# Governor's Task Force on the Protection of Children

## Initial Recommendations

## December 2014

**Preamble**

Minnesota's child protection system has moved from one end of a spectrum to another since 1999. Prior to 2000, it was very focused on forensic investigations, working in concert with law enforcement and often at odds with communities and families. There was not enough client engagement and too few efforts to strengthen families. Fast forward to our system today when family engagement is our primary focus, paramount in all we do. At times this focus is at odds with protecting children.

We need to stop and readjust the pendulum. We need to recognize there is a continuum of approaches and services that are necessary and appropriate. To best protect children, we need all available tools and the discretion to use them. We need investigatory tools and quick access to courts when necessary to keep children safe. We need improved coordination with law enforcement throughout the state. And, we need to better support parents in culturally appropriate ways, whenever we can do so while also keeping children safe.

But with discretion comes the opportunity for misinterpretation and misuse, so increasing transparency in the child welfare system is critical. So are more effective audits and case reviews to ensure that the guidelines in place are being followed, and that reports to law enforcement and follow-up with mandated reporters are a priority. The Minnesota Department of Human Services (DHS) needs to step up its efforts in these areas and become a center of excellence in child protection; a resource for county and tribal agencies that continue to focus on the difficult frontline work of child safety and well-being.

Readjustment of the pendulum must be public. That is best signaled by revising the public policy statement which begins Minnesota's Reporting of Maltreatment of Minors Act. At the core this Act must better emphasize child safety and the best interests of children as the paramount consideration for decision making. The Act should also recognize that children and their families are best served by interventions that engage their protective capacities. In order to do so, the child protection system must be equipped to provide culturally competent services aimed to reduce the racial and cultural disparities, which permeate the system. Public policy, statutes, guidelines and training should be reexamined through this lens as well. One aspect of the Act's redirection would delete a "preference" for a family assessment track following a screened in report. If Minnesota maintains a two track system, the track selected should reflect the best interests of a child, with a critical focus on safety. Finally, the Reporting of Maltreatment of Minors Act should parallel Chapter 260C of the Minnesota Statutes that govern child protection actions to create a common framework for decision making.

To implement this redirection, we recommend the following initial recommendations:

**Screening Decisions**

The current statutes and screening guidelines need to be revised to better reflect protection of children. Decisions regarding whether to "screen in" maltreatment reports should be made by more than one individual, and based on all available evidence. To this end:

1) In January 2015, DHS should seek legislative repeal of the statutory provision barring consideration of screened out reports. Such immediate action is necessary to guide screening decisions, and should not be delayed while more complicated systemic changes move through the legislative process.

   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.

2) 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.

3) Make screening decisions in a team-based environment, using a multi-disciplinary approach whenever possible. Input from law enforcement can strengthen decisions and should be encouraged. At a minimum, decisions should be reviewed by a supervisor. 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.

4) Screen in new reports as duplicate reports when they include the same allegations that are currently under assessment or investigation. When a new report is received that contains different allegations than what are currently being assessed or investigated, the new report will be screened and assigned based on the new allegations.

5) Send all reports of maltreatment to law enforcement, regardless of whether the report is screened in or screened out.

6) DHS should examine and provide stronger direction on how county and tribal agencies are recording reports received, reports screened in, and reports screened out, so that future evaluation and use of prior screened out reports is possible.

7) Amend the mandated reporter statute and screening guidelines to allow screeners to seek collateral information when making a screening decision. As is, the statute is silent regarding this prohibition, but in 2012 the guidelines were amended to prohibit any

collateral information from being collected prior to a report being screened in and assigned for family assessment or family investigation.

8) DHS should make Information Technology (IT) changes necessary to ensure accessibility across the system to maltreatment reports, including justification for screening decisions and other pertinent records across counties. The planning process to include tribal social service reports should begin as well.

   These changes would allow screeners to gather information about prior or current social service involvement when evaluating a new report. At a minimum, this would include information from other counties. Also, SSIS would include information about prior reports, services offered/completed/refused/failed, as well as prior court involvement.

9) Clarify the statutory provisions addressing the release of data to mandated reporters to state that child protection agencies must provide relevant private data to mandated reporters who made the report, who have an ongoing responsibility for the health, education or welfare of a child affected by the data, except in limited cases where it is not in the best interest of the child. Further, county agencies are 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.

