Chris Steller

From: Dellwo, Amy A (DHS) <amy.dellwo@state.mn.us>
Sent: Wednesday, December 20, 2017 1:22 PM
Subject: Human Services - Legislatively Mandated reports
Attachments: MN Out-of-home Care and Permanency Report (2016).pdf; MN Child Maltreatment Report (2016).pdf

MN Child Maltreatment Report: This report has been a single report on all of the child welfare system in previous years. Beginning this year, we are reporting on the front end child protection system in one report, titled Minnesota's Child Maltreatment Report, and on children in out-of-home care and in adoptions in a second report. The child maltreatment report will include information on child maltreatment intake, screening, child protection response path assignment, the assessment and investigation process, and the outcomes of child protection assessments and investigations. This report is less focused on recommendations and is focused more on reporting what is happening to children in Minnesota who may have been maltreated.

MN Out of Home Care and Permanency: Previously, the division has published a single report on the entire child welfare system. Beginning with last year's report (i.e., report year 2015), we began reporting on the front end child protection system in one report, titled Minnesota's Child Maltreatment Report, and on children in out-of-home care and in adoptions in a second report titled, 'Minnesota's Out-of-Home Care and Permanency Report. These reports should be published around the same time. This report includes information on the characteristics of children in out-of-home care, where they are while in out-of-home care, the length of time spent in out-of-home care and information on their permanency outcomes including reunification, transfer of permanent, legal and physical custody, and adoption. This report does not include recommendations but is focused more on reporting what is happening to children in Minnesota who have experienced out-of-home care, guardianship, and adoption.

Amy Dellwo
Government Relations Director | External Relations

Minnesota Department of Human Services
540 Cedar Street
St. Paul, MN
O: 651-431-2585
C: 651-295-6974
mn.gov/dhs

DHS-5408I-ENG 11-17

DEPARTMENT OF HUMAN SERVICES

Minnesota's Child Maltreatment Report, 2016

Children and Family Services

October 2017

For more information contact:

Minnesota Department of Human Services
Child Safety and Permanency Division
P.O. Box 64943
St. Paul, MN 55155

651-431-4660

Minnesota Statutory Requirements for Report:

This report was prepared by the Minnesota Department of Human Services, Children and Family Services Administration, Child Safety and Permanency Division, for the Minnesota Legislature in response to a legislative directive in Minn. Stat., section 257.0725. This report also fulfills reporting requirements under the Vulnerable Children and Adults Act, [Minn. Stat., section 256M.80, subd. 2] the Minnesota Indian Family Preservation Act, [Minn. Stat., section 260.775] required referral to early intervention services, [Minn. Stat. 626.556 Subd. 10n] and Commissioner's duty to provide oversight, quality assurance reviews, and annual summary of reviews. [Minn. Stat., section 626.556, subd. 16]

Minn. Stat., section 257.0725: The commissioner of human services shall publish an annual report on child maltreatment and on children in in out-of-home placement. The commissioner shall confer with counties, child welfare organizations, child advocacy organizations, the courts, and other groups on how to improve the content and utility of the department's annual report. In regard to child maltreatment, the report shall include the number and kinds of maltreatment reports received and any other data that the commissioner determines is appropriate to include in a report on child maltreatment.

Minn. Stat., section 256M.80, subd. 2: Statewide evaluation. Six months after the end of the first full calendar year and annually thereafter, the commissioner shall make public the counties' progress in improving the outcomes of vulnerable children and adults related to safety, permanency, and well-being.

Minn. Stat. 626.556 Subd. 10n: A child under age three who is involved in a substantiated case of maltreatment shall be referred for screening under the Individuals with Disabilities Education Act, part C. Parents must be informed that the evaluation and acceptance of services are voluntary. The commissioner of human services shall monitor referral rates by county and annually report the information to the legislature beginning March 15, 2014. Refusal to have a child screened is not a basis for a child in need of protection or services petition under chapter 260C.

