Governor's Task Force on the Protection of Children

Final Report and Recommendations

March 2015

TABLE OF CONTENTS

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.

As we noted in our initial recommendations, Minnesota needs to stop and readjust the pendulum. The question is how to do so. Very quickly, the debate then turns to whether to continue with a two track system (where family investigation is focused on forensic techniques to "get the facts" and family assessment where the focus is on family engagement) or to move to one unified child protection system with maltreatment determinations made in every case.

This debate misses a critical point. When responding to an accepted ("screened in") child maltreatment report there must be a continuum of child protection responses designed to meet the safety needs of children. This continuum of responses must enable child protection workers to consistently use their statutory protective role and their role as a "helper" to protect children and engage families. Put another way, child protection workers should not only wear one hat, either a protective hat or a helper hat. The best workers wear both – or at least keep both ready to don—throughout any child protection response, regardless of the label. How we ensure that this best practice is *the* practice throughout Minnesota is critical to protecting our children. This commitment is consistent with the Task Force's initial recommendations which noted that "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."

In addition, we need to readjust how we measure outcomes. We need to move beyond the debate about how many reports are "screened in", what services are provided, and what "track" is assigned to asking whether the intervention provided by the system made a difference in the child's life. In short, are the child and family better off because our child protection system stepped into the family's life? To assess this, we need to periodically evaluate the child's well-being and use the individual data both to change course, where necessary, and to inform system-level planning for the future.

These outcomes need to be as public as possible. While child-specific information should make sure we are addressing the individual needs of the child, at the system level we should be able to learn what types of interventions are working for different populations, keeping in mind the large

disparities we have in our current system. These outcomes should also be tied, ultimately, to accountability for state and county governments through a robust Human Services Performance Management System.

In summary, our goal is a child protection system that is child-focused. Where the safety and the best interests of the child is paramount, but where we never lose sight of the fact that parent support is often the most effective way to provide for the child's wellbeing. That we need a system that responds differently to different needs and not be wed to singular or dual tracks. We need a system that provides referrals for clinical assessments for those children who have trauma or mental health needs identified during screenings. At the same time, the system must have its "eyes wide open" to signs of maltreatment and neglect. And we need a system that provides for periodic evaluations and monitoring so that (both on a child level and a system level) we know whether we are making progress.

This child protection system cannot be created overnight. It must evolve. And it cannot evolve without additional resources, training, and workforce adjustments. This evolution cannot occur in a vacuum. It must include a multi-prong strategic effort to establish better connections with racial, ethnic and tribal communities to implement a culturally responsive service array. There must be ongoing dialogue between DHS, counties, field experts, key stakeholders and legislators so that child protection reform can be an ongoing process. As a result, the Task Force recommendations below set out short and mid-term steps, as well as lay the ground work for longer term system redesign.

SCREENING

The screening function for reports of child maltreatment is one that requires the practitioner to have high level knowledge and skill competencies. The screening decision is a very important child safety decision and we have to get it right every time. Additionally, statute and practice guidance must provide clear criteria and instruction to ensure more consistency uniformity and accurate decision making by local county and tribal child welfare agencies throughout the state.

The screening of alleged child maltreatment reports involves the crucial task of systematically gathering and critically thinking through the facts of a report. There is recognition that this fact-gathering cannot and should not occur in isolation. Decisions made that involve the best practice thinking and judgment of a variety of professionals and cross-disciplines serves to improve the overall quality and consistency of decision making. It also increases transparency and accountability to the citizens of Minnesota.

There is a need for new protocols and guidance to help provide front-line workers with better supports to guide their decision making in the short and mid-term. In the longer term, the state

should consider a centralized child abuse and neglect reporting system similar to those recently adopted in the state of Colorado and in Minnesota's Adult Protection System.

The following recommendations are made regarding the screening process:

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.

2. The legislature should repeal of 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.

3. Make intake/screening decisions, whether a report is screened in or out, in consultation with a Multi-Disciplinary Team (MDT) or a minimum with a supervisor.

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 code with plain and understandable language.

