and use of prior screened out reports. It will also permit a true measure of the number of reports screened by county and tribal agencies. The documentation should also identify referrals to early intervention services and/or pertinent community services and resources.	
c) Consider additional nonexclusive examples in the guidelines of what may be considered when making screening decisions, even when the report is made by someone other than a police officer or health care provider, including but not limited to: • Reports of driving under the influence with children present • Medical neglect reports • Mental and emotional harm reports	
d) Provide additional guidance on criteria for screening in a report of child maltreatment to include: • A description of behavior or an action that a reasonable person would conclude may have resulted in maltreatment of a child • Injuries to or a condition of the child that a reasonable person would construe to be a result of maltreatment	

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	• Guidance on screening cases involving parental drug/alcohol use and factors for consideration including the age of the child, the type of drug involved, drug use in the home regardless of whether the children are present, prior services to the parent for chemical use concerns. • Educational neglect and truancy. The Guidelines must be amended to reflect that school absences are often the symptom or indicator of another problem such as mental health issues involving the child or within the family, chemical use of the child or within the family, physical or sexual abuse, and/or other expressions of neglect. e) Guidance as to limiting pathway response assignment to Differential Response where similar issues/concerns and/or the same family unit has received a previous child protection services response.	
6	Require the professional receiving and documenting the report of child maltreatment to be a child welfare professional with a minimum of a bachelor's level degree and someone who has completed training specific to child maltreatment intake provided by DHS. If a county lacks capacity and need based on minimum volume of maltreatment reports, the county could consider establishing multi-county collaborative models for screening and accepting reports of child maltreatment. The professional receiving and documenting the report should not be the only professional making the final screening or pathway decision on that report. In the absence of a team-based screening, the screening decisions must be confirmed by the Social Work Supervisor or the Social Work Supervisor's designee. Input from other professionals, such as law enforcement, mental health professionals and physicians can strengthen decisions and should be encouraged. DHS should work with counties to form models to implement a multi-disciplinary approach to screening. Screeners and/or supervisors should consult with the County Attorney's Office when there is ambiguity regarding whether a case should be screened in or out, and on all agency policies implementing screening decisions.	• Requiring the person receiving a report of child maltreatment to be a child welfare professional with a minimum of a bachelor's level degree would require a legislative change. Additionally, it would present an employment constraint in staffing such positions particularly in greater Minnesota. • Certification requirement including completing training specific to receipt of child maltreatment report is linked to recommendation #65B and our proposed plan and fiscal analysis for a MN Child Welfare Training Academy. • Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines provide guidance on screening decisions being made by a team • Version 17.3 of SSIS includes a screen for specifically documenting if screening decision was made by a team or an individual; and, if by an individual, the supervisor who was consulted and/or reviewed the screening decision
7	Screen new reports in as duplicate reports when they include the same allegations that are currently receiving a child protection response. When a new report is received that contains different allegations than what are currently being responded to, the new report will be screened and assigned based on the new allegations.	• Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines provide guidance on screening duplicate reports • Version 17.3 of SSIS includes ability to identify duplicate reports in SSIS.
8	Require local county and tribal child welfare agencies to take a report even if that county/tribal agency is not responsible for the screening of a particular report because of jurisdictional issues. This ensures the information is received and does	• Addressed in Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines • The ability for electronic transfer of child maltreatment reports between agencies was included in the most recent release of SSIS (Sept. 2018).

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	not require additional action by the reporter. The receiving county/tribal agency must then immediately refer the report to the jurisdictionally appropriate county/tribal agency of screening responsibility. The Social Service Information System (SSIS) system should be modified to create a drop down selection for "transfer" to reflect the protocol for the processing of these referrals.	
9	DHS should make Information Technology (IT) changes necessary to ensure accessibility across the state system to maltreatment reports, including narrative justification for screening decisions and other pertinent records across counties. These changes must allow screeners to gather information about prior or current social service involvement when evaluating a new report. It should include information about specific services offered/completed/refused/failed, as well as prior court involvement. The planning process to include tribal social service reports should begin as well.	• SSIS currently allows access to information from other local agencies. • MN.IT and DHS are currently working on enhancements to SSIS to improve documentation related to offerings of referrals to and delivery of services.
10	DHS should coordinate with the State Court Administrator to require reporting of Orders for Protection (OFP) and Harassment Restraining Orders (HRO) where a child was present, or dismissals of the same.	• The Domestic Violence Response Path Work Group has completed analysis of the issue and concluded that coordination should take place, however, the department does not have legal authority over the State Court Administrators Office. Therefore, the work group recommends that a smaller subgroup partner with the State Court Administrators Office to address relevant issues in order to further define a referral process. This smaller subgroup could also determine the time of a referral (ex. Ex parte, contested hearing) and how to communicate the referral process to judges and other court personnel."
11	DHS should further develop practice models to not close cases where an OFP or HRO has been filed due to the high number of dismissals of these actions shortly after filed and reunification of the victim and perpetrator.	• Information on under what circumstances case closure is appropriate when and OFP or HRO is in place are addressed in the Domestic Violence Child Maltreatment Response Path Best Practice Guide, released on Jan. 1, 2018.
12	Complete, at intake, a search of a family's pertinent Child Protective Services (CPS) and Child Welfare records as well as CPS records of any person named by report as a suspected offender. This should include, at minimum, a complete records review of the electronic Minnesota Public Access Court Records system. DHS should work with the Judicial Branch to ensure access to all relevant court records, not just those publically accessible, when it would be helpful to enhance child protection. Additionally, data practices must be amended to allow the agency access to Statewide Supervision System by the individual assigned to complete the child protection Traditional and/or Differential Response. DHS should work with the Department of Corrections to ensure access to all statewide supervision records for purposes of completing a child protection services response.	• Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines require a search of a family's pertinent CPS and Child Welfare records. However, further consultation with DOC is required re: CPS access to court records beyond publically accessible information, including the Statewide Supervision System. A literature review should be completed to determine criminogenic domains as predictors to child maltreatment and the likely disproportionate impact on African American and Native American children and families before access to such records and implementation of this recommendation.

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13	Send all reports of maltreatment to law enforcement, regardless of whether the report is screened in or screened out.	• M.S, 626.556, Subd. 10 requires cross-reporting of child maltreatment reports both orally and in writing. • Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines clearly describes the requirement to cross-report all reports; screened in and screened out
14	Amend the mandated reporter statute and screening guidelines to allow screeners to seek collateral information from mandated reporters when making a screening decision.	• M.S. 626.556, subd. 7 (b) authorizes agencies to communicate with treating professionals and other individuals when making screening decisions • Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines • Version 17.3 of SSIS includes a designated section for documentation of collateral contacts.
15	Clarify statutory provisions addressing the release of data to mandated reporters to state that child protection agencies must provide relevant private data of a child affected by the data to mandated reporters who made the report, except in limited cases where it is not in the best interest of the child. Further, county agencies should be encouraged to provide such communication to other mandated reporters who did not make the original report when that mandated reporter has an ongoing responsibility for the health, education, or welfare of a child and the information is pertinent to the mandated reporter's caring for a child.	• Addressed in M.S. 626.556, subd. 10j • Included in Minnesota's Best Practices for Family Assessment and Family Investigation
16	Amend Substantial Child Endangerment to include: a) Injury to the face, head, back, or abdomen of a child under the age of six and injury to the buttocks of a child under age three. Bruising to the buttocks of a child over age three does not preclude a traditional response. The Department, after consultation with counties, tribes and stakeholders, will develop and provide guidance for responding to allegations involving injuries to a child's buttocks to differentiate between "reasonable and moderate physical discipline of a child administered by a parent or legal guardian which does not result in an injury" and "physical injury inflicted by a person responsible for the child's care on a child other than by accidental means". The department will include this guidance as part of its 2016 reporting submission to the legislature in 2016. b) Neglect that substantially endangers the child's physical or mental health, including a growth delay, which may be referred to as failure to thrive, which is due to parental neglect. c) Withholding a medically indicated treatment from a child with a life threatening condition unless exempted in Minnesota Statute 260C.007 subd. 6 (5).	• The Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines address letters a), c) and e). • Letter b) has been incorporated into M.S. 626.556, Subd. 2(o) • Letter d) was included as a proposal in the department's 2017 policy bill, but was not passed. One of the charges of the Legislative Task Force is to "clarify the definition of Substantial Child Endangerment, and provide language in bill form by Jan. 1, 2017." The Task Force convened a subcommittee in summer 2016 and draft language was presented to the Task Force in late 2016 for discussion.