Minn. Stat., section 626.556, subd. 16: Commissioner's duty to provide oversight; quality assurance reviews; annual summary of reviews. (a) The commissioner shall develop a plan to perform quality assurance reviews of local welfare agency screening practices and decisions. The commissioner shall provide oversight and guidance to counties to ensure consistent application of screening guidelines, thorough and appropriate screening decisions, and correct documentation and maintenance of reports. Quality assurance reviews must begin no later than September 30, 2015. (b) The commissioner shall produce an annual report of the summary results of the reviews. The report must only contain aggregate data and may not include any data that could be used to personally identify any subject whose data is included in the report. The report is public information and must be provided to the chairs and ranking minority members of the legislative committees having jurisdiction over child protection issues.

This information is available in accessible formats to individuals with disabilities by calling 651-431-4671 or by using your preferred relay service.

For other information on disability rights and protections, contact the agency's ADA coordinator.

Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $10,667.30.

Printed with a minimum of 10 percent post-consumer material. Please recycle.

651-431-4670

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်၊ ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လ်ာ် တီလံာ်မိတခါအံၤန္ဉ်,ကိးဘဉ်လီတဲစိနိ်ဂ််လၢထးအံၤန္ဉ်တက့်၊.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB2 (8-16)

For accessible formats of this publication or additional equal access to human services, write to dhs.info@state.mn.us, call 651-431-4670, or use your preferred relay service. (ADA1 [9-15])

Contents

The 2016 Annual Child Maltreatment Report Summary

Purpose

The purpose of this annual report is to provide information on children involved in child maltreatment reports and the work that happens across the state to ensure and promote the safety, permanency and well-being of children who may have experienced maltreatment. For more information about performance on all state and federal performance measures, see the Minnesota Child Welfare Data Dashboard.

Findings

Intake

- Local child protection agencies across Minnesota received **75,624** reports of child maltreatment in 2016. This represents an **11.2** percent increase over 2015.[1]

The screening process

- Of the **75,624** child maltreatment reports received in 2016, local agencies screened in and completed **30,936** assessments or investigations, or **40.9** percent of all reports.
- Mandated reporters made the vast majority of reports of maltreatment to local agencies, with nearly four of five reports (**60,334** of **75,624** reports or **79.8** percent) coming from mandated reporters.
- There were **39,736** alleged victims who had at least one screened in child maltreatment report in 2016.
- The most recent year saw a **25.3** percent increase in screened in reports from 2015, and a **25.6** percent increase in alleged victims with at least one screened in report.
- Since 2009, there has been a **79.7** percent increase in screened in reports; despite this increase in the volume of work, funding levels only recently returned to 2002 levels.
- American Indian children were **5.2** times more likely to be involved in screened in maltreatment reports than white children, while children who identify with two or more races and African-American children were both approximately **three** times more likely to be involved.
- The opportunity gaps for families of color and Native American families continues to grow in Minnesota. The disproportionality seen in child protection is further evidence of this gap in services and opportunities for children and families of color.
- Children age 8 and younger represented the majority of children involved in screened in maltreatment reports (**59.6** percent) in 2016.
- Alleged victims with allegations of neglect constituted the largest group of children by far, with approximately **60** percent of all children in 2016 having an allegation of neglect.

[1] The methodology for calculating the total number of reports was updated in 2016. Maltreatment reports that were screened out due to all allegation(s) already having been assessed, a report was not in the county or tribe's jurisdiction, or a receiving agency had a conflict of interest and referred a report to another county or tribe were no longer included. These screened out reports are duplicative and over represent the number of screened out reports. For comparisons made between the 2015 and 2016 child maltreatment reports, the new methodology is applied to data from 2015. A detailed description of this methodology is on page 6 of this report.

- Prenatal exposure to alcohol or substances is one form of neglect. In 2015, **1,330** children were prenatally exposed to alcohol or illegal substances. This represents a **113** percent increase since 2012.

Child protection response path assignment

- The most recent year saw a **52.7** percent increase in the number of child maltreatment reports that were assigned for Family Investigation.
- Approximately **60** percent of the **30,936** screened in child maltreatment reports were assigned to the Family Assessment path (N = **18,334**), while the rest received either a Family or Facility Investigation.