   The Task Force will review the Minnesota Government Data Practices Act to determine if it needs to be amended so that it is consistent with Minn. Stat. §626.556.

10) Require county agencies to use screening guidelines, at least as a floor for decision making, and have increased reviews and quality assurance to provide oversight. Any modifications to the screening guidelines must be approved by DHS.

    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.

11) DHS screening guidelines should provide more examples of what may be considered when making screening decisions, even when they are 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.

12) 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.)*

A recommendation regarding the future of a two-track child protection system is still under review. If there continues to be two tracks, the Task Force will provide further recommendations regarding when and how track decisions should be made. Regardless of the decision about family assessment, there is agreement that the definition of substantial child endangerment must be broadened. The Task Force recommends:

13) Broaden the statutory definition of "substantial child endangerment," which requires a child protection investigation response. It is recommended that DHS create additional substantial child endangerment criteria on research-based vulnerability factors such as: child's age, vulnerability, and presenting dangerousness of a report.

**Transparency**

14) Increase consistency and comprehensive reporting by county agencies to DHS. More specific details will be provided in the final report.

15) Support changes to the child mortality review process in terms of public information accessibility and conformance with federal requirements. More specific details will be provided in the final report.

16) Refine the annual Child Welfare report to include a section that identifies themes in data and where the child protection system is improving, as well as identifying potential areas of concern.

**Family Assessment**

As noted in the preamble, family assessment currently is the preferred response to child protection reports. Family assessment means a comprehensive assessment of child safety, risk of subsequent maltreatment, and family strengths and needs that is applied to a child maltreatment report that does not allege substantial child endangerment. Family assessment does not include a determination as to whether child maltreatment occurred but does determine the need for services to address the safety of family members and the risk of subsequent maltreatment.

Since the implementation of family assessment in the early 2000s, its use and application has grown exponentially. Currently, more than 70 percent of all screened in reports are assigned to family assessment. This has included high risk maltreatment allegations, sexual abuse

allegations, and cases that meet the definition of substantial child endangerment. It is clear that Minnesota's use of family assessment is beyond that of other states and beyond what the statute allows. The use of family assessment continues to rise despite the fact that the re-report rate for family assessment has been higher than family investigation in five of the last seven years. This practice is of concern and must be addressed.

Differential Response (DR) is a child protective services practice that allows for more than one method of initial response to reports of child abuse and neglect. It has been reported that Differential Response (DR) is a critical tool in the assessment of and provision of services to children that have experienced abuse and neglect. Definitions and approaches vary from state to state. In Minnesota, the DR system consists of Family Assessment and Family Investigation. The lack of a finding of maltreatment, and the family friendly, strength-based approach are two of the reported advantages of the family assessment response. A panel of family assessment workers indicated the strengths of family assessment to be that it more quickly enables parents to engage in safety and case planning, and allows faster implementation of needed services. In some cases, the lack of a change in workers from an assessment to case management provides increased continuity with a family, and clarity on the presenting child safety concerns.

Research on DR either describes the effectiveness of the approach or the flaws within the model. Dr. Ronald Hughes identifies many concerns with DR. These concerns include there is no consistent model, it forgoes fact-finding, and it is not an evidence-based program. Despite his findings, Dr. Hughes has indicated that DR can work as an effective child protection response in a limited number of cases if it includes a comprehensive assessment of past history and current abuse dynamics, it accepts judicial oversight when needed, and that the intervention and corresponding services are provided with or without parent engagement.

In reviewing Governor Dayton's executive order convening the Task Force for the Protection of Children, the Task Force must address whether the protocols for family assessment are adequate and adhered to. It is clear that there is wide variation across the state, with 87 county agencies potentially practicing family assessment differently. Improved protocols that define the family assessment model are needed as well as clear and consistent guidance by DHS.

Changes to statutes, policy, and practice are needed to further define and enhance the family assessment model so that it effectively provides for child safety. The recommendations are:

17) Make child safety the focus of any assessment or investigation. The statute should no longer identify family assessment as the preferred method.

18) Require child protection staff to consult with the county attorney on the legal basis to file a CHIPS petition if services and recommendations are not followed. Today, undergoing either family investigation or family assessment is mandatory. However, accepting services is voluntary.