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	d) Abandonment of the child which is defined as occurring when a parent has no contact with their child on a regular basis and has not demonstrated consistent interest in the child'swell-being. e) Behavior that constitutes "a pattern of past child abuse", as referenced in Minn. Stat. § 609.223, subd. 2, which is defined as an act committed against a minor victim that constitutes a violation of the following laws of this state or any similar laws of the United States or any other state: section 609.221 (Assault 1); 609.222 (Assault 2); 609.223 (Assault 3); 609.224 (Assault 5); 609.2242 (Domestic Assault); 609.342 (Criminal Sexual Conduct 1); 609.343 (Criminal Sexual Conduct 2); 609.344 (Criminal Sexual Conduct 3); 609.345 (Criminal Sexual Conduct 4); 609.377 (Malicious Punishment); 609.378 (Neglect or Endangerment of a Child); or 609.713 (Terroristic Threats). Within the Guidelines, the references to criminal statutes must be included in plain language along with the statutory reference.	
17	Recommend referrals alleging domestic violence in the presence of children not immediately be included as Substantial Child Endangerment; however, a 24-hour response time for the first face-to-face contact with the alleged child subject is required to look into the following concerns so that appropriate track decisions can be made: a) There is reason to believe the child is intervening or will intervene, placing him or her at risk, or b) The child is likely to be injured during the violence (e.g. being held during the violence, physically restrained from leaving, or used asa shield, or c) The alleged offender dos not allow the protective parent and child access to basic needs impacting their health and safety, or d) The alleged perpetrator has killed, substantially harmed, or is making a believable threat to do so to anyone in the family, including extended family members and pets, or e) The child exhibits observable behavioral, emotional or psychological effects, or f) Serious injury to non-offending parent (e.g. broken bones, internal injuries, strangulation, etc.), or g) Violence is increasing in frequency and severity, or h) Weapons were used or threatened, or i) Threats of kidnapping, suicide, orhomicide.	• Domestic Violence Response Path Work Group's analysis: "The work group agrees that the agency would respond in some way in 24 hours of accepting a report for assessment or investigation, whether it be face-to-face contact with alleged victims and caregivers, or planning a well-coordinated response with agency partners, taking into account the safety of everyone involved. Specific protocols are documented in the best practice guide addressing activities to complete and consider within the first 24 hours." • The best practice guide developed by the work group was released Jan. 8, 2018.

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	DHS must develop and provide guidance for a Domestic Violence Child Protective Services Response Track as part of its response continuum.	
18	Amend the definition of medical neglect in Minnesota Statute 626.556, subd. 2(f)(7) to state that medical neglect does not need a diagnosis from a physician to be screened in. In addition, medical neglect should be broadened from medical neglect of an "infant" to medical neglect of a "child". The current definition is a cross-reference to the definition in Chapter 260C which is for cases in court and is too restrictive for the reporting and screening in statute.	• The Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines provide instruction that reports of medical neglect can come from medical personnel or others. • Regarding the broadening of the definition of "medical neglect", there are multiple types of medical neglect described in M.S. 626.556, Subd. 2 (now paragraph (g)) that appear to sufficiently include medical neglect of a "child" versus "infant".
19	Amend the statutory definition of "physical abuse" set forth in Minn. Stat. 626.556, subd. 2 (g), to delete the language "that are done in anger or without regard to the safety of the child." Instead, the statute should simply state that "Actions which are not reasonable and moderate include, but are not limited to, any of the following:" (1-10 which includes throwing, kicking, burning, cutting, etc.)	• Addressed by 2015 legislature: M.S. 626.556, subd. 2(k) • Included in Minnesota's Best Practices for Family Assessment and Family Investigation
20	Amend the definition of "Threatened injury" under Minnesota Statutes 626.556, subd. 2 (n) to include: a) Child who was exposed prenatally to chemical or alcohol use. This is measured by a child who tests positive for any chemical, including alcohol, that is not prescribed to the mother or any mother who tests positive any time during the pregnancy or delivery for a chemical, including alcohol, not prescribed to her; b) Domestic violence where a child is present in the home at the time of the alleged abuse; c) Exposing a child to someone whose parental rights were terminated or whose parental rights were transferred to another following the filing of an involuntary petition of termination of parental rights or an involuntary transfer of legal and physical custody to another, regardless of whether the termination or custody transfer was deemed voluntary orinvoluntary.	The Prenatal Exposure Child Welfare Work Group's analysis to 20 a): • "The work group does not support moving forward with a change in the definition of threatened injury proposed in task force recommendation 20. There is a current provision in Minn. Stat. 626.5561 requiring an appropriate assessment and offer of services when a pregnant woman is reported to be using controlled substances or alcohol. Revising the definition of threatened injury would include woman previously assessed while pregnant regardless of whether they accepted services while pregnant or gave birth to a child who was substance free. Essentially, changing the definition would broaden too far, including women who have already received and successfully completed services related to their substance use. The current screening guidelines have provisions for screening in reports when a newborn or woman tests positive for controlled substances or alcohol at the time of delivery. Further, the work group has made suggestions for improvements to the screening guidelines, which have already been implemented. The work group recommends focus on development of resources and services to address the needs of mothers, both prenatally and post-birth. See below for full recommendations." Additionally, the MN Best Practice Guide for Responding to Prenatal Exposure to Substance Use was released. • Domestic Violence Response Path Work Group's analysis to 20b): "The work group believes the current Intake, Screening and Response Path guidelines that local agencies are required to follow, addresses this issue. The guidelines outline when a child maltreatment report involving domestic violence meets the threshold of threatened injury or another type of alleged child maltreatment. The work group identified concerns with changing, and thereby

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		broadening, the statutory definition without further defining both "domestic violence" and "present in the home at the time." Concerns about using a broad definition of "present in the home" would only overwhelm the child protection system (CPS) by dramatically increasing CPS reports, similar to when statute was changed in 1999 and later repealed in 2000. It is important that the intervention of child protection be targeted to children and families where an intervention is going to increase safety. This means there needs to be targeted, versus overly broad interventions. This approach fails to acknowledge the leading protective factor for children who live in homes with domestic violence, which is the relationship between the child and the non-abusive parent. This approach penalizes the non-abusive parent, who is often taking action to protect children." • 20 c) In the process of review for implementation
21	Require efforts to notify the other parent of a Traditional (TR) or Differential Response (DR): a) If the DR or TR will not be compromised, the other parent should be notified at the same point as the custodial parent of the report and DR or TR. b) If the DR or TR will be compromised, the other parent should be notified as soon as possible once the threat of the interference with the DR or TR is removed. c) Notification should not occur in the event an OFP or HRO is in place unless the agency determines that the notification is in the best interests of the child. d) The other parent should be provided with notification of the TR or DR outcome including the services that are offered to the custodial parent and child. e) To obtain contact information for the other parent, the agency may utilize the information available through the child support enforcement unit to the extent not inconsistent with federal law. f) In no case shall the inability to locate or notify the other parent impair the agency's ability to respond to the maltreatment report.	• The Minnesota's Best Practices for Family Assessment and Family Investigation includes guidance on contacting non-custodial parents.
22	Amend the statutory definition of "Investigation" under 626.556 subd. 2 (b) and subd. 10 (a) (1) to clarify that investigation must be used, at a minimum, for all cases that involve substantial child endangerment or high risk allegations of harm, neglect, or injury to the child. Currently the statute is being misinterpreted to limit investigation to only cases involving substantial child endangerment. In addition, "Investigation" will be renamed as "Traditional Response".	• M.S. 626.556, subd. 2(e) clearly requires investigations when reports involve allegations of sexual abuse or substantial child endangerment The Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines provide additional direction on other reports that should be assigned for Family Investigation. • The department will review and determine necessary changes subsequent to the recodification of 626.556.
23	Change the statutory definition of reports to: "Report" means information given to the responsible agency or law enforcement which describes alleged child	• Changed in 2015: M.S. 626.556, subd. 2(m)