Assessment or investigation of safety, risk and service need

- Minnesota must make improvements in its performance on the timeliness of first face-to-face contact with alleged victims in screened in maltreatment reports which is critical for ensuring safety, with only **80.1** percent of victims seen within the time frames established in statute.
- A higher percentage of maltreatment reports that were Family Investigations indicated families were at high risk of future maltreatment (**48.4** percent) than were reports that were Family Assessments (**26.8** percent).
- There were **18,506** children in reports who experienced a Family Investigation, **46.6** percent had a determination of maltreatment; there were **1,442** children in reports who received a Facility Investigation, **25.2** percent had a determination of maltreatment.
- There were **26** child deaths and **36** life-threatening injuries determined to be a result of maltreatment in 2016.

Outcomes after child maltreatment reports have concluded

- In 2016, Minnesota met the federal maltreatment recurrence standard, with **8.2** percent of all children having had a recurrence of maltreatment within 12 months of their first determination of maltreatment.

Child Maltreatment Appendix

- The Child Maltreatment Appendix has five tables that break down data from 2016 by agency:
    - The number and percent of child maltreatment reports by screening status and agency
    - The number of alleged victims in screened in maltreatment reports by maltreatment type and rate per 1,000 children for each agency
    - The number of unique alleged victims in screened in maltreatment reports by age group for each agency
    - The number of unique alleged victims in screened in maltreatment reports by race and ethnicity for each agency
    - The number of screened in child maltreatment reports by response path and agency
    - The number of child maltreatment reports by SDM Risk Assessment status for each agency.

Introduction

Child maltreatment is a devastating social problem that faces this country. Maltreatment can not only disrupt children's current development but, if not addressed appropriately, can also have long-term consequences on the development, health, and well-being of children. [Harvard Center on the Developing Child, 2007] Additionally, research has shown that maltreatment can negatively impact communities, schools, the economy, and future generations through the transmission of maltreatment from one generation to the next.

Therefore, it is critical that the Minnesota Department of Human Services monitors and reports on the work of child protection, as it is an important indicator of not only how well children are doing, but also how well communities and the state are protecting and caring for children.

Minnesota children

Minnesota continues to see substantial increases in both the number of child maltreatment reports and alleged victims over the last few years, and even more so within the past year. Many factors are likely related to these increases. One possible factor is the increase in substance abuse among parents. [Collins, 2016] Another possible explanation relates to a new law passed in 2015 requiring local agencies to follow revised screening and reporting guidelines.

What is child maltreatment?

Minnesota Statutes provide a detailed description of what constitutes child maltreatment (see Minn. Stat. 626.556). In general, Minnesota Statutes recognize six types of maltreatment: Neglect, physical abuse, sexual abuse, mental injury, emotional harm, medical neglect and threatened injury. Threatened injury was added as a specific type of maltreatment that workers could identify in August 2016.

Minnesota's child protection system

Minnesota is a state-supervised, locally-administered child protection system. This means that local social service agencies (87 counties and two American Indian Initiative tribes) are responsible for screening reports, assessing allegations of maltreatment, and providing child protective services for children and families. The Child Safety and Permanency Division, Minnesota Department of Human Services, provides oversight, guidance, training, technical assistance, and quality assurance monitoring of local agencies in support of that work. The purpose of this annual report is to provide information on the children affected, and the work that happens across the state to ensure and promote the safety, permanency and well-being of children who may have experienced maltreatment. For information about performance on all state and federal performance measures, see the Minnesota Child Welfare Data Dashboard.

How do children who may have been maltreated come to the attention of Minnesota's child protection system and receive services from local child protection?

Intake process → **Screening process** → **Child protection response path assignment** → **Assessment/ investigation of safety, risk and service need**