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 information should not be decisive to whether a report is screened in. This information should minimally include:

        - Description of allegations
        - Child's injury conditions 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
- 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
- Guidance as to limiting pathway response assignment to Differential Response where similar issues/concerns and/or the same family unit as 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.

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.

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 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 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.

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.

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.

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.

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

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.

16. **Amend Substantial Child Endangerment to include:**

    a. **Domestic violence where a child is present in the same room at the time of the alleged violence.**

    b. **Injury to the face, head, neck, or torso of a child under the age of six.**

    c. 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.

    d. Withholding a medically indicated treatment from a child with a life threatening condition unless exempted in Minnesota Statute 260C.007 subd. 6 (5).

    e. 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's well-being.

    f. 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. 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. 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.

18. 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.)*

19. 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 who 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 or involuntary.

20. 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 even an OFP or HRO is in the 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.

21. 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 statue is being misinterpreted to limit investigation to only cases involving substantial child endangerment.

22. Change the statutory definition of reports to: "Report" means information given to the responsible agency or law enforcement which describes alleged child maltreatment and which includes enough information to identify the child victim and the child's caretaker or the alleged offender.

Longer Term Reforms:

23. 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. Exploration of a "cloud" system for interactive voice response, call data, call recording, and consideration for data practices implications.

e. Accommodations for callers who do not speak English and accessibility for people who are deaf or have hearing impairments.

f. A public awareness campaign to promote the statewide hotline and reporting of suspected child maltreatment.

g. Central record-keeping and tracking of both "reports" and "inquiries".

h. Process by which counties can opt to have DHS or another county to receive reports and inquiries on their behalf.

i. Standardized training and certification for all staff prior to taking reports and inquiries.

j. Consistency in information gathering.

k. 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.

l. Continuous quality improvement: listening to audio taped calls and providing training, feedback, coaching to workers and supervisors.

m. System-side data collection.

n. State hotline administration/unit, help desk functions and escape features from automated system to talk to a live person.

24. 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.

25. 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.

26. 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.

27. Complete, by the Revisor of Statutes, 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.

THE FUTURE OF OUR TWO-TRACK CHILD PROTECTION SYSTEM

Today, once a maltreatment report is screened into our child protection system, that screener[1] makes a decision whether to place the case on the "family investigation" track or the "family assessment" track. Currently, Minnesota Statute 626.556 directs this decision in cases of Substantial Child Endangerment to the Family Investigation track and there is no agency discretion. As noted in the Task Force's preliminary recommendations, family assessment has been the "preferred response" to child protection reports and more than 70 percent of all screened in reports are assigned to family assessment. The reported benefits of Family

[1] In some counties, the track assignment is made in a team environment which may include supervisors, investigators, and others.

Assessments are a less adversarial process (leads parents to more readily engage in safety and case planning) by reducing resistance through a strength-based approach. However, as noted in the Task Force's preliminary report, "it is clear that Minnesota's use of family assessment is beyond that of other states and beyond what the statute allows".

In its final recommendations, the Task Force recommends short term changes to Family Assessment, including steps on how that "track" decisions are made as well as narrowing the types of cases in the Family Assessment Track. In the longer term, the Task Force questions whether a two track system is appropriate and recommends, as part of its overall redesign, that DHS consider moving toward one child protection system, with fact finding for all "screened in" cases, but several potential "branches" of that system available depending upon the best interests of the child.

Our recommendations for short term improvements are made with the idea that they could be building blocks for long term reform as well. Fundamental to our recommendations are the belief that:

- All children, regards less of track, should receive a comprehensive assessment which provides the foundation for assisting children, youth and families with what they need
- That progress should be monitored to see if the child (and the family, where appropriate) is getting better because of child protection intervention
- Child Protection workers (in both tracks) should review progress with both forensic and family engagement tools close at hand.

If these fundamental building blocks are in place, a continuum of safety-focused child protective responses can and should protect children and meet the unique service needs of families. It is best to proceed methodically and with care and make thoughtful short term changes to the current model, while examining long term redesign options.

Therefore, the following recommendations are made which relate to Family Assessment:

28. 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.