Moreover, clear standards must be developed and practice guidance provided on how best to provide enforceability when services are mandated. In practice, there appears to be a gap between when child protective services are needed and the threshold for filing a CHIPS petition. This will be addressed further in the final report.

19) Place in statute the requirement that county child protection staff consult with the county attorney about whether to file a CHIPS petition prior to closing a family assessment when child protective services are not providing sufficient protection for a child, or a parent is not cooperating with needed child protective services without going back through the investigation process. While DHS states that a CHIPS case can be brought following completion of a family assessment under current law, there is confusion around this, which needs clarification and training.

20) Include comprehensive "fact finding" in family investigation and family assessment. It is also recommended that DHS research "fact finding" tools from other states (e.g., Ohio). Further definition of "fact finding" is needed and will be expanded on in the final report.

21) Evaluate child safety through individual contact with a child. Similar to a family investigation, a family assessment should involve meeting with a child(ren) individually to best assess safety. This individual meeting may occur with or without parental notification. This recommendation will be further defined in the final report.

22) 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) remain in the home.

23) It is recommended that referrals be made for child trauma and child development screenings when there is a maltreatment determination and/or a determination that services are needed. Family assessment and family investigation responses should pay particular attention to the trauma impact of child maltreatment and its effects on healthy childhood cognitive, emotional and physical development. Further recommendations about the timing of screenings or assessments will be expanded on in the final report. This recommendation must also give consideration to available resources, including the individuals qualified to complete the screening and/or assessment, and the infrastructure needed to support this recommendation.

24) DHS should develop indicators and outcome measures to inform practice and measure effectiveness of service delivery. These should include child-centric measures that address trauma and child development, as well as systemic issues.

25) 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 guidance.

26) Review and analyze the current Structured Decision Making (SDM). This analysis should be done to assess and assure fidelity to the tools. In addition, it is recommended that the Safety Assessment be updated to better reflect dangerousness factors, coupled with child vulnerability factors. DHS should be directed to change SDM tools as best practices change or emerge. Tools should be developed and updated to reduce racial and cultural bias. Changes to the tools should result in re-validation of the tools, and should be reviewed by the Legislature.

27) DHS should explore and develop comprehensive screening and track assignment tools to guide decision making.

28) Use multi-disciplinary teams in family assessment response. The workgroup will provide further recommendations on the use of multi-disciplinary teams in the final report.

**Adequacy of Resources**

The Task Force also reviewed and discussed the current and past levels of financial resources available to support county implementation of child welfare services to children and families. The review included looking at national trends, Minnesota's statewide trends, and individual county variances in availability of child welfare resources.

A recent national comparison through 2012 by Child Trends (footnote 1) indicated that total U.S. child welfare spending decreased for the first time since it began surveying states in 1996, and that total federal spending was at its lowest level since 1998. While most states have experienced decreases, there is wide variation in expenditure changes. The combined state/local share of funding has increased, however, and there is tremendous variation in state reliance on particular funding streams.

In reviewing Minnesota's trends, it is noted that there has been a significant reduction of $41.8 million in annual funding from all sources of revenue when comparing 2013 to funding levels available to county agencies for child welfare activities back in 2002 (See Appendix C). While residential services and case management services continue to be the counties' predominant expenditure categories, most categories have seen significant expenditure reductions, while significant increases have occurred for the assessment and prevention category.

County-specific reviews indicate that 2013 per capita spending by counties on children's services varies widely from $92 to $647, with a statewide average of $303. Fifty- three counties reduced expenditures from 2002 to 2013, while 31 increased expenditures for children's services over that time. Sample 2013 profiles of county expenditures for various children's services also show wide variation among counties in the types of services and supports they provide to children and their families. Overall, local property tax funding covers about half of all child welfare expenditures in Minnesota. Revenue for children's services available through county agencies includes 54% county, 27% federal, and 15% state.

While the Task Force needs to continue to develop its recommendations on resources for the final report, the baseline information verifies that funding for child welfare overall has decreased over the past decade.