The intake process

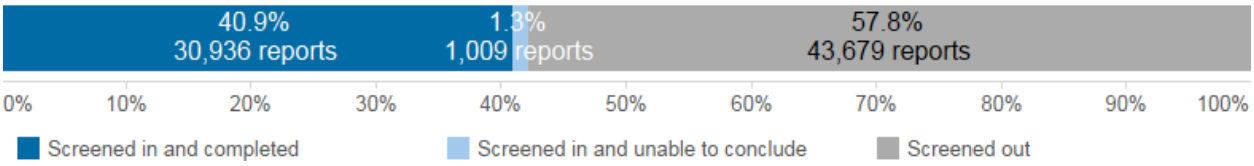
- When a community member has a concern that a child is being maltreated, they can (or must if they are a mandated reporter – see Minn. Stat. 626.556, subd. 3, for information about who is a mandated reporter) call their local child protection agency to report this concern. Local agencies document reports of maltreatment, including information about the reporter, child(ren) involved, alleged offenders, and specifics of the maltreatment being alleged.
- In prior annual reports, the method for counting the number of child maltreatment reports received by local agencies included some duplicate reports. Beginning in 2016, a new method for counting the total number of maltreatment reports received was created. The new method removes any report that was received but screened out for the following reasons: All allegations were previously assessed, the report contained allegations that were not in the county's jurisdiction (and were referred to the appropriate jurisdiction), or there was a conflict of interest and a report was referred to another county or tribe. Reports that were screened out for these reasons were found to be duplicative as they either contained allegations that were in a different child maltreatment report already assessed by that same agency, or another agency in the state. In order to give an accurate comparison between last year and this year, the number of reports received in 2015 using the revised methodology is shown below.
- In the 2015 Child Maltreatment Report, the Child Safety and Permanency Division reported that local child protection agencies across Minnesota received **78,178** reports of maltreatment. Using the new methodology that removes duplicate reports, the number of maltreatment reports received across Minnesota in 2015 was **68,029.**
- In 2016, local child protection agencies across Minnesota received **75,624** reports of child maltreatment. This represents an **11.0** percent increase over 2015 using the new methodology.

The screening process

Once a report of maltreatment has been received, local agency staff reviews the information in a report and determines if the alleged maltreatment meets the statutory threshold for child maltreatment. If it does, and the allegations have not been previously assessed or investigated, staff screen in the maltreatment report for assessment or investigation. Additionally, the local agency cross reports all allegations of maltreatment to local law enforcement, regardless of the screening decision.

- Figure 1 shows the percent and number of reports that were screened out (**43,679** reports or **57.8** percent), and screened in for assessment or investigation and completed (**30,936** reports or **40.8** percent).
- Agencies screened in, but were unable to conclude an assessment or investigation of **1,009** reports (**1.3** percent). Agencies may not be able to conclude a report due to inaccurate information about the location or identity of a child and/or family, or because a child moved and could no longer be located.

Figure 1. Screening decisions of child maltreatment reports in 2016



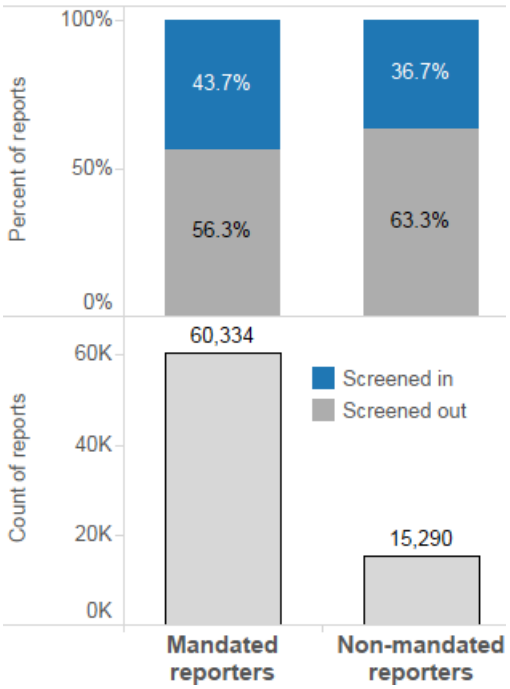
Note: A new methodology for counting reports was created in 2016 (see p. 6 for further description of this change); use caution when comparing 2015 and 2016 data.

Screened out maltreatment reports

- In 2016**, 39,370** of the **43,679** screened out reports (**90.1** percent) were screened out because allegations did not meet the statutory threshold for maltreatment. The rest of the reports (**4,309** or **9.8** percent) were screened out for various reasons, including the following:
  - Report did not include enough identifying information (**3.3** percent)
  - Allegations referred to an unborn child (**3.8** percent)
  - The alleged victims were not in a family unit or covered entity (**2.7** percent) and were referred to the appropriate investigative agency.
- Information regarding the identity of alleged victims was provided and entered for **35,352** of the **43,679** screened out reports (**80.9** percent).
- The Child Safety and Permanency Division instituted a new statewide screening review process in September 2014. This process involves a review of a random selection of approximately 5 percent of screened out reports each month. Each review was completed by a team and was appraised both for screening decisions and also for the quality of information in reports. In 2016, the review team disagreed with and contacted the local agency regarding its screening decision in **291** of **3,786** reports reviewed (**7.7** percent).