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	maltreatment and which includes enough information to identify the child victim and the child's caretaker or the alleged offender.	
24	DHS should work with counties, tribes and other stakeholders and experts to examine the possible development of a statewide child abuse and neglect reporting system creating one number with a system to route calls to the appropriate local child welfare agency. Local county and tribal child welfare agencies would be permitted to maintain practices for accepting reports of suspected maltreatment and the decision making authority on how to handle the reports would remain with counties. The statewide system should be able to route calls 24 hours per day, seven days per week, necessitating counties to have designees in place to accept calls outside of normal business hours. In designing this new system, the following items should be considered: a) Creation of a steering committee composed of state, county, and community stakeholders as well as individuals with telephone experience. b) Review of New York's and Colorado's statewide systems and outcomes to see if they have created greater quality in intake and screening leading to increased child safety. c) Promotion of one 24/7 statewide child abuse reporting hotline with calls routed to the appropriate county or tribe. d) Review for impact recording may have on a reporter's willingness to freely share critical information regarding a child and a family e) Exploration of a "cloud" system for interactive voice response, call data, call recording, and consideration for data practices implications. f) Accommodations for callers who do not speak English and accessibility for people who are deaf or have hearing impairments. g) A public awareness campaign to promote the statewide hotline and reporting of suspected child maltreatment. h) Central record-keeping and tracking of both "reports" and "inquiries". i) Process by which counties can opt to have DHS or another county to receive reports and inquiries on their behalf. j) Standardized training and certification for all staff prior to taking reports and inquiries. k) Consistency in information gathering. l) Adequate staffing and resources for counties and the state to implement the hotline, especially with anticipated increased reports with the visibility of a single state-wide number. m) Continuous quality improvement: listening to audio taped calls and providing training, feedback, coaching to workers and supervisors.	• The department developed an implementation proposal and fiscal analysis for a centralized intake/call center which was not included in the Governor's budget for the 2017 Legislative Session. This recommendation has not been fiscally supported to date.

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	n) System-side data collection. o) State hotline administration/unit, help desk functions and escape features from automated system to talk to a live person.	
25	DHS should, as part of redesign review, engage an independent reviewer with expertise in child protection services to review Minnesota's child maltreatment screening statutes, guidelines, and practice and make recommendations on needed changes to complete the shift to a system focused on the best interest of the child. The review should address and provide recommendations on the following: • Appropriateness of the rate of screened out reports and screened in reports and the resulting impact on child safety • Are the parameters reflected within the scope of Minnesota's child maltreatment screening statutes appropriately designed to ensure child safety • Are the parameters reflected within the scope of Minnesota's screening guidelines appropriately designed to ensure child safety • Is Minnesota's practice for receiving and screening reports of child maltreatment sufficiently assessing and responsive to child safety • Are there recommended strategies or system modifications that could better ensure uniformity in practice across the state.	• The Department is working with the Child Welfare Capacity Building Center for States for technical assistance on this recommendation. The Department chose this agency because there is not a cost to MN for their assistance.
26	Revise the guidelines to provide explicit guidance on reports related to older children. Presently, too many older children do not receive adequate protection or services. Often their avoidance response to abuse/neglect makes them particularly vulnerable: running away, joining a gang, using drugs and entering endangering relationships. More thorough assessment must be done and alternative living arrangements with statutory authorization should occur.	• The Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines include guidance on responding to reports involving older children/youth.
27	Review and change the focus of Chapter 260C of runaway/truancy CHIPS from punishing/addressing only the juvenile's problems to a whole family assessment to look to the reason for the behavior. Too often the running and truancy is the reaction to an underlying family problem that is not limited to the child's behavior or issues.	• In the absence of changes to M.S. 260C, the Minnesota Child Maltreatment Intake, Screening, and Response Path Guidelines address "Older Youth" and identifies the vulnerability of runaway youth as a child protection matter. The Legislative Task Force should review recommendation #27 to determine desired implementation activity and timeline. • Additionally, training about assessment, placement and case planning is planned for Children's Justice Initiative (CJI) teams in August/October 2017 in Judicial Districts 5 and 8. • The Department also issued DHS Bulletin 16-68-09 providing instruction for responding to youth who runaway from foster care practice guide. • In addition, the 2018 annual Minnesota Child Welfare Conference is focused on practice, policy and resource issues related to older youth in Minnesota's child welfare system.

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28	Complete, by the Reviser of Statutes, in collaboration with DHS and Ann Ahlstrom, Staff Attorney and Co-manager of Children's Justice Initiative (CJI), an organizational revision of Minnesota Statute 626.556 to alphabetize definitions, create internal consistency, eliminate redundant language, reorganize the statute into new statutes (i.e. separating institutional investigations from non-institutional investigations), and correct internal references and references to other statutes.	• This recommendation has been initiated by the Legislative Task Force in conjunction with the reviser.
29	Rename Family Assessment to Differential Response (DR) and Family Investigation to Traditional Response (TR). This renaming would be consistent with national practice and help avoid confusion when interpreting federal laws and regulations.	• Upon review, this recommendation does not appear to be of substantial significance in terms of child safety or child protection services practice. It should be reviewed by the Leg. Task Force to determine if it continues to be a priority recommendation. This recommendation would result in expenditures with minimal to no benefit to children and families. This can be reassessed at the point of recodification of 626.556.
30	Differential Response and Traditional Response are both involuntary child protection responses to reports of alleged child maltreatment. It is critical that either response provide a critical and methodical assessment of child safety while identifying key family strengths that can be built upon to mitigate safety and risk concerns. The goals of any child protection response should be to: • Make child safety paramount in a decision making • Assess and ensure the safety of any child involved • Conduct thorough fact finding to determine if a child has been harmed and/or if services are needed • Identify family strengths to mitigate risk factors and ensure child safety • Be culturally affirming • Coordinate and monitor services to families • Address effects of maltreatment through trauma-informed interventions • Promote child well-being and permanency • Increase positive outcomes (i.e., reduced re-reports, avoid subsequent harm).	• The Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines identify Family Investigations and Family Assessments as involuntary, serious child protection responses. The guidance provided between that document and the Minnesota's Best Practices for Family Assessment and Family Investigation address the pieces included in this recommendation.
31	Make child safety the focus of any child protection response. The statute should no longer identify Differential Response as the preferred method.	• This change was made to M.S. 626.556, Subd. 1 in the 2015 Legislative Session
32	Interview children individually first and prior to contact with parent/legal guardian whenever possible. In addition, DHS should research and implement training on best practices in regards to child interviewing protocols. These protocols would be developed in consultation with content experts, cultural advisors, counties and other key stakeholders. Specific practice guidance should be provided regarding audio recording of interviews, locations of child interviews, and interview techniques that are culturally responsive and trauma-informed. Child safety must be the primary guide as to when and how to structure interviews.	• As instructed by the recommendation, content experts, cultural advisors, counties and other key stakeholders worked together to create the Minnesota Best Practices for Family Assessment and Family Investigation September 2016 Department Guidelines. Their work was informed by a literature review completed by the University of Minnesota, Center for Advanced Studies in Child Welfare. The best practice identified in the Guide reflects the input of over one hundred stakeholders and a scholarly literature review. It is important to note that the MN Best Practices for Family Assessment and Family Investigation serve as advisory to local county and tribal child welfare agencies and are not mandated in the State of Minnesota.