**Training and Supervision**

The quality of state training and oversight of local agency practice is a critical factor in supporting a high performing child welfare system. DHS must support on-going development of front-line staff and supervisors by providing training that is accessible and research-based. To accomplish this, the following recommendations should be considered:

29) Establish requirements for competency-based initial training, support, and continuing education for child protection supervisors. This would include developing a set of competencies specific to child protection supervisor knowledge, skills and attitudes based on the Minnesota Child Welfare Practice Model.

30) DHS should increase its efforts to monitor county social service agencies' compliance with statute, and to conduct reviews and quality assurance as part of its oversight responsibilities.

31) Develop new training for child protection workers and supervisors specifically related to the following topic areas, including, but not limited to:

    a. Screening
    b. Family assessment
    c. Family investigation
    d. Injury identification
    e. Cultural competency.

    These topics are included in the Child Welfare Foundation Training; however, additional training focused on developing and applying day-to-day skills, and access to specific training on these topics beyond the first six months of employment is needed. Additionally, DHS is encouraged to explore various modalities for delivering training, including online or Web-based training, to make these trainings more accessible.

32) Provide multi-disciplinary training on the appropriate techniques for child abuse assessment and investigation, to minimally include child protection and law enforcement professionals.

The Training and Supervision workgroup continues to gather and consider information for making additional recommendations specific to provision of training and support to child protection front-line and supervisory staff, and state oversight of local agency practice. Some of the topic areas that continue to be explored are listed below.

- Workforce issues, including social work licensure, student loan forgiveness programs for social work students, and recruitment and retention of qualified staff.
- Training adequacy of and for mandated reporters.
- Oversight issues, including statutory authority for state oversight, Child Mortality Reviews, Child and Family Services Reviews, use of Citizen Review Panels, possibility of additional oversight reviews, DHS random review of screening decisions, DHS Rapid Consultation and Support system, and DHS' plan for monthly review of various child protection data elements.

**Conclusion**

The above initial recommendations are critical steps in refocusing priorities of the child protection system. The focus must be child safety. The vision statement of the Task Force encompasses this realignment:

> *Minnesota Children and Families: Safe, Supported and Strong. The vision of the Task Force is to put children first; to ensure they remain safe and protected, and they develop to their full potential. We envision a system committed to the strengthening of families and communities.*

In the course of this work there also must be an emphasis on the disparities that exist in the child protection system and how to address racial and cultural bias from a policy, practice and resource perspective. The safety and well-being of Minnesota children depends on the cultural competency of the entire system.

Governor Dayton's executive order charged the Task Force with making initial recommendations by December 31, 2014 and final recommendations by March 31, 2015. Much work remains for the Task Force, including defining and refining of the initial recommendations. This will be the focus of the Task Force's work moving into 2015. Critical attention must be given to the adequacy of resources to support these recommendations, and recommendations yet to come. In addition, the transparency recommendations will be instrumental to ensuring ongoing accountability, as well as restoring public trust in what is too often an opaque system.

**Appendix A**

## ***DEFINITIONS: RELATIVE TO CHILD PROTECTION INVESTIGATIONS AND ASSESSMENTS***

Screening Guidelines – Provide direction to county social service agencies; to promote statewide consistency in definition and practice; and to inform the general public about types of child safety concerns that should be reported. These guidelines are based on Minnesota Statute (M.S.) 626.556, Reporting of Maltreatment of Minors Act.

Family Assessment – The fact finding period between the time a maltreatment report is screened in for assessment and a determination of whether ongoing child protective services are needed.

Family Investigation – The fact finding period between the time a maltreatment report is screened in for investigation and a determination of whether maltreatment occurred and whether child protective services are needed.

Child Protection Case Management Services – Services that are provided to a family following a determination of maltreatment or need for services from a family investigation or the need for services following a family assessment.

Child Welfare Case Management Services – Services that are provided to a family on a voluntary basis either based upon a referral or a request for services from a family.

Risk Assessment - A tool used to identify families with high, moderate or low probabilities of future child abuse or neglect; provides an objective appraisal of the likelihood that a family will maltreat their children in the next 18 to 24 months. **Looks at the likelihood of future maltreatment to occur, it is a classification** (completed at the end of the assessment phase and every 90 days of a case and informs case disposition decisions)

Safety Assessment – A tool used to help assess whether a child is likely to be in immediate danger of serious harm and may require protective intervention; helps determine what intervention should be maintained or initiated to provide appropriate protection. **Assesses the child's present danger and determines the interventions immediately needed to protect the child.** (completed early in assessment/investigation, every 90 days, and when there is a substantial change in circumstances)

CHIPS – A child in need of protection or services action filed under Chapter 260C.