Referral source of child maltreatment reports

Figure 2. Reports screened in and out by source of reporter in 2016



- Mandated reporters made the vast majority of reports of maltreatment to local agencies, with nearly four of five reports (**60,334** of **75,624** reports or **79.8** percent) coming from mandated reporters.
- Mandated reporters include those in health care, law enforcement, mental health, social services, education and child care, among others who work with children.
- As seen in Figure 2, mandated reporters were the most likely to have their reports accepted (**43.7** versus **36.7** percent). The difference in acceptance rates may be due to mandated reporters being better trained to identify maltreatment and, therefore, more likely to report incidents that meet the threshold.

Screened in maltreatment reports

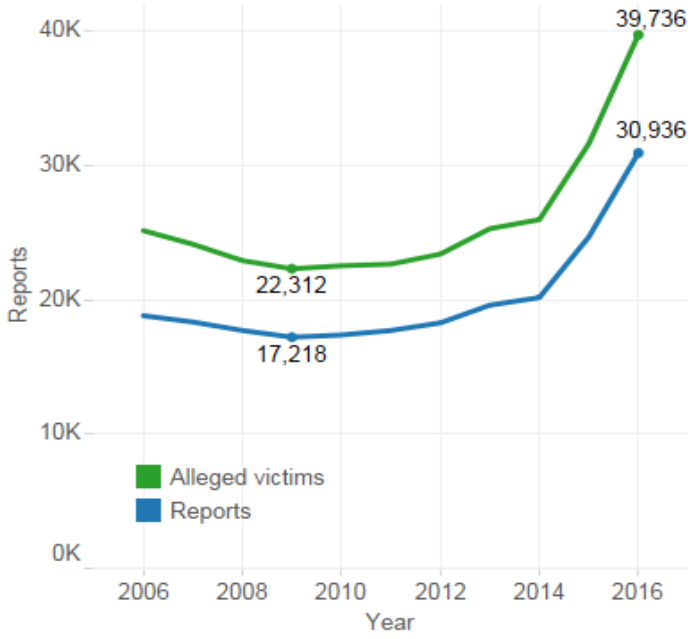
- There were **30,936** screened in reports of maltreatment in 2016 including one or more allegations involving **39,736** alleged victims. However, many of these alleged victims had more than one screened in maltreatment report in the year. Table 1 provides information about how many victims had one or more screened in maltreatment reports in 2016.
- There were **34,654** alleged victims who had at least one screened in child maltreatment report in 2016. As seen in Table 1, the vast majority (**87.2** percent) had a single screened in report in 2016.
- There are often multiple screened in reports for the same incident which accounts for some of the children who have multiple reports; currently, there is no way to indicate when a screened in report is a duplicate in the data system.

Table 1. Number of victims with one or more screened in maltreatment reports in 2016

	Number	Percent
1 report	34,654	87.2%
2 reports	4,221	10.6%
3 reports	702	1.8%
4 or more reports	159	0.4%

- As shown in Figure 3, the number of screened in reports and alleged victims with at least one report has risen since reaching a low in 2009. Overall since 2009, there has been a **79.7** percent and **78.1** percent increase in reports and alleged victims, respectively.
- From 2015 to 2016 there was a **25** percent increase in reports, and a **25.6** percent increase in alleged victims with at least one report.
- The increase in reports means increased caseloads for a child protection system that is still funded at 2002 levels.