29. 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
- Engage children and families as an approach to reduce resistance and gain information on family dynamics
- 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).

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

31. Interview children 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.

32. Ensure fact-finding occurs in all child protection response. 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.

33. 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.

34. Adopt stronger and more robust intake and screening tools for data gathering prior to pathway assignment to strengthen the quality of the information available.

35. 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 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.

36. 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.

37. 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:

    - 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. This 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.

38. 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.

39. 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.

40. 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.

41. 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.

42. 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.

43. 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.

44. 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. The Department should provide guidance on criteria and best practice for making the determinations and require supervisory review and approval.

45. 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.

Longer Term Reforms:

46. 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 protect 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 the Task Force.

47. 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
- Parent(s)
- Child Welfare Focused Academic Institution
- Child Safety/Risk Subject Matter Experts.

48. 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

49. 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.

50. 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.

51. **While the Governor's Executive Order directs the Task Force to focus on the pre-court side of child protection, we cannot close our eyes to the needs of children who are removed from their homes and placed in care. We also note the diminishing number of qualified foster care providers in Minnesota. As a result, we recommend that planning begin to address the needs of the foster care system and the children it serves. DHS should:**

    - **Develop a comprehensive foster care policy to ensure child safety in licensing, placement, care/treatment, visitation, discharge/reunification planning, and guidance for post reunification services**

- **Address guidance for foster care child specific recruitment and family finding strategies/tools in an effort to place children with family members/relatives when that can be done safely**
- **Promote a best practice protocol for removing a child from their home and placing a child in care in a manner that proactively attends to and reduces the child's stress, pain, and trauma of separation from persons, places, and things that are important to them**
- **Develop a training curriculum for foster care providers, child protection case workers and law enforcement on established guidance, removal/placement practice protocols designed to ensure a primary focus on child safety, and strategies to minimize the traumatic effects of separation and placement.**

RACIAL, EQUITY and DISPARITY REDUCTION

The most recent *Minnesota's Child Welfare Report 2013* highlights the continued concern for disproportional over-representation of children by race and ethnicity. When compared to Caucasian children, all children of color and American Indian children, with the exception of Asian/Pacific Islander children, experience a higher rate of involvement in child protection services, out-of-home placements, and adoption.

However, to effectively address disproportionality there must be an understanding not only about populations that are overrepresented but also populations that are underrepresented. Underrepresented communities often lack access to the continuum of child welfare services and may be under identified due to bias or lack of knowledge.

To safely reduce racial disproportionality requires a multi-prong, strategic effort which must reach far beyond the human services systems. In order to further this work, however, we need to establish better connections with racial, ethnic, and tribal communities, to fund and examine research into promising practices to reduce disparities and to change public systems to implement a culturally responsive service array within the child welfare system.

Racial disparities in the child welfare system must be viewed as a call to action to all of us, regardless of race, to come together, to better understand the cause of the disparities, and to work together to identify institutional resources and practices that can be adopted that will genuinely improve the lives of children and their families.

Culture is not simply determined by ethnicity and a particular set of beliefs, norms and values, but also involves the historical circumstances leading to a group's economic, social and political status in the social and economic structure. As people develop different responses to their life circumstances, the child welfare system must realize that eliminating bias and discrimination and improving cultural responsiveness and inclusion is critical in the provision of ethical and

effective services to children, youth, and families.

Varying approaches are needed in the service delivery systems to address cultural differences among consumers and to identify ways to transform public services to be more effective in protecting children. Practitioners must provide culturally responsive services. In addition, collaborative work across systems must be done in order to achieve the goal of sustained safety and stability for children and their families through a rehabilitative process.