TPR – Termination of parental rights.

PSOP – Parent Support Outreach Project – voluntary services offered to a family often initiated after a child protection report is made to social services that does not meet screening criteria, but where the family could benefit from the receipt of services.

Substantial child endangerment – the following includes the statutory definitions with an attempt to include some plain language clarification reflected in italics. This is not intended to be a full recitation of the statute.

The following constitutes substantial child endangerment: Acts or omissions committed or attempted to be committed against a child by a person responsible for a child's care, and in the case of sexual abuse includes a person who has a significant relationship to the child as defined in section 609.341, or a person in a position of authority as defined in section 609.341:

(1) egregious harm (Minn. Stat. § 260C.007, subd. 14): *infliction of bodily harm or neglect to a child which demonstrates a grossly inadequate ability to provide minimally adequate parental care. It specifically includes several of the crimes already listed under the definition of substantial child endangerment*;

(2) sexual abuse;

(3) abandonment (Minn. Stat. § 260C.301, subd. 2): *no contact by parent on a regular basis and no demonstration of consistent interest in the child for 6 months; or if under 2 years of age, the parent deserted the child under circumstances that show an intent not to return*;

(4) neglect that substantially endangers the child's physical or mental health, including a growth delay, which may be referred to as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(5) murder in the first, second, or third degree (Minn. Stat. § 609.185, 609.19, or 609.195);

(6) manslaughter in the first or second degree (Minn. Stat. § 609.20, 609.205);

(7) assault in the first, second, or third degree (Minn. Stat. § 609.221, 609.222, or 609.223) *which includes assaults with a dangerous weapon **or** a thresh hold of harm to include temporary but substantial loss of use or impairment of a bodily member, disfigurement, or a broken bone*;

(8) solicitation, inducement, and promotion of prostitution (Minn. Stat. § 609.322);

(9) criminal sexual conduct under sections 609.342 to 609.3451;

(10) solicitation of children to engage in sexual conduct (Minn. Stat. § 609.352);

(11) malicious punishment or neglect or endangerment of a child (Minn. Stat. § 609.377 or 609.378);

(12) use of a minor in sexual performance (Minn. Stat. § 617.246); or

(13) parental behavior, status, or condition which mandates that the county attorney file a termination of parental rights petition (Minn. Stat. § 260C.503, subd. 2). *This includes cases where the parent has involuntarily lost custody of another child in a child protection action, committed prior acts of egregious harm, sexual abuse against the child, or abandoned an infant.*

## Appendix B – Recommendation Implications

***All recommendation implications will be updated when final recommendations are issued in March 2015.***

### Screening

| | Recommendation | The recommendation has implications for: | | | | | |
|---|---|---|---|---|---|---|---|
| | | **Statute** | **Practice** | **Training** | **SSIS** | **DHS Fiscal** | **County Fiscal** |
| 1. | In January 2015, DHS should seek legislative repeal of the statutory provision barring consideration of screened out reports. Such immediate action is necessary to guide screening decisions, and should not be delayed while more complicated systemic changes move through the legislative process.<br><br>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. | X | X | X | X | | |
| 2. | 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 | X | | | | | |
| 3. | Make screening decisions in a team-based environment, using a multi-disciplinary approach whenever possible. Input from law enforcement can strengthen decisions and should be encouraged. At a minimum, decisions should be reviewed by a supervisor. Screeners and/or supervisors should consult with the County Attorney's Office when there is ambiguity regarding whether a case should be screened in/out. | | X | X | | | X |
| 4. | Screen in new reports as duplicate reports when they include the same allegations that are currently under assessment or investigation. When a new report is received that contains different allegations than what is currently being assessed or investigated, the new report will be screened and assigned based on the new allegation. | | X | X | X | | |
| 5. | Send all reports of maltreatment to law enforcement, regardless of whether the report is screened in or screened out. | X | X | X | | | |
| 6. | DHS should examine and provide stronger direction on how county and tribal agencies are recording reports received, reports screened in, and reports screened out, so that future evaluation and use of prior screened out reports is possible. | | X | X | X | | |