Figure 3. Trends of screened in reports and alleged victims, 2006 – 2016



- Although the exact reasons for the increase in the number of screened in maltreatment reports are unknown, there are several possible explanations:
    - Minnesota has not been immune to the opioid crisis that the U.S. is currently experiencing. Minnesota had an 11 percent increase in the number of opiate-related adult deaths between 2014 and 2015. [Minnesota Department of Health, 2016] The increase in alcohol and substance use in Minnesota may be impacting the number of maltreatment reports since parental alcohol and substance use is a known risk factor for child maltreatment. [Children's Bureau, 2016]
    - Revisions made to the requirement to follow intake and maltreatment screening guidelines as a result of the 2014 Governor's Task Force recommendations may have provided clarity and promoted more consistent screening and response by child welfare agencies.
    - It is typical for community and agency standards to shift as a result of system examination following the death of a child involved in child protection. Minnesota had a child death in 2013 that was highly publicized in 2014 that resulted in

The most recent year saw a 25 percent increase in reports from 2015, and a 25.6 percent increase in alleged victims with at least one report. This increase means increased caseloads for a child protection system that is still funded at 2002 levels.

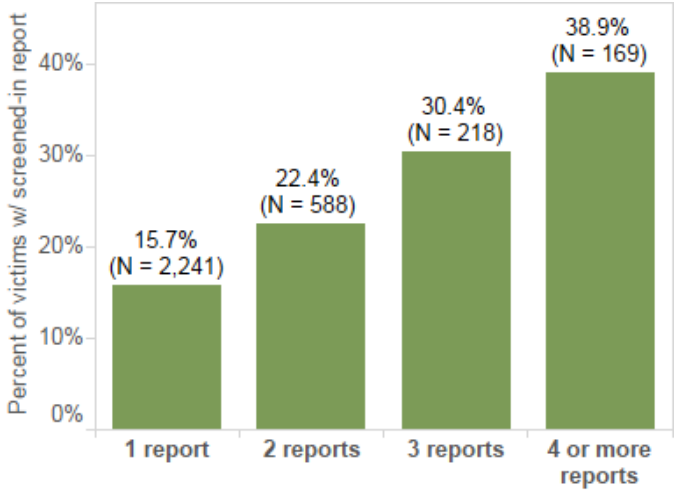
creation of the Governor's Task Force on the Protection of Children to examine the effectiveness of the child protection system. As evidence of this change, the number of maltreatment reports being received from community members (both mandated and non-mandated reporters) has shown a steep increase since 2014. The percent of maltreatment reports being accepted for further assessment has also increased, from **37.6** percent in 2015 to **42.1** percent in 2016.

Sidebar: Were children who had a screened out maltreatment report in 2015 involved in a screened in maltreatment report within 12 months?

Following the recommendation of the Governor's Task Force in 2015, statutory changes were made that require county and tribal child welfare agencies to consider a child's prior screened out report history when making a decision to screen in a new report. A child's history of screened out maltreatment reports has been shown to be a predictor of future maltreatment. [Morley & Kaplan, 2011] The following analysis examines whether children who had been involved in a screened out maltreatment report were eventually involved in a screened in maltreatment report. To conduct this examination, children who were in a screened out report during 2015 and had no prior child protection history within the last four years were followed to see if they were an alleged victim in a screened in report within 12 months of their initial screened out report.

- There were **17,988** children who had at least one screened out report in 2015 and no prior history in the previous four years. Of these children, **14,235** had one screened out report, **2,607** had 2, **715** had 3, and **431** had 4 or more screened out reports in 2015.
- Overall, **18** percent (N = **3,216**) of children with at least one screened out report were involved in a screened in maltreatment report within 12 months following their initial screened out report. As shown in Figure 4, children who were in multiple screened out reports were more likely to have a screened in child maltreatment report within 12 months of their first screened out report.