To reduce the disparities in our child protection system, the Task Force recommends:

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.**

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.**

54. **DHS should identify and link previous and current disparities work to future intervention strategies aimed at racial equity and disparity reduction.**

55. **Develop a certification program that would prepare students and current workers and supervisors to work in specific cultures through field placements/internships.**

56. **Promote and improve the representation of racial and ethnic communities' among child protection and child welfare ranks using recommendation #55.**

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. 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 and tribal representation in the development of policy guidance, and best practice strategies and protocols.**

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.**

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 for American Indian children served by these programs.** [2]
    - **Recognize and support the sovereignty of Tribal Governments.**

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. This should include programs such as the Parent Support Outreach Program (PSOP) that can work across many different racial, ethnic, and cultural communities.**

62. **Increase monitoring and evaluation:**

    - **Monitor and report disparities, as well as outcomes for African American and American Indian children and families, using the Social Services information System and review indicators**
    - **Identify areas of underrepresentation and pilot methods to promote access for those populations who are not yet visible to the system**

[2] 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.

- **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.**

Longer Term Reforms:

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.**

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.**

TRAINING

The quality of training for child protection workers, supervisors and managers is a critical factor in supporting a high performing child protection system. The Department is statutorily required to develop and provide competency-based training to child protection staff, including foundation training for local child protection workers within the first six months of employment. DHS must support on-going development of the child protection workforce by developing and providing training that is accessible, research-based, and builds competencies critical for child protection staff at all levels to perform effectively.

As the Task Force considered recommendations to enhance the training provided to child protection staff, they heard from county and tribal staff, educators and trainers, and representatives from community agencies and organizations. In addition to learning what is currently available and required, Task Force members learned of challenges and opportunities related to developing a competent child protection workforce.

Recommendations must support and enhance the initial training and ongoing development of

child protection staff. Cultural awareness must be embedded into all child welfare training. Cultural responsiveness is not an event whereby one can attend a single training and become competent. Cultural awareness comes from a thoughtful examination of one's own culture and beliefs, and how those attitudes and beliefs impact others.

In addition to the recommendations, the Task Force encourages the DHS to collaborate with local social services agencies and other community agencies and organizations to ensure the training provided to Minnesota child protection staff is relevant and grounded in current research and best practice.

To improve the capacity of the workforce, the following training recommendations are made:

65. **Enhance the Minnesota Child Welfare training system by:**

A. DHS 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 MN 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 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. The Department is encouraged to 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.**

67. **DHS should continue to support the IV-E educational programs available through Minnesota colleges and universities.**

68. **Expand the existing student loan forgiveness program in Minnesota to include Social Work graduates who are employed as child protection/child welfare social 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.**

Longer Term Reforms:

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.**

71. **DHS to 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.**

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.**

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.**

74. **DHS should explore the fiscal implications of making Child Welfare Training System trainings available to stakeholders and/or community members.**

OVERSIGHT OF COUNTY PERFORMANCE

In a state-supervised, county-administered system such as Minnesota, the role of DHS is legislative and policy development, compliance with federal requirements and monitoring of local systems to ensure compliance with state and federal policies, rules and statutes. The Minnesota Child Welfare Practice Model identifies that Minnesota's child welfare system is committed to holding itself accountable to the highest standards of practice. This requires a robust continuous quality improvement system that utilizes both qualitative and quantitative data to support system improvements at all levels.

The Task Force examined the adequacy of current DHS practices and processes in place for monitoring compliance and outcome achievement at the local and state level, and considered options for expanding and enhancing current processes.

The following oversight recommendations are made to improve outcomes:

75. **DHS 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.**

    - **Public Health Review Model:**
        - **Purpose: Review child fatalities and near fatalities related to accidents, suicides, SIDS, natural causes, and other fatalities and near fatalities not related to maltreatment**
        - **Focus: Developing and issuing community-based prevention messages**
        - **Process: Utilize the process currently being used to review all child fatalities and near fatalities in Minnesota.**
    - **Child Protection Mortality Reviews:**
        - **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**
        - **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.**
        - **Process: Develop a new process in which DHS mortality review staff lead and conduct the on-site local morality review, and utilizes 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.**

    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;

b. The age and gender of the child;

c. Information describing any previous reports of child abuse or neglect that are pertinent to the abuse or neglect that led to the child fatality or near fatality;

d. Information describing any previous investigations/assessments pertinent to the abuse or neglect that led to the child fatality or near fatality;

e. The result of any such investigations/assessments;

f. 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;

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.**

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.**

78. **Address workload/caseload size issues:**

a) **Short-term: Establish workload standards for child protection workers and supervisors as follows:**