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| | | **Statute** | **Practice** | **Training** | **SSIS** | **DHS Fiscal** | **County Fiscal** |
| 7. | Amend the mandated reporter statute and screening guidelines to allow screeners to seek collateral information when making a screening decision. As is, the statute is silent regarding this prohibition, but in 2012 the guidelines were amended to prohibit any collateral information from being collected prior to a report being screened in and assigned for family assessment or family investigation. | X | X | X | | | X |
| 8. | DHS should make Information Technology (IT) changes necessary to ensure accessibility across the system to maltreatment reports, including justification for screening decisions and other pertinent records across counties. The planning process to include tribal social service reports should begin as well.<br><br>These changes would allow screeners to gather information about prior or current social service involvement when evaluating a new report. At a minimum, this would include information from other counties. Also, SSIS would include information about prior reports, services offered/completed/refused/failed, as well as prior court involvement. | | X | X | X | X | X |
| 9. | Clarify the statutory provisions addressing the release of data to mandated reporters to state that child protection agencies must provide relevant private data to mandated reporters who made the report, who have an ongoing responsibility for the health, education or welfare of a child affected by the data, except in limited cases where it is not in the best interest of the child. Further, county agencies are encouraged to provide such communication back 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.<br><br>The Task Force will review the Minnesota Government Data Practices Act to determine if it needs to be amended so that it is consistent with Minn. Stat. 626.556 | X | X | X | | | |

## Appendix B – Recommendation Implications

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| | | **Statute** | **Practice** | **Training** | **SSIS** | **DHS Fiscal** | **County Fiscal** |
| 10. | Require county agencies to use screening guidelines, at least as a floor for decision making, and have increased reviews and quality assurance to provide oversight. Reasons for screening out cases should be documented. Any modifications to the screening guidelines must be approved by DHS.<br><br>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. | X | X | X | | X | X |
| 11. | DHS screening guidelines should provide more examples of what may be considered when making screening decisions, even when they are made by someone other than a police officer or health care provider, including but not limited to:<br>• Reports of driving under the influence with children present<br>• Medical neglect reports<br>• Mental and emotional harm reports. | | X | X | | | X |
| 12. | 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.)* | X | X | X | | | |
| 13. | Broaden the statutory definition of "substantial child endangerment," which requires a child protection investigation response. It is recommended that DHS create additional substantial child endangerment criteria on research-based vulnerability factors such as: child's age, vulnerability, and presenting dangerousness of a report. | X | X | X | X | X | X |

## Transparency

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| | | **Statute** | **Practice** | **Training** | **SSIS** | **DHS Fiscal** | **County Fiscal** |
| 14. | Increase consistency and comprehensive reporting by county agencies to DHS. More specific details will be provided in the final report. | | | | X | X | X |
| 15. | Support changes to the child mortality review process in terms of public information accessibility and conformance with federal requirements. More specific details will be provided in the final report. | X | X | X | | X | X |
| 16. | Refine the annual Child Welfare report to include a section that identifies themes in data and where the child protection system is improving, as well as identifying potential areas of concern | | | | | X | |

## Family Assessment

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 17. | Make child safety the focus of any assessment or investigation. Statute should no longer identify family assessment as the preferred method | X | X | X | | | |
| 18. | Require child protection staff to consult with the county attorney on the legal basis to file a CHIPS petition if services and recommendations are not followed. Today, undergoing either family investigation or family assessment is mandatory. However, accepting services is voluntary.<br><br>Moreover, clear standards must be developed and practice guidance provided on how best to provide enforceability when services are mandated. In practice, there appears to be a gap between when child protective services are needed and the threshold for filing a CHIPS petition. This will be addressed further in the final report. | X | X | X | | | X |
| 19. | Place in statute the requirement that county child protection staff consult with the county attorney about whether to file a CHIPS petition prior to closing a family assessment when child protective services are not providing sufficient protection for a child, or a parent is not cooperating with needed child protective services without going back through the investigation process. While DHS states that a CHIPS case can be brought following completion of a family assessment under current law, there is confusion around this, which needs clarification and training. | X | X | X | | | X |