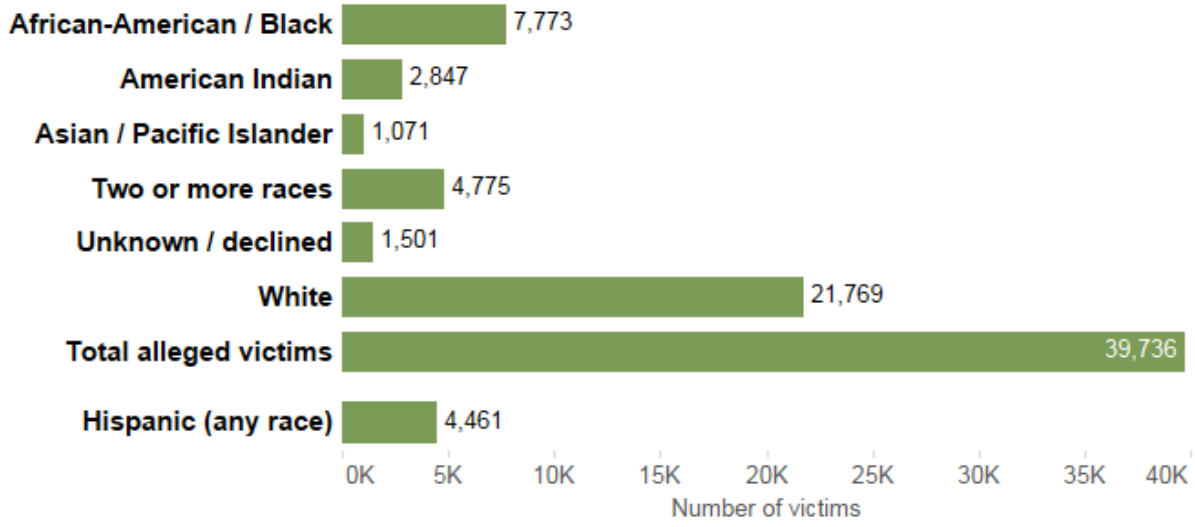
Figure 4: Percent and number of alleged victims with a screened in report by number of prior screened out reports



Characteristics of alleged victims in screened in maltreatment reports

- Consistent with the general population of Minnesota children, the largest group of children with a screened in maltreatment report are white (see Figure 5 below).

Figure 5. Number of alleged victims with at least one screened in maltreatment report by race/ethnicity* in 2016



*The race/ethnicity categories used in this report match those used by the U.S. Census.

- Children who are African-American, American Indian, and those who identify with two or more races, were disproportionately involved in screened in maltreatment reports (see Figure 6).
- American Indian children were **5.2** times more likely to be involved in screened in maltreatment reports than white children, while children who identify with two or more races and African-American children were both approximately **three** times more likely.
- Between 2015 and 2016, the number of children who identified as Hispanic and were alleged victims in a screened in maltreatment report increased by **33** percent. The number of children who identify as Hispanic has increased steadily over the past four years.

Sidebar: A closer look at the two or more race category

Minnesota is becoming more diverse with many children and families identifying with more than one race or ethnicity. In child welfare, the number of families self-reporting as more than one race has nearly doubled since 2012. Of children who identify with more than one race:

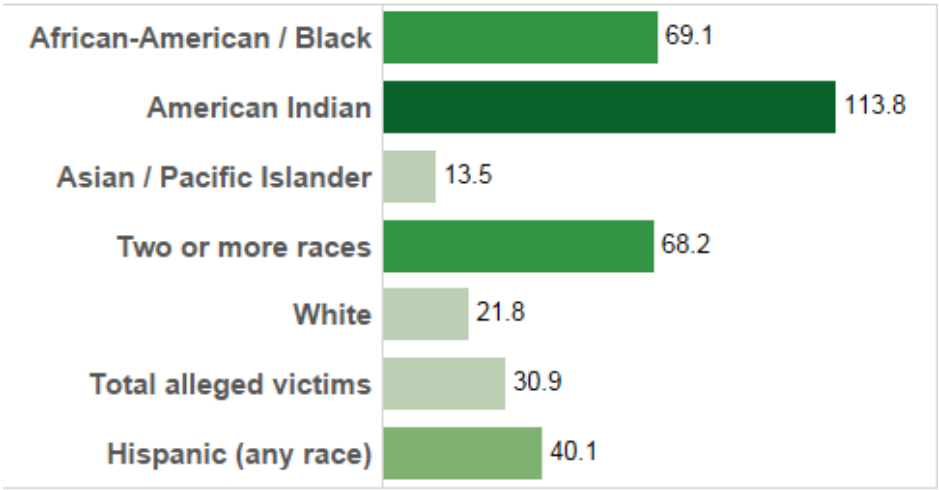
- **88.8** percent identified at least one race as white
- **64.9** percent identified at least one race as African-American/Black
- **44.7** percent identified at least one race as American Indian
- **7.6** percent identified at least one race as Asian, and less than **2** percent identified as Pacific Islander.