- **No more than 10 child protection case management cases per worker**
- **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**
- **Establish a supervisor-worker ration of 1:8.**

b) **Long-term: DHS, in collaboration with the Workforce Training and Oversight Advisory Group, will:**

- **Review methodologies for establishing caseload/workload standards that considers weighting of cases based on factors such as type of case, case complexity, out-of-home placement, court involvement, etc. Following review, the Department to make a recommendation for implementing caseload/workload standards.**
- **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.**

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:**

   - **In the early stages of a child protection investigation or assessment (social service), and**
   - **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.**

TRANSPARENCY

Balancing Client Confidentiality and the Creation of Transparency in Child Protection

Much of the work of Minnesota's Child Welfare system is invisible to the public due in part to Minnesota data practices, federal funding requirements, and the ethical standards for privacy and confidentiality for Social Workers. This is true for both efforts that contribute toward positive client outcomes and those that insufficiently meet the needs of vulnerable children and families.

We need to strike a better balance.

At a minimum, the public requires Minnesota's Child Protection System to protect children. Beyond protection, the public expects children to exit the system in a better condition than which they entered. Attending to the developmental and well-being needs of children is paramount to better ensuring their long term safety and better preparing them for a more positive future.

Transparency mechanisms must be developed to allow the public to review and assess the work of Minnesota's Child Protection System and the impact it is having on children and families. While the protection of children is a multi-system community responsibility. Child Protection plays a central role in the coordination of partner system and fostering community cultures that better meet the needs of children. Transparency mechanisms must transcend from the Department of Human Services through all local child welfare agencies to engage partners, re-establish system credibility, and regain the public's trust in the system's ability to keep children safe.

To enhance the transparency and accountability of the child protection system, the Task Force makes the following recommendations:

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.

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.

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. percentage of children who experience repeat abuse/neglect

            - within 6 months of a maltreatment finding or Differential Response

- within 12 months of a maltreatment finding or Differential Response

ix. percentage of children in the aggregate and by age who exit foster care and re-enter foster care within 12 months
x. child protection worker caseload numbers and turnover rates (including supervisor and line-staff numbers)
xi. number/percentage of cases that are reopened after being closed
xii. 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…
xiii. 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.)
xiv. identify federal measures and standards that DHS is not meeting
xv. number of family investigation 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

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

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).

ADEQUACY OF RESOURCES

Funding for child welfare services in Minnesota relies primarily on county local property tax dollars (54%) and federal dollars (27%). The aggregate state share of child welfare costs is 14 percent, one of the two lowest state shares in the country.

In reviewing Minnesota's trends, it the Task Force noted that there had 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. Most counties experienced decreases. The current heavy reliance on local property tax revenues has likely contributed to the wide variation in levels of county activities and provision of services.

One charge to the Task Force was to assess the adequacy of resources for child protection and identify what would be needed to implement its recommendations. Subsequent to the Task Force's review of the current and past levels of financial resources available to support county implementation of child welfare services to children and families, the workgroup on resources analyzed the projected cost estimates to implement the preliminary recommendations and determined that current levels of funding are not adequate to address and improve the provision of child welfare services. Those cost estimates focused on: 1) county staffing to carry out the additional responsibilities outlined in the recommendations; 2) additional potential services necessary to support children and families as a result of changes in screening, assessment, etc.; and, 3) additional state oversight.

There is also recognition that the implementation of changes as recommended by the Task Force has potential fiscal implications on tribes, county attorneys, court, public defenders, law enforcement, possibly more out-of-home placements, additional needs around foster care licensing and for more cultural resources, and workforce pressure.

The following recommendations are made to increase resources to the child welfare system as a means to support and promote positive outcomes for children and families:

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.

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.)

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.

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.

    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.

91. Increase funding for State oversight, including monitoring, training, child fatality reviews, grant management, quality assurance, etc.

92. Increase funding for intake and screening tools to promote more robust data gathering during the intake and screening process.