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33	Ensure fact-finding occurs in all child protection responses. DHS should develop protocols to support thorough fact-finding. At minimum, information to be gathered should include gathering details from a variety of sources including the alleged victim(s), sibling(s), parent(s), and other relevant collateral contacts regarding: • Who, what, when, where and how regarding the reported allegation • Patterns of behavior that present risk to a child (i.e., recentness, frequency, duration, severity) • Harm (current and historical) and its respective impact it has on said child • Protective parental capacities (e.g., knowledge of parenting and child development; nurturing and attachment; parental resilience; social and emotional competence; concrete supports in times of need; and social connections) • Child vulnerability factors (e.g., age, disability, etc.) • Family and/or child(ren) strengths that promote resiliency • Context and times within the family when the child is safe as a starting point for additional safety planning or services. DHS should develop a required case summary form for Traditional Response and Differential Response cases in the Social Service Information System (SSIS) where results of fact-finding must be documented. This would include details surrounding the reported allegations and include a statement about whether or not the reported maltreatment incident occurred and identify the victim(s) and offender(s). Data from this case summary form will be gathered and tracked to identify county, tribal, and state trends.	• Portions of this recommendation have been completed via guidance provided in the Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines, Minnesota's Best Practices for Family Assessment and Family Investigation, and the Structured Decision Making (SDM) manual. • As a part of DHS' work with the Child Welfare Capacity Building Center for States (referenced throughout this document), we will be reviewing current use of SDM tools and whether other tools that facilitate decision making at critical points. • Additional attention and guidance to ensure fact-finding occurs in Family Assessment is needed and currently under review.
34	DHS to encourage and support the use of Multi-Disciplinary Team (MDT) decision making by developing the infrastructure to support the development of MDTs across the state. The MDT infrastructure would address: • Philosophy behind MDTs • MDT specific training • An evaluation component • Ongoing training for MDTs. Any and all statutes, policies, and/or practice guidance that discourage use of MDTs should be discontinued.	• DHS sponsored an MDT conference in 2016 • DHS completed an RFP soliciting consultants to work with local agencies on the development of MDTs and executed contracts.
35	Adopt stronger and more robust intake and screening tools for data gathering prior to pathway assignment to strengthen the quality of the information available.	• DHS is working with the Child Welfare Capacity Building Center for States for technical assistance on identifying tools that would promote more robust data gathering.
36	DHS should, as an interim measure, retain dual pathways for responding to reports of alleged child maltreatment. The dual pathways should include Traditional Response (Family Investigation) and Differential Response (Family	• Work is needed to build a decision making tree for track assignment and address other components of this recommendation.

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	Assessment). Explicit criteria for immediate assignment of High Risk and Low Risk allegations of child maltreatment must be defined: • High Risk (all Substantial Child Endangerment and can include other risk factors) – Traditional Response • Low Risk (Reports of alleged child maltreatment that are clearly low risk. These are reports that exclude all Substantial Child Endangerment and Moderate and High Risk. Additional criteria is necessary to ensure the proper parameters that clearly define a maltreatment report as low risk)- Differential Response • All other cases, which include those with moderate risk and those which are difficult to assign without additional information (excludes all Substantial Child Endangerment). These maltreatment referrals require fact-finding before track assignment can be made. DHS is to provide guidance on necessary fact finding inclusive of collateral contacts and face-to-face interviews with child subjects and parents or caregivers.	• Risk levels are not determined and fact-finding is not completed until the conclusion of the investigation or assessment process. Track assignment defines, in part, the approach to a child/family in response to a maltreatment report. Agencies make the best track decision possible with the information available in the initial report and from collateral sources contacted during the screening process. Once a response has been initiated, track-switching can occur; guidance for which has been provided in the Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines
37	DHS must develop, in consultation with counties, tribes, stakeholders and subject matter experts, a required information standard for making pathway response determination. This standard should reflect what is required and be implemented with a practice understanding that more information is better. Fact finding must occur until such time the pathway assignment required information standard is met. Fact finding efforts may include collateral contacts and "in-person" interviews with the child subject and the family.	• See response to #36 above. • Guidance of initial path assignment is included in the Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines
38	DHS shall, in consultation with counties, tribes, subject matter experts, and stakeholders, define clear and consistent pathway assignment criteria to either pathway including a definition for cases appropriate for Differential Response. Cases that clearly should follow pathway assignment into Traditional Response will be assigned within 24 hours, consistent with the substantial child endangerment statute. DHS should develop guidance regarding the timing for those cases that require initial fact finding. Criteria should also be provided for when path switching is or is not allowed and identify specific documentation requirements to support the decision. It is important to note that pathway determination should not extend any existing timeframes for the initial face-to-face contact with the alleged child victim. These criteria should be developed on or before December 31, 2015. In addition to existing statutes that define specific child protection responses for defined actions (i.e., Substantial Child Endangerment), other criteria for pathway assignment to be considered should minimally include:	• See response to #36 above. • Guidance of initial path assignment is included in the Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines

	Recommendation	Status Notes
	• Necessary fact finding before a track decision is made for those alleged maltreatment referrals believed to present moderate risk • Multiple differential response cases within a certain time period • The age of the child and other children in the home. The identified age should be based on clearly defined objectives which could include the risk for fatal, or near fatal injury, brain development, social isolation, or the child's ability to protect him/herself • Other vulnerabilities (child is developmentally delayed, pre-verbal, etc.) • The presence of unrelated adults in the household.	
39	DHS will monitor and evaluate initial pathway assignment and path changes using the established criteria and provide feedback to counties and tribes regarding the quality of decision making. A culture of continuous quality improvement should be supported and promoted. Results of pathway assignment should also be used for training and accountability.	• DHS currently conducts reviews to monitor initial pathway assignment and consults with local agencies regarding those decisions, targeting those in which an inappropriate initial track assignment was made and reports in which the alleged offender was a licensed or legally unlicensed provider assigned to Family Assessment. Plans to expand the review of track assignment to a broader array of cases are underway. Changes in SSIS version 17.3 have made the initial track assignment to investigation for all allegations containing Substantial Child Endangerment automatic.
40	DHS should immediately review, update, and validate all decision making tools with priority given to the safety assessment. In general, any tools used by DHS and counties are to have a clear purpose, to facilitate decision making at critical points in the child protection response, and that such tools are updated, and valid. In addition, that any tools adopted are culturally responsive and appropriate for families from different racial, ethnic, and socio-economic backgrounds. Overall, regarding all tools, DHS should clearly define: • What decision-making tools are to be used at key decision making points along the child protection continuum • The purpose for each decision making tool, and • How the specific tools are to guide decision making.	• DHS is working with the Child Welfare Capacity Building Center for States for technical assistance on identifying and reviewing tools that facilitate decision-making at critical points in the child protection continuum
41	Identify a validated safety assessment tool that better reflects dangerousness and child vulnerability factors. A safety assessment should address any factors proven to predict safety concerns. Some potential factors could include: • Recentness of abuse/neglect • Frequency • Severity • Child characteristics.	• DHS is working with the Child Welfare Capacity Building Center for States for technical assistance on identifying and reviewing tools that facilitate decision-making at critical points in the child protection continuum

	Recommendation	Status Notes
42	DHS should review research on protective factors and predictive analytics for how it can reduce or eliminate risk factors, and implement this information in trainings and practice. This would include use of screening and assessment instruments that have been validated. This should be done through a long-term contract arrangement to improve child safety outcomes over time.	• DHS is working with the Child Welfare Capacity Building Center for States for technical assistance on identifying and reviewing tools that facilitate decision-making at critical points in the child protection continuum
43	Require in statute a mandatory consultation with the county or tribal attorney to determine the appropriateness of filing a Child in Need of Protection or Services (CHIPS) petition in the event that a family does not engage in necessary services and child safety and/or risk issues have not been mitigated prior to closure of a child protection case, regardless of track.	• This was addressed by the 2015 legislature: M.S. 626.556, subd. 10m (b) requires consultation with the county attorney
44	Include in statute the requirement for a minimum of monthly face-to-face contact with children for cases in which a family is receiving protective services while the child(ren) remains in the home.	• While not currently in statute, Minnesota Administrative Rule provides direction around face-to-face visits with families who are receiving protective services when a child remains in the home. Minnesota Administrative Rule 9560.0228, subp. 4 states a child protection worker shall meet with the family monthly or have contact with the family monthly and ensure that a services provider meets with the family monthly. • This direction will be further supported through the development of an ongoing services best practice guide for families receiving in-home protective services to be fully developed in second quarter of 2019.
45	Traditional Response cases should result in the following determinations: maltreatment determined (yes or no) and are child protective services needed, (yes or no). For Differential Response cases the determination would include whether or not child protective services are needed. Documentation for DR cases will include a case summary form which will include a statement that will identify if the child experienced maltreatment. This data should be entered into SSIS so that they can be reviewed in future cases and so that summary data on a county-wide basis can be collected. DHS should provide guidance on criteria and best practice for making the determinations and require supervisory review and approval.	• No changes have been made to Minnesota statute to change the final determinations required in investigations and Family Assessment Response cases. Family Assessment Response cases require only one determination of whether child protective services are needed. However, under current Minnesota statute, child protection workers are required to document the outcome of the Family Assessment or Investigation, including a description of services provided and the removal or the reduction of risk to a child, if it existed. While the current statute doesn't specifically require a determination in Family Assessment Responses cases, it does require documentation of the agency's efforts in reducing or removing risk. Further analysis would need to be conducted to determine the legal ramifications of a change to Minnesota statute requiring documentation of whether maltreatment occurred in Family Assessment Response cases, including notifications, appeal rights and procedures. • In September 2016, the department issued Minnesota's Best Practices for Family Assessment and Family Investigation, which does outline practices around making final determinations.