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| | | **Statute** | **Practice** | **Training** | **SSIS** | **DHS Fiscal** | **County Fiscal** |
| 20. | Include comprehensive "fact finding" in family investigation and family assessment. It is also recommended that DHS research "fact finding" tools from other states (e.g., Ohio). Further definition of "fact finding" is needed and will be expanded on in the final report. | | X | X | | | |
| 21. | Evaluate child safety through individual contact with a child. Similar to a family investigation, a family assessment should involve meeting with a child(ren) individually to best assess safety. This individual meeting may occur with or without parental notification. This recommendation will be further defined in the final report. | X | X | X | | | |
| 22. | 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) remain in the home. | X | X | X | | | X |
| 23. | Make referrals for child trauma and child development screenings where there is a maltreatment determination and/or a determination that services are needed. Family assessment and family investigation responses should pay particular attention to the trauma impact of child maltreatment and its effects on healthy childhood cognitive, emotional and physical development. Further recommendations about the timing of screenings or assessments will be expanded on in the final report. This recommendation must also give consideration to available resources, including the individuals qualified to complete the screening and/or assessment, and the infrastructure needed to support this recommendation. | | X | X | X | X | X |
| 24. | DHS should develop indicators and outcome measures to inform practice and measure effectiveness of service delivery. These should include child-centric measures that address trauma and child development, as well as systemic issues. | | X | X | X | X | |
| 25. | 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 guidance. | | X | X | | X | |

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|---|---|---|---|---|---|---|---|
| | | **Statute** | **Practice** | **Training** | **SSIS** | **DHS Fiscal** | **County Fiscal** |
| 26. | Review and analyze the current Structured Decision Making (SDM). This analysis should be done to assess and assure fidelity to the tools. In addition, it is recommended that the Safety Assessment be updated to better reflect dangerousness factors, coupled with child vulnerability factors. DHS should be directed to change SDM tools as best practices change or emerge. Tools should be developed and updated to reduce racial and cultural bias. Changes to the tools should result in re-validation of the tools, and should be reviewed by the Legislature. | | X | X | X | X | |
| 27. | DHS should explore and develop comprehensive screening and track assignment tools to guide decision making. | | X | X | X | X | |
| 28. | Use multi-disciplinary teams in family assessment response. The workgroup will provide further recommendations on the use of multi-disciplinary teams in the final report. | | X | X | | | X |

**Training and Supervision**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 29. | Establish requirements for competency-based initial training, support, and continuing education for child protection supervisors. This would include developing a set of competencies specific to child protection supervisor knowledge, skills and attitudes based on the Minnesota Child Welfare Practice Model. | X | | X | | X | X |
| 30. | DHS should increase its efforts to monitor county social service agencies' compliance with statute, and to conduct reviews and quality assurance as part of its oversight responsibilities. | X | | | | X | X |
| 31. | Develop new training for child protection workers and supervisors specifically related to the following topic areas, including, but not limited to:<br>a. Screening<br>b. Family assessment<br>c. Family investigation<br>d. Injury identification<br>e. Cultural competency. | | | | | X | X |
| 32. | Provide multi-disciplinary training on the appropriate techniques for child abuse assessment and investigation, to minimally include child protection and law enforcement professionals. | | X | X | | X | X |

## Resources Information

The above recommendations cannot be achieved without a critical examination of funding of the child welfare/child protection system. The following information provides some context from a national perspective as well as Minnesota's profile.

### Background: National Picture

Quoted from the Child Trends' survey of all states in the *Federal, State, and Local Spending to Address Child Abuse and Neglect in SFY 2012* report, issued September 2014.

- Total U.S. child welfare spending decreased for the first time since the survey began (SFY 1996)
- All federal funding sources declined since SFY 2010, and total federal spending was at its lowest level since SFY 1998.
- Most states experienced decreases, but wide variation in expenditure changes exist between SFY 2010 and SFY 2012
- The federal share of total child welfare expenditures decreased since SFY 2010, while the combined state/local share increased
- States showed tremendous variation in reliance on particular funding streams.