93. DHS should, absent sufficient funding, prioritize all recommendations to develop a multi-year implementation plan.

CONCLUSION

It is with concern for our children, and admiration for the child protection workers who make difficult decisions everyday (often without adequate resources) that our Task Force makes these recommendations. We believe they are foundational to achieve the vision of the Task Force:

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.

We also believe that this is just a foundation. Much work lies ahead. Transforming our system is a multi-year project and only with resources and continued focus will our children and families be safe, supported and strong.

Appendix A

IMPLICATIONS FOR FINAL RECOMMENDATIONS

Appendix B

TASK FORCE MEMBERS BIOGRAPHIES

Comm. Lucinda E. Jesson – Co-chair

Lucinda Jesson has been the Commissioner of the Minnesota Department of Human Services, the state's largest agency, since 2011. Child protection is part of DHS' mission, in cooperation with Minnesota's Counties. Jesson was an associate professor of law at the Hamline University School of Law, where she founded and directed the Health Law Institute. She has served both as the chief deputy Hennepin County attorney, and as Minnesota deputy attorney general, and has extensive private sector experience as well.

Comm. Toni Carter – Co-chair

Toni Carter has been a Ramsey County Board member since 2005 and has just completed her term as President of the Association of Minnesota Counties (AMC). She is co-chair of the Minnesota Human Services Performance Council, and Chair of the Human Services and Education Steering Committee of the National Association of Counties. She has been a teacher, a School Board Chair, a systems engineer, an author, an actor and an arts consultant. She is the first African-American ever to serve on a county board in Minnesota.

Terese Amazi is the Mower County Sheriff. She has 28 years of Law Enforcement experience, including 26 years in Mower County. She worked in Child Protection as an investigator for seven years. She worked on meth lab legislation, making it a felony for any adult found with a child at meth lab. She also worked on recent legislation making it a felony to chain/confine a child causing demonstrable harm.

Wm. Blair Anderson is Chief of the St Cloud Police. He was the Chief Deputy of the Carver County Sheriff's Office, and served 15 years at the Dakota County Sheriff's Office, including tenure as Jail Commander at the Dakota County Jail. He has a Master's Degree in Public Safety Administration from St. Mary's U and serves as Adjunct Professor at St. Cloud State. He is an 8 year US Army veteran, including duty active duty service during Operation Desert Storm. He has served on many nonprofit and community service boards. He has two sons, aged 26 and 20.

Hon. Kathleen Blatz was the first woman Supreme Court Chief Justice in Minnesota history; she championed the issue of improving the court's handling of abused and neglected children. Earlier, she was the youngest woman ever elected to the Legislature; as chair of the House Crime & Family Law Committee, she led a reform of child protection statutes. She was a Psychiatric Social Worker, an Assistant County Attorney, and a District Court Judge. She has a BA from Notre Dame and an MA in Social Work and a JD from the U of M and is now in private practice.

Larene Broome is a Parent Coordinator with the William Mitchell Parent Mentor Program. She began as a parent wanting parents' voices heard; she is on the Parent Leadership for Child Safety and Permanency team (a partnership between Prevent Child Abuse MN and DHS Children's Trust Fund) and is a master trainer/curriculum writer. She co-chaired the African American Disparities Committee at DHS and is an IEP advocate at the MN Organization of Fetal Alcohol Syndrome. She is pursuing her degree at Metropolitan State U, focusing on Civic Leadership.

Judith Brumfield is the Scott Co. Health & Human Services Director. She worked in county social service for over 30 years, primarily direct service and supervision in child protection, children's mental health and juvenile probation. She chaired the group to implement the Child Welfare Training Program, chaired the Children's Committee for the MN Assn of County Social Service Administrators (MACSSA), and is now co-chair of the MACSSA legislative committee. She is a Licensed Independent Clinical Social Worker and has her MSW from the U of M.

Peggy Flanagan is Executive Director of the Children's Defense Fund-MN. She founded the Native American Leadership Program at Wellstone Action and is adjunct faculty at George Washington University. She is a member of the White Earth Band of Ojibwe and was named one of the top 100 influential people in Minnesota politics. She was the first Native American on the Minneapolis School Board and has served on many nonprofit boards. She has a BA in American Indian studies and child psychology from the U of M and lives with her husband and daughter.