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46	Complete trauma pre-screenings on any child during a child protection response. DHS should pilot a trauma pre-screen tool in 2015 and expand statewide in 2016. Implementation of trauma pre-screening should be consistent with research on best practices.	• In 2016-17, Wilder Research conducted a study to determine the validity of the trauma prescreen tool that had been developed by the Children's Research Center. The research was concluded and the department is awaiting the final report. However, the study did not validate the trauma prescreen tool as a trauma screening tool. The department has begun efforts with the Children's Mental Health Division to explore modification of another set of tools to meet this need.
47	DHS should, as part of a redesign review, engage an outside expert to work with the agency, counties, tribes and stakeholders to advise, develop and implement Minnesota's child protection response continuum. This evaluation should consider when and how pathway decisions should be made and whether Minnesota should move to a single child protection response, albeit one with different branches and approaches depending upon how to best meet the interests of child safety and welfare. Part of this review should consider the impact of any changes which result from the work of this Task Force.	• DHS is working with the Capacity Building Center for States for technical assistance developing and/or revising and implementing Minnesota's child protection response continuum.
48	DHS shall convene a workgroup for further analysis and definition of threats to child safety and risk of maltreatment as the foundation for development of a comprehensive long-term child protective services response continuum. This continuum must be designed for appropriate response alignment based on child safety and risk and may include multiple pathways, depending upon the best interests of the child. This response continuum design should be completed by January 1, 2017. The workgroup shall minimally include the representation from the following agencies/disciplines: • Minnesota DHS • Administrative and frontline County/Tribal Child Welfare Agency staff • Law Enforcement • County Attorney • Court • Defense Attorney • Guardian Ad Litem • Pediatrician • Child Development • Mental Health • Parent(s) • Child Welfare Focused Academic Institution • Child Safety/Risk Subject Matter Experts.	• DHS' work plan with the Child Welfare Capacity Building Center for States, referenced throughout this document, includes engagement of stakeholders.

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49	Coordinate services and financing across the system in the fields of mental health, chemical dependency, housing and other related areas within the State of Minnesota-Department of Human Services for children and families who need child protection case management services so as to prioritize services for interventions that would increase safety and reduce risk of future harm. This would promote more holistic and effective responses for children and families who have experienced trauma, abuse, neglect and/or other egregious harm to reduce recidivism into the child protection system	• A model for coordination of financing should be based on the preferred model for service coordination. • While this means that work on a model of coordination of funding will lag that of coordination of services, preliminary work can begin: o Development of basic analysis outline, including but not limited to identification of funds at the child and family level, and opportunities/barriers in technology and data practices requirements, o Identification of amount of resources needed. o Determination of whether any private funding streams might be leveraged or funds sought from the legislature. • Systems of care grant • The Department completed work on the Results First initiative to identify a compendium of effective services in a variety of program areas.
50	Make referrals for clinical, mental health and functional assessments on children, along with their families, who receive child protective case management services, who have trauma or mental health needs identified during screening. These assessments should be conducted by experts in the field. For example, if significant trauma to a child has occurred, a clinical trauma assessment with a qualified mental health professional should be required. For this recommendation to be effectively implemented, resources must be allocated to counties and community providers to improve the social and emotional well-being of children to heal from trauma, as well as reducing physical harm.	• This recommendation is closely linked to recommendation #46. The department is partnering with the Children's Mental Health (CMH) Division in hopes to develop a validated trauma screening tool and processes. This would assist child welfare workers in the referral process and specifically identify those children needing further assessment by a qualified mental health professional. • Networks of qualified mental health professionals have been in the process of development through the CMH Division. Professionals from across the state have been trained in trauma focused assessment and therapy from birth through age 18. • Further, child welfare workers have been required to complete a CMH screening on all children in out-of-home care and those receiving in-home case management services. These screenings assist the worker in identifying children who may need a further mental health assessment.
51	DHS should adopt a plan to monitor the provision of services and outcomes to assure that children and families receive appropriate, effective and needed services. This plan should include a periodic functional assessment of a child's well-being while in the child protection system and evaluate whether such services actually improved and benefitted children and their families.	• DHS has continuous quality improvement (CQI)/quality assurance (QA) processes in place to review adequate assessment of needs and provision of appropriate services. Redesign of the CQI processes are currently underway to better assess whether children and families receiving appropriate services.
52	DHS should model and provide leadership to reduce disparities by making progress with key staff and leaders within DHS to become more racially conscious and culturally competent in the delivery of child welfare services. DHS must be seen as an effective leader in this effort to ensure that policies and practices are assessed to enable decision making and oversight that does not perpetuate more racial, ethnic, and socioeconomic disparities.	• The Department's Children and Family Services (CFS) Area has hired a full time Equity Coordinator to work with CFS professionals to decrease bias driven by racial, ethnic, and socioeconomic status. • CFSR leadership has completed the Intercultural Development Inventory (IDI) designed to increase people's capacity to better understand culture and develop culturally responsive and appropriate strategies for engaging cultural differences.

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		• Additionally, the Child Safety and Permanency Division is working to focus upstream, prior to Child Protection involvement to link parents to mental health and chemical health services and other social determinates identified as predictive risks for Child Protection involvement.
53	Support the development of "cultural navigator" and parent mentor positions to act as liaisons with racial and ethnic communities, using a community health worker model. Ideally, this person would be from the same culture as the family being engaged and graduate from a rigorous training program with a certification, to ensure an understanding of the child welfare system. The role of this position would be to: • Help parents and the child welfare/child protection worker communicate more effectively. • Help parents understand, navigate and ultimately meet the requirements of the child protection and court system. • Facilitate connecting families with culturally relevant services.	• $1.5 million in grants to address disproportionality and disparities in the state's child welfare system were provided to the following organizations: o EVOLVE Adoption & Family Services: culturally appropriate support and education for parents o Indian Child Welfare Act Law Center: ICWA Family Advocacy Center o Lower Sioux Community and Southwest Health and Human Services: collaborative approach to decrease number of American Indian children in placement o Minneapolis American Indian Center: Bright Beginnings Recovery Support Project o NorthPoint Health & Wellness Center: Karegivers Family Project o Olmsted County Community Services: Project Hope, Opportunity, Pride and Empowerment o Ramsey County: Community liaisons from African American, Somali, Hmong, and Karen communities o Washington County: Disproportionality and IDI o White Earth Indian Child Welfare: Cultural Placement & Reentry Prevention Coordinator o YMCA-Duluth: Spring Valley Young Mothers' Supportive Housing Program • A new RFP will be issued in spring 2019.
54	DHS should identify and link previous and current disparities work to future intervention strategies aimed at racial equity and disparity reduction.	• ACET Inc. is the evaluator for the $1.5 million in disparity grants and findings from their analysis will be used to replicate and scale promising and best practice programming learned through the disparity grant endeavor.
55	Develop a certification program that would prepare students and current workers and supervisors to work in specific cultures through field placements/internships.	• The Child Welfare Training System is assessing the possibilities of delivering the "Intercultural Development Inventory" (IDI) to all new workers as a part of Foundation Training. This could provide the start for development of a certification program through the Child Welfare Training Academy if needed funds are allocated.
56	Promote and improve the representation of racial and ethnic communities' among child protection and child welfare ranks using recommendation #55.	• Ongoing
57	Develop culturally supportive services that assist children in transitioning home following an out of home placement as a means to prevent foster care re-entry.	• See Disparity Grants response in recommendation #53.