### Background: Minnesota

**Expenditures**

- In calendar year 2002, Minnesota counties spent $429,302,984 from all sources of funding on children's services. (CY 2002 is chosen as a base starting year for review since it was prior to significant reductions in state appropriations as a result of recent recessions and state budget deficits.) By CY 2013, counties spent $387,469,364 on children's services. This is a reduction of $41,833,620.
- The statewide percentage profile between 2002 and 2013 has changed very little across the larger categories of children's services, with residential and case management services being the predominant expenditure categories. However, each of these categories has seen significant expenditure reductions while significant increases have occurred for the assessment and prevention category.

| Children's Service Category | CY 2002 Expend. | CY 2002 % | CY 2013 Expend. | CY 2013 % | Difference over Time |
|---|---|---|---|---|---|
| Remedial Residential | $167,262,963 | 39% | $137,237,284 | 35% | ($30,025,679) |
| Case Mgt/Resource Devel | $155,283,610 | 36% | $135,436,209 | 35% | ($19,847,401) |
| Assessment and Prevention | $38,729,225 | 9% | $60,730,463 | 16% | $22,001,238 |
| Remedial Outpatient | $37,165,717 | 9% | $26,500,324 | 7% | ($10,665,393) |
| Supportive | $19,195,334 | 4% | $17,086,534 | 4% | ($2,108,800) |
| Facilitative | $11,666,135 | 3% | $10,478,550 | 3% | ($1,187,585) |
| **Total** | $429,302,984 | 100% | $387,469,364 | 100% | ($41,833,620) |

- Calendar year 2013 per capita spending by counties on children's services ranged from $92 to $647, with a statewide average of $303.
- Fifty-three counties reduced expenditures from CY 2002 to CY 2013, while 31 increased expenditures for children's services.
- Sample CY 2013 profiles of county expenditures for various children's services shows wide variation among counties. (Tier 1 county having a large population. Tier 6 county having a small population.)

| Children's Service Category | Tier 1 County % | Tier 2 County % | Tier 3 County % | Tier 4 County % | Tier 5 County % | Tier 6 County % |
|---|---|---|---|---|---|---|
| Remedial Residential | 29% | 36%% | 26% | 18% | 21% | 40% |
| Case Mgt/Resource Devel | 33% | 40%% | 48% | 50% | 42% | 24% |
| Assessment and Prevention | 15% | 13% | 18% | 17% | 17% | 23% |
| Remedial Outpatient | 7% | 9% | 4% | 9% | 18% | 12% |
| Supportive | 12% | 0% | 0% | 2% | 1% | 0% |
| Facilitative | 4% | 1% | 3% | 3% | 2% | 1% |

Note: Definitions for the above categories are taken from Budgeting, Reporting and Accounting for Social Services (BRASS) that identify:

- Manual of Services and Definitions for the Minnesota Standard Social Service Classification Structure
- Social Service Information System (SSIS) use of BRASS codes as basis for tracking county social service activity.

**Revenues**

- Minnesota counties use local dollars, dedicated state dollars where available, and portion of state and federal block grants (Vulnerable Children and Adults Act/Title XX Social Services Block Grant) for administration and services across the child welfare continuum, as needed.
- Primary state resources cover state payments for adoption assistance, payments to counties to cover costs of Relative Custody Assistance, and formula-driven

allocations to counties under the Vulnerable Children and Adults Act. [Minn. Stat. 256M].

- Federal funds primarily cover the federal share of Title IV-E adoption assistance maintenance costs, Title IV-E foster care maintenance costs, and Title IV-E eligible county administrative activities. Federal formula-driven allocations for the Title XX block grant are a component of the allocations to counties under the Vulnerable Children and Adults Act.
- Local property tax funding covers about half of all child welfare expenditures.

| **Children's Services Revenue Sources (2013 SEAGR Data)** | **Revenue for Children's Services Available Through Counties** | | **Revenue for Children's Services, including DHS Centralized Payments** | |
|---|---|---|---|---|
| **Source of Revenue** | Amount | Percent | Amount | Percent |
| County | $208,823,068 | 54% | $209,952,554 | 45% |
| Federal | $103,939,036 | 27% | $134,695,945 | 29% |
| State | $56,350,689 | 15% | $100,205,741 | 22% |
| Miscellaneous | $18,356,571 | 5% | $18,356,571 | 4% |

**Appendix C**