Rich Gehrman is Executive Director of Safe Passage for Children of MN; he founded it to advocate for systemic improvements to MN's child protection and foster care system. He has worked with runaways and street youth; he was chief finance/admin officer for Westchester Co. (NY) Social Services, MD Dept of Human Resources, City of St Paul, and Catholic Charities (Archdiocese of Mpls-St Paul). His firm serves clients in state, county and nonprofit human services programs. He is a graduate of Williams College, Harvard Divinity School, and Harvard Business School.

Kraig Gratke has served as the Early Head Start Manager at Tri-County Community Action Program, Inc. since 1999, serving Crow Wing, Morrison and Todd Counties. Kraig serves some of the most high risk infants and toddlers referred from Child Protection in his three-county service area. Kraig is the President of the Minnesota Head Start Association. He has BA degrees in Applied Psychology and in Child and Family Studies, and an MA in Early Childhood Special Education. He has been a teacher and an early childhood education coordinator.

MayKao Y. Hang is President and CEO of the Amherst H. Wilder Foundation, a non-profit health and human services organization. She was previously Division Director for Adult Services in Ramsey Co. and Director of Resident Services with St. Paul Public Housing. She is dedicated to achieving an equitable society where everyone can prosper. She has a BA in Psychology from Brown University, an MA in Social Policy and Distributive Justice from the Humphrey School of Public Affairs at the U of M, and is enrolled in the DPA program at Hamline University.

Stacey Hennen has been the Director of Grant County Social Services for six years; prior to that she was a child protection worker and a supervisor at a Rule 5 facility for adolescents. In 2015 she became President of the Minnesota Association of County Social Service Agencies (MACSSA), where she has already chaired and served on several committees related to child welfare and mental health. She has served on the Human Services Performance Council and was part of Minnesota's team to address the use of psychotropic medications in foster children.

Lisa Hollensteiner, M.D., has cared for patients in the Fairview Southdale Emergency Department for 26 years and in Family Practice at North Memorial for 3 years. She served on Fairview's Pediatric Committee, working to best provide services to children, and chaired the Service Excellence Committee for the Emergency Department. She volunteers with Boy Scouts and middle-school church ministry and is mother to 3 boys. Lisa attended Lawrence University, University of Exeter in England, and University of Pennsylvania Medical School.

Mark Hudson, M.D. is a Board Certified Child Abuse Pediatrician. He is the Medical Director of Midwest Children's Resource Center, a medically based Child Advocacy Center at Children's Hospitals and Clinics of MN, and is the Executive Director of the Midwest Regional Child Advocacy Center. He is a graduate of the University of Minnesota Medical School, completed his Pediatrics residency there, and now has an adjunct faculty appointment there as well. Following residency he completed two years of fellowship training in Child Abuse Pediatrics.

Kathy Johnson has worked for Kittson Co. Social Services 20 years, serving as director for 15. She has a BA in Social Work from Concordia College, Moorhead and attended the Family Studies Institute at North Dakota State University for graduate studies. She has been manager of the Ronald McDonald House in Fargo; an Intensive In-Home Therapist with Lutheran Social Services of Minnesota; and School Social Worker, Kittson Co. Schools. Kathy brings to the Task Force her experience of delivering social services to residents of a small, rural county.

Carri Jones was elected Tribal Chair of the Leech Lake Band of Ojibwe in 2012, becoming the first woman and youngest person to ever hold the position. She is an alumnus of Bemidji State University. Jones is currently completing the Healthcare Administrative Master's Program at the College of St. Scholastica. She established a successful 12 year career in Tribal Government Administration, Finance, and Indian Gaming. Jones has two children.

Molly Kenney is Family Services Director at Greater Minneapolis Crisis Nursery. She holds an MSW from the College of St. Catherine/U of St. Thomas, a BA in Sociology from the U of M, and is currently in the U of M's Infant and Early Childhood Mental Health program. She directs Crisis Nursery's Family Advocates, 4th Day Home Visiting program, parent support groups and education classes, and its licensing standards under DHS. She is a state-licensed Clinical Social Worker with over 20 years' experience supporting high risk families and children in crisis.