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	With additional funding, request for proposals (RFP's) could be submitted in support of this service.	
58	DHS should include representation from the African American community, tribal representation and other underrepresented groups in the development of policy guidance, and best practice strategies and protocols.	• Diverse representation was sought for each of the implementation workgroups convened to address implementation ofrecommendations. • Ongoing.
59	DHS should to provide clear policy and practice guidance about the need to include a tribal representative as part of a multi-disciplinary team whenever a case of a tribal child is reviewed.	• Inclusion of tribal representatives in addressed in the Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines Screening Guidelines and Minnesota's Best Practices for Family Assessment and Family Investigation,
60	Expand Initiative Tribes. This will: • Support tribes in their ability to provide the types of child welfare services they know to be culturally meaningful and effective with their children and families. • Improve county and tribal government relationships and establish methods to measure success in this area. • Improve child safety, permanency, and well-being outcomes forAmerican Indian children served by these programs. [1] • Recognize and actively support the sovereignty of Tribal Governments.	• In 2016, the legislature appropriate funds for a planning grant to expand the number of initiative tribes. • A Department proposal for implementation of expansion did not receive funding in the 2017 legislative session. • The Department has a current proposal of expansion of the Initiative for Mille Lacs and Red Lake tribes.
61	The state should directly fund more front-end services, including prevention and early intervention that have the capacity to promote safety, reduce risk and promote healing from abuse and neglect. This may include the direct funding of services for families involved in the child protection system and allow DHS to work creatively with providers to support the service array. This allows for more proactive service delivery by providing services to families before concerns reach higher risk warranting involuntary services and to also reduce re-occurrence into the child protection system.	• The Department has a fellow from Foster America working to research prevention and early intervention strategies and where linkages can be made with other public and community based organizations. The Fellow is charged with developing a design that can be implemented in Minnesota to assist children and families at risk of entering the Child Protection System.
62	Increase monitoring and evaluation: • Monitor and report disparities, as well as outcomes forAfrican American and American Indian children and families, using the Social Services Information System and review indicators	• See the responses for recommendations #53 & #54. • The Department is also now reporting on all state and federal performance measures on the Child Welfare Data Dashboard by race, and that disparities by race

[1] The American Indian Child Welfare Initiative is a collaboration between tribal, county and state governments with the shared goal of improving the child welfare outcomes for American Indian children, and reducing the disproportionate number of American Indian children in the state's child welfare system. Data reveals promising results. Tribal programs exceed statewide performance on federal child welfare outcomes measures in areas such as relative care and placement stability. Programs participate in the Minnesota Children and Family Service Reviews, federal Title IV-E audits and fiscal audits conducted by the department.

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	• Identify areas of underrepresentation and pilot methods to promote access for those populations who are not yet visible to the system • Work with the Human Services Performance Council to further develop new data reporting, gathering, and analysis methods, instruments and procedures to track county performance measures and accountability as it relates to demographic indicators for children. This information should be used to increase action steps to improve child welfare • Dedicate a section of future annual child welfare report to racial equity in which specific measures are followed through a lens of race and ethnicity • Use information and apply the outcomes to increase action steps to improve child welfare • Develop and use an external advisory committee including stakeholders and service recipients to assist in monitoring and evaluating outcomes.	are included throughout both the Child Maltreatment and Out-of-Home Care and Permanency Annual Reports.
63	Research, identify, develop curriculum and train on culturally affirming approaches and practices that work with African American and American Indian families, the two populations overrepresented in the child protection system. Also, trainings should include cultural and racial self-awareness, professional ethics, the difference between equal access and equity, and culturally appropriate ways to delivery services and work with families. Training should be provided to child welfare professionals and supervisors as well as other system stakeholders.	• See response to recommendation #55.
64	Identify services that can be replicated and scaled up and fund them with dollars to operate. These services should be evaluated and research used to build promising practices in order to provide a research base for interventions that are responsive to racial and cultural communities.	• See the responses for recommendations #53 & #54.
65	Enhance the Minnesota Child Welfare Training System: A. DHS should develop a Workforce Training and Oversight Advisory Group (comprised of state, county, tribal, communities of color and academic representatives) to advise DHS Child Welfare Training System to: 1) Develop, review and/or revise competencies for child protection workers and supervisors, 2) Identify workforce training needs and gaps, and 3) Consider development of a tiered child protection pre-service training program which would include: a) Online orientation training that child protection workers would be required to complete prior to case assignment. b) Tier I: Deliver basic theoretical and philosophical foundations upon which to build child protection specific knowledge and skills. This	• The Department views recommendation #65 as a top priority recommendation for immediate implementation because of the significant need for improvement to the MN Child Welfare Training System and the overall development, wellbeing, and stability of Minnesota's Child Welfare Workforce. This alone would improve the safety of Minnesota's most vulnerable children and improve outcomes for children and families. • The Professional Development Work Group developed a framework for a Child Protection Training Academy that included a tiered delivery system that addressed all components of this recommendation. • This recommendation requires legislative action and an appropriation.

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	would be required for all newly hired workers without social work degrees. c) Tier II: Deliver child protection specific knowledge and skills. This would be required for workers who complete Tier I and those hired with social work degrees. 4) Implement a Child Protection Training Academy that will include scenario-based training for child protection staff, supervisors, and managers. This training would replace the current Child Welfare Foundation Training currently required for new child protection workers. DHS should explore various modalities for delivering training, including online or Web-based training, to make training more accessible. The Academy should address the following topic areas: a) Intake b) Screening c) Differential Response d) Traditional Response e) Trauma-informed care f) Culture and biases g) Injury identification h) SSIS case documentation i) Minnesota rules and statutes. B. DHS should develop a certification process that includes completion of the training(s), structured on-the-job training activities, successful demonstration of applicable competencies and verification from the staff/supervisor's employment agency of completion of prescribed training and activities. C. Require all new child protection workers, supervisors and managers with child protection supervisory responsibilities to complete the training(s) and certification(s) specific to their job duties and responsibilities prior to or within 180 days of employment and as a condition of employment.	
66	Establish requirements for competency-based initial training and continuing education for new and existing child protection supervisors.	• See response to #65. • Requirements for child protection workers are outlined in M.S. 626.559 and 626.5591. These requirements have not been changed since the recommendations were issued; no proposals for changes have been brought forward. Without the additional funding and resources for the Child Welfare Training Academy, the resources to meet additional requirements for training are not available.
67	DHS should continue to support the IV-E educational programs available through Minnesota colleges and universities.	• DHS continues to support these programs via contracts with Minnesota colleges and universities for the IV-E Scholars program.
68	Expand the existing student loan forgiveness program in Minnesota to include Social Work graduates who are employed as child protection/child welfare social	• This recommendation is outside of the scope of DHS.

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	workers. The program will reduce debt encumbered while earning a social work degree in exchange for a social worker taking a child protection position for a minimum of two years post-graduation. A goal of the program should be that agencies are able to recruit and hire social workers with diverse backgrounds that match the population being served.	
69	Require local agencies, with the support of DHS, to develop and submit a comprehensive Secondary Traumatic Stress (STS) support plan which will support the workforce in the identification and treatment of STS.	• This recommendation will be addressed and implemented in coordination with the Child Welfare Training Academy which will focus on Workforce Wellbeing.
70	Require license mandated reporters to submit evidence of completion of mandated reporter training as a requirement for licensure/re-licensure, and develop a certificate of completion that can be printed upon completion of DHS online mandated reporter training.	• This recommendation is outside of the scope of DHS.
71	DHS should develop a variety of Web-based trainings for mandated reporters on multiple topic areas that expand beyond the specific responsibilities for reporting suspected child maltreatment, e.g. culture and bias.	• This is a recommendation that can be pursued through the Child Welfare Training Academy if/when funding and additional resources are appropriated. Current resources do not allow for the inclusion of non-child welfare staff. With the influx of new child protection staff, the Child Welfare Training System, with its current resources, was barely able to provide required training to those new staff in FY 2017; non-mandated training was put on hold until the start of the new fiscal year. Adding additional responsibilities to the training system without additional resources is not feasible.
72	Require child protection staff, supervisors and managers to participate annually in advanced training developed by DHS in collaboration with the workforce training and oversight advisory group as a condition of continued employment.	• See response to #65. • Since prior to the task force, M.S. 626.559, Subd. 1 has included the requirements for annual training for child protection workers. No proposals for changes to these requirements have been brought forward. Without the additional funding and resources for the Child Welfare Training Academy, the resources to meet additional requirements for training are not available.
73	DHS should, in collaboration with the workforce training and oversight advisory group, Department of Public Safety, the Department of Health and the Minnesota County Attorney's Association, develop curriculum that fosters a multi-disciplinary approach to responding to reports of child maltreatment. This training should be offered, minimally, on an annual basis to county/tribal child protection staff, law enforcement, medical professionals and county attorneys. DHS is encouraged to use the formerly provided TEAM Conference as a model for development.	• DHS sponsored a Multi-Disciplinary Team (MDT) conference in 2016. • Without additional funding, DHS does not have the resources to develop and offer the curricula referenced in this recommendation. • In 2017, the Department issued the "Sex Trafficked Children and Youth Investigative Protocols" that encouraged an MDT approach.
74	DHS should explore the fiscal implications of making Child Welfare Training System trainings available to stakeholders and community members.	• The Child Welfare Training System relies heavily on federal Title IV-E reimbursement for operations and delivery of training. Title IV-E provides reimbursement specifically for child welfare staff; inclusion of other professionals places that reimbursement at risk. Additional analysis is needed to determine the full impact.