Rep. Ron Kresha is a former coach, teacher, curriculum coordinator and technology specialist. In 2000, he co-founded Atomic Learning, which specialized in online professional development internationally. Ron has helped students be successful in high school and beyond; he has focused on helping early learners and ensuring students have a stable, loving learning environment. He was elected to the MN House in 2012, and became an Assistant Majority Leader in 2015. Ron and his wife have been married for 21 years and have one son and four daughters.

Rep. Joe Mullery was elected to the MN House in 1996, serving North Minneapolis. He has served as Chair of the House Early Childhood and Youth Development Policy Committee, as well as the House Public Safety and Civil Justice Committee. He has worked on many legislative issues, including juvenile justice, consumer protection, affordable housing, foreclosure prevention, tenants' rights, anti-crime laws, neighborhood livability, and jobs, wages, and economic development. His BA and JD degrees are from the University of Minnesota.

Robert O'Connor is Assoc. Prof. and Director of the Multicultural Title IV-E Child Welfare Program at Metro State, where he is a speaker and consultant on diversity in the workplace and child welfare issues. A former state ward turned state ward administrator, he served as a Program Consultant at DHS and the federal Children's Bureau's National Resource Center's Training and Technical Assistance Teams. Areas of interest include structural and interpersonal cultural bias training, transracial adoption, community engagement, and issues of social justice.

Todd Patzer is a Lac Qui Parle County Commissioner in his 3rd term on the County Board. He is on the Health and Human Services policy committee of the Association of Minnesota Counties (AMC), and also serves on the AMC State Board of Directors. Todd is on the Woodland Centers Board of Directors (a regional mental health center) as well as the Region 6W Community Corrections Executive Board. Todd and his wife Sarah also operate a family farm in western Minnesota and are raising two teenage sons.

Professor Jean K. Quam, Ph.D., is the Dean of the College of Education and Human Development (CEHD) at the University of Minnesota. For sixteen years, she served as the Director of the School of Social Work at the University and was a co-founder with Professor Esther Wattenberg of the Center for Advanced Studies in Child Welfare.

Sen. Julie Rosen was elected to the MN Senate in 2002. She has served as Chair of the Energy, Utilities and Telecommunications Committee. Special legislative concerns include jobs, health care, agriculture/renewable energy, drug treatment, and child protection. She is the ranking minority member on the Health and Human Services Budget Division. She has a BS degree in Agronomy from Colorado State University. Counties in her district have included Blue Earth, Faribault, Jackson, Le Sueur, Martin, Waseca and Watonwan. She has three children.

Sen. Kathleen Sheran from Mankato was elected to the Minnesota Senate in 2006. She is the Chair of the Senate Health, Human Service, and Housing Committee, and serves on the HHS Finance Division, the Judiciary Committee, and the Higher Education Committee. Prior to her election, Senator Sheran taught nursing at Minnesota State University-Mankato, and has over 35 years of experience in public health, including practice as an advanced practice registered nurse (APRN) inn mental health.

Hon. Edward Toussaint, Jr. is a Distinguished Professor at William Mitchell College of Law. From 1995-2010, he was the Chief Judge of the MN Court of Appeals, where he authored over a thousand opinions. He worked as a public school teacher and a Claims Counsel, and has been a Workers' Compensation Judge and a District Court Judge. He was on the board of the African American Adoption Agency and co-chaired the MN Supreme Court Foster Care and Adoption Task Force. His BA is from Chicago State U and his JD is from DePaul U College of Law.

Michelle Zehnder Fischer is the Nicollet Co. Attorney and is on the Board of Directors for the Minnesota Co. Attorneys' Association; since 1996 she has handled all child protection cases in Nicollet Co. She is a member of the Nicollet County Children's Justice Initiative. She has written about child abuse investigation and prosecution for multiple legal publications. Her BA is from St. Cloud State University and her JD is from William Mitchell College of Law. She is married and has two children and is active in projects that benefit children in her community.