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		• Current resources do not allow for the inclusion of non-child welfare staff. With the influx of new child protection staff, the Child Welfare Training System, with its current resources, was barely able to provide required training to those new staff in FY 2017; non-mandated training was put on hold until the start of the new fiscal year.
75	DHS, in consultation with the Minnesota Department of Health, should redesign the current child mortality review process to include two separate processes, one specifically for reviewing child fatalities and near fatalities due to maltreatment and/or suspected maltreatment; the other to review fatalities and near fatalities not due to maltreatment. a) Public Health Review Model: o Purpose: Review child fatalities and near fatalities related to accidents, suicides, SIDS, natural causes, and other fatalities and near fatalities not related to maltreatment o Focus: Developing and issuing community-based prevention messages o Process: Utilize the process currently being used to review all child fatalities and near fatalities in Minnesota. b) Child Protection Mortality Reviews: o Purpose: Review child fatalities and near fatalities due to child maltreatment, and those that occur in licensed facilities that are not due to natural causes o Focus: Critical examination of the elements of the case and the agency's involvement with the child and child's family. Review would also attend to the secondary-trauma involved with the worker, supervisor and agency. o Process: Develop a new process in which DHS mortality review staff lead and conduct the on-site local mortality review, and utilize child protection supervisors from other counties as peer reviewers in the process. The reviews would include developing a program improvement plan to address any practice issues identified through the review, and define technical assistance needs of the respective county. This would include developing a process for Mortality Reviews of Deaths and Near Death Reports by a multi-disciplinary committee inclusive of representation of MN DHS, local county/tribal child welfare agencies, county attorneys, physicians, and other child welfare stakeholders. The review process should expand the information currently provided to the public to include: a) The cause and circumstances regarding the child fatality or near fatality;	• In 2015, M.S. 256.01, Subd. 12a was enacted, requiring a DHS led review of cases involving child fatalities and near-fatalities due to maltreatment and those occurring in licensed facilities that are not due to natural causes. The 2015 legislature appropriate funds for three staff specifically to conduct reviews of cases involving child fatalities and near-fatalities due to maltreatment. • In 2016, DHS contracted and began working with Collaborative Safety, LLC, to develop a critical incident review process. That process has been implemented and is currently being utilized to review fatalities and near-fatalities. The review process is led by DHS child mortality review staff, utilizes child protection supervisors/managers/directors from county and tribal agencies as peer reviewers and includes engagement of professionals from various disciplines, including those specifically referenced in the recommendation.

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	b) The age and gender of the child; c) Information describing any previous reports of child abuse or neglect, whether screened in or not, that are pertinent to the abuse or neglect that led to the child fatality or near fatality; d) DHS should explore the Child Abuse and Prevention Act requirements for the possible inclusion of any previous reports involving all children in the household as public information; e) Information describing any previous investigations/assessments pertinent to the abuse or neglect that led to the child fatality or near fatality; f) The result of any such investigations/assessments; g) The services provided by the local child welfare agency and actions of the local child welfare agency on behalf of the child that are pertinent to the child abuse or neglect that led to the child fatality or near fatality; h) The review should look at the entire system from the point of the mandated reporter making a report through the case court process.	
76	DHS should continue with Minnesota Child and Family Service Reviews (MnCFSRs) in counties and tribes, and increase the frequency of reviews in counties with small populations of children.	• DHS is working with the Child Welfare Capacity Building Center for States to revision continuous quality improvement processes, with the goal of modifying existing and/or implementing new CQI processes that will result in the improved, sustainable outcomes for children and families served by the child welfare system across Minnesota.
77	DHS should identify outcome measures for child safety and child well-being. This data should be used to determine the effectiveness of interventions and system improvements	The following outcome measures currently exist: • Child & Family Service Review (CFSR) Safety, Permanency &Well-being Outcomes • Federal data indicators • Child Welfare Data Dashboard measures • Performance withhold measures • Human Service Performance Council measures
78	Address workload/caseload size issues: a) Short-term: Establish workload standards for child protection workers and supervisors as follows: o No more than 10 child protection case management cases per worker o Newly hired child protection workers will carry no more than three quarters of a caseload and will not carry high-risk cases until certification through the Child Protection Training Academy o Establish a supervisor-worker ration of 1:8. b) Long-term: DHS, in collaboration with the Workforce Training and Oversight Advisory Group, should: o Review methodologies for establishing caseload/workload standards that considers weighting of cases based on factors such as type of case, case	• The CSP Division requested funding in 2017 and 2018 to conduct a study of the child welfare workforce to measure both caseloads and workloads as there exists no current reliable method to measure caseloads of workers in Minnesota given the data available on workforce.

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	complexity, out-of-home placement, court involvement, etc. Following review, DHS recommends implementing caseload/workload standards. o Review and make recommendations for establishing an optimal supervisor to staff ratio. c) Enhance the workload analytic tool to make it user-friendly for local agencies and provide training on the use of the tool. d) Make enhancements to SSIS that allow for the gathering and review of caseload and workforce information that minimally allow for examination of caseload sizes, identification of education backgrounds of child protection staff and supervisors, and monitoring of completion of required training.	
79	DHS should continue to conduct the statewide review of screened-out reports which started in the fall of 2014. DHS should have the authority to require a child protection response from the local agency based on the screening review. Summary results of reviews should be public information and produced on an annual basis by DHS. Legislative oversight following publication of these reports is encouraged.	• Enacted in 2015, M.S. 626.556, Subd. 16 requires the department to conduct reviews of local agency screening practices and decisions and to produce an annual report of summary results of the reviews. Review of screening decisions has continued; starting with the 2015 report, summary information of results of those reviews is included in the Annual Child Maltreatment report.
80	Change and expand the role of the Minnesota Office of Ombudsperson for Families by: a) Renaming to "Minnesota Office of Ombudsperson for Children and Families"; b) Expand scope to include all Minnesota children and families (257.0762, Subd. 1); c) Include a specific reference to M.S. 626.556, Reporting of Maltreatment of Minors Act, to the statutorily defined duties of the Ombudsperson office (257.0762, Subd. 1); d) Require courts and social services to distribute information regarding the Minnesota Office of Ombudsperson for Children and Families in the following situations: o In the early stages of a child protection investigation or assessment (social service), and o When a Child in Need of Protection or Services (CHIPS) petition is filed (courts). e) Convene a committee/workgroup specifically for the purpose of exploring the expansion and placement of the Minnesota Office of Ombudsperson for Children and Families' role in oversight of child protection activities.	• The Legislative Task Force on Child Protection is charged with implementation of this recommendation per their charge "review of the roles and functions of the Office of Ombudsperson for Families."
81	Update the SSIS system so that data and reporting is accurate and trustworthy, and that the opportunities for effective case management and the efficient use of human resources are greatly improved.	• The department has obtained funding for a comprehensive review of SSIS and has completed the Advanced Planning Document for a Comprehensive Child Welfare Information System (CCWIS).

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82	DHS should develop/enhance the "Child Welfare Data Dashboard" to provide counties and the public with quarterly performance updates focused on key child safety, permanency and well-being measures. These measures should parallel the measures identified from the Human Services Performance Council. DHS should also publish quarterly scorecards for local county and tribal child welfare agencies by which the Department and the public can track progress and performance outcome improvements. The dashboard and scorecard should be designed in a manner that allows local child welfare agencies to drill down to client specific data.	• The Department has purchased Tableau and has developed internal and external facing dashboards. This has been a very large undertaking and has required significant funding and staffing expertise and resources. • The Child Welfare Data Dashboard has been changed to be updated on a monthly basis and includes on the third tab of the dashboard information on how local agencies are performing on all state and federal performance measures so far this year. The federal performance measures are not calculated in such a way as to be able to show performance on a quarterly basis and so quarterly score would not be easily calculated or derived. • Tableau server will allow drill-down for performance review on all performance measures available through the web-based application to local agencies. Currently, the Research and Evaluation Unit produces row-level lists on a monthly basis and makes them available to all local agencies upon request.
83	DHS should restructure the statewide annual child welfare report to focus on meaningful outcome measurements that are directed to measure whether interventions are effective and whether the screening process at the front-end is effective. As part of the annual child welfare report, DHS shall include the Child and Family Service Reviews. The annual report is to be made public and should contain the following sections and information: a) "Transparency" section with county breakdown of the following performance measures. When issuing the Transparency section, DHS may aggregate the data from counties with populations less than 10,000. Individual county social service departments and county boards may obtain the numbers for their individual counties i. number of intake calls received ii. number of reports screened out iii. number of child protection responses conducted and type of response pathway iv. number of reports that resulted in a determination of substantiated child maltreatment v. number of reports that resulted in a determination that child protective services were needed vi. percentage of children seen within required timelines for both response pathways vii. percentage of children who return home within 12 months of removal viii. number of children who were exposed prenatally to chemical or alcohol use as measured by a child who tested positive for alcohol or any chemical that	Section a): • The 2016 Annual Child Maltreatment Report (not yet published) includes a breakdown by agency of the following data included in this recommendation: o i, ii, iii, iv, v, and xvi. o Note regarding xvi: The report includes a breakdown of cases with "high risk" being closed without services. Including information regarding court involvement is not possible because SSIS does not contain court data, and SSIS and the court's data system do not have a link between them. • The Child Welfare Data Dashboard includes a breakdown by agency of the following data included in this recommendation (this data is updated monthly): o vi, vii, ix, and xv. o Note regarding ix: The Dashboard includes a "Maltreatment recurrence" measure that indicates, of children who were determined victims of maltreatment during the previous year, the percentage who were victims of another determined maltreatment report within 12 months of the first report. Family Assessments are not included in this measure because no determination of maltreatment is made in a Family Assessment. The "Maltreatment re-reporting" measure described below includes Family Assessment and Family Investigation. • "xii" asks for the number/percentage of cases reopened after being closed. Cases do not get reopened after they have been closed. The Dashboard includes a "Maltreatment re-reporting" measure that identifies the percentage

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	is not prescribed to the mother or any mother who tests positive any time during the pregnancy or delivery for alcohol or a chemical not prescribed to her. ix. percentage of children who experience repeat abuse/neglect o within 6 months of a maltreatment finding or Differential Response o within 12 months of a maltreatment finding or Differential Response x. percentage of children in the aggregate and by age who exit foster care and re-enter foster care within 12 months. The data should be further broken down to show what percent of children are corrections related and what percentage of children are child protective services related xi. child protection worker caseload numbers and turnover rates (including supervisor and line-staff numbers) xii. number/percentage of cases that are reopened after being closed xiii. number of cases of sexual abuse that were assigned the differential response track with a breakdown per county and identification of the role of the alleged offender, e.g. parent, foster parent, daycare, etc… xiv. number of cases of sexual abuse that switched tracks from Traditional Response to Differential Response with a breakdown per county and identification of the role of the alleged offender (e.g. parent, foster parent, daycare, etc.) xv. identify federal measures and standards that DHS is not meeting xvi. number of traditional response and differential response cases closing at "high risk" with no services or court involvement broken down per county. b) Number of children and/families with three or more reports within the past five years that were screened out with the following details: • Nature of allegations • Age of the child subject • Role of person making the report • Screening decision and justification • Break out number of prior reports.	of children who had a screened in maltreatment report in the previous year, and another screened in report within the subsequent 12 months. We believe this is meeting the intent of the recommendation. • DHS has a quality assurance process to identify those cases described in "xiii". When those cases are identified, local agencies are contacted by DHS quality assurance staff and instructed to switch to a Family Investigation track. • The remaining data elements referenced are either not possible to report, even aggregately, due to small numbers and/or the data isn't available. Section b): • There is a pull out box in the 2016 Child Maltreatment report that provides this data to the best of our ability.
84	DHS should, by January 2016, provide a report to the Legislature that describes: • Progress on implementation of Task Force recommendations • The key drivers that result in children/families entering the system. • Plans for longer term child welfare reforms, including those recommended by the Task Force.	• Completed
85	DHS should develop a public website for the purpose of posting information on child fatalities that is classified as public by the Child Abuse, Prevention and Treatment Act (CAPTA).	• Counsel for the Department has determined that due to Minnesota's data privacy laws, developing and posting to a website is not possible.

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		• DHS, with representatives from the Minnesota Association of County Social Services Administrators (MACSSA) and the Minnesota County Attorney's Association (MCAA) developed a process that will result in more timely and consistent responses to requests for public disclosure of information related to child fatalities and near-fatalities.
86	Use of the following criteria by the Legislature when considering additional resources: • Target funds to children and families in the child protection system while supporting state-wide consistency in provision of services • Make available a full array of intervention services to support the needs of children and their families • Address gaps related to disparities and use information generated to create practice change, scale-up promising practices, and inform future investments • Support a family strengths-based approach and access to other services; accelerating access to these other services for children in child protection. • Direct funding and fiscal incentives toward outcomes at child level • Support technology for better data reporting, sharing, transparency, and outcome monitoring • Improve balance among federal, state and local shares • Support innovation, particularly regarding addressing disparities and disproportionality in the child welfare system • No supplantation of existing resources with the addition of new resources. • Reward effective child protection practices and services.	• Out of the scope of the Department.
87	Increase funding for county staffing to carry out additional case work responsibilities (e.g., county child protection workers, county child protection supervisors and county child protection case aides.)	• Please see response to #78.
88	Provide additional funding for additional intervention services necessary to support children and families as a result of changes in screening, assessment, etc. that address needs of children and families earlier in the process of a child protection response to prevent recidivism into the child protection system.	• Please see response to #78.
89	Provide additional funding for accelerated access to services including but not limited to: • Child care, • Head Start/Early Head Start • Home visiting for children • Transitional housing and shelter, and • Psychiatric/mental health services.	• This requires a legislative appropriation.

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	The goal is to remove children in the child protection system from waiting lists in these programs.	
90	Allocate competitive grants to identify, develop, adapt and scale-up culturally affirming promising practices (e.g., mental health services, mentoring, etc.) or programs that address disparities and disproportionality in the child welfare system. Dollars should be allocated to evaluate results and apply learning to transform the child protection system to be more effective. Funding preference should be given to non-profit and grass-root community organizations that are led by or already serve communities of color, ethnic and tribal communities and low income communities.	• See responses to recommendations #53 & #54.
91	Increase funding for state oversight, including monitoring, training, child fatality reviews, grant management, quality assurance, etc.	• Department received funding for oversight and monitoring of intake, screening and development and implementation of child fatality reviews in 2015. • Additional funding is needed for state oversight and quality assurance.
92	Increase funding for intake and screening tools to promote more robust data gathering during the intake and screening process.	• DHS is working with the Child Welfare Capacity Building Center for States for technical assistance on identifying tools that would promote more robust data gathering. In that process, there may be future requests for funding from the legislature.
93	DHS should, absent sufficient funding, prioritize all recommendations to develop a multi-year implementation plan.	• Prioritization and implementation planning for all recommendations is an ongoing multi-year collaborative stakeholder endeavor led by the Legislative Task Force on Child Protection, Minnesota Department of Human Services, and local county/tribal child welfare agencies. • Stakeholder implementation groups have developed implementation plans and the Child Safety and Permanency Division have developed corresponding proposals and fiscal analysis for the following recommendations, none of which have received necessary funding to date: o #24 statewide child abuse and neglect reporting system. o #60 expand Initiative Tribes o #65, #71 & #72 enhance MN Child Welfare Training System, web-based trainings, and advanced training o #78 & #87 address workload / caseload size issues o #89 additional funding: child care, head start/early head start, home visiting…