- Minnesota social service agencies are increasingly struggling with opportunity gaps for families of color and American Indian families across all systems serving children and families. The

Between 2015 and 2016, the number of children who identified as Hispanic and who were alleged victims in a screened in maltreatment report increased by 33 percent.

disproportionality seen in child protection is further evidence of this gap in services and opportunities.

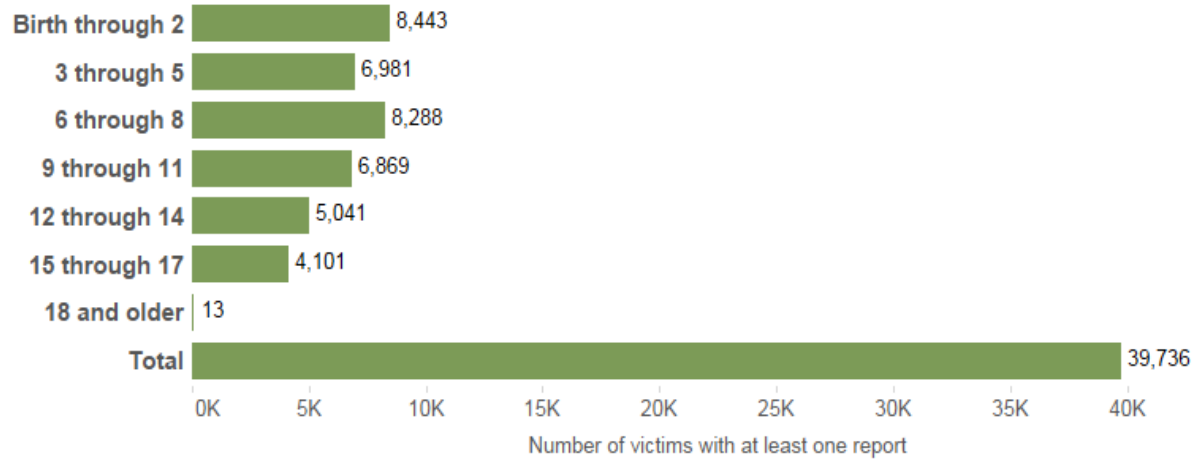
Figure 6. The per 1000 rate of alleged victims in screened in reports by race/ethnicity in 2016



- Children age 8 and younger represented the majority of children involved in maltreatment reports (**59.6** percent) in 2016. There were likely multiple reasons why this age group constituted the largest number involved in screened in maltreatment reports, including:
    - Young children rely almost exclusively on their caregivers for survival – this makes them particularly vulnerable to maltreatment. Data from the National Incidence Study [Sedlak et al., 2010] show that young children are more likely to be maltreated.

- Young children and their families often have more frequent contact with multiple family-serving systems who are mandated reporters for suspected maltreatment, increasing the likelihood that someone will report suspected maltreatment for these families.

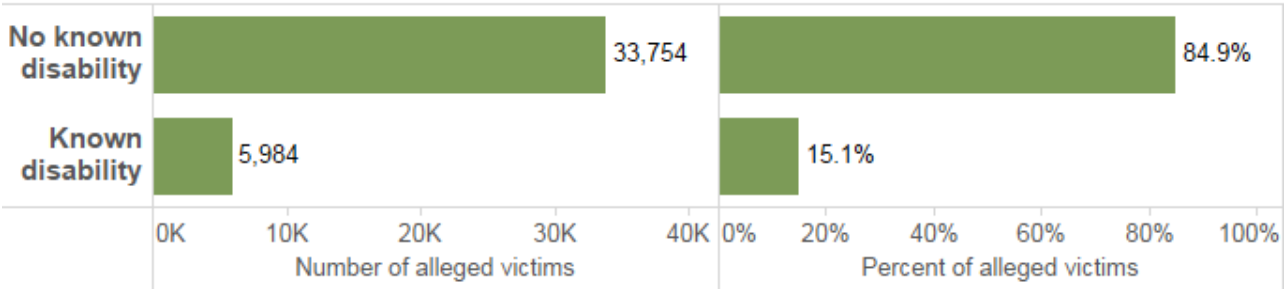
Figure 7. Number and percent of alleged victims with one or more screened in reports by age group in 2016



Note: For victims with more than one report during the report year, the age at their first screened in and completed maltreatment report was used to determine their age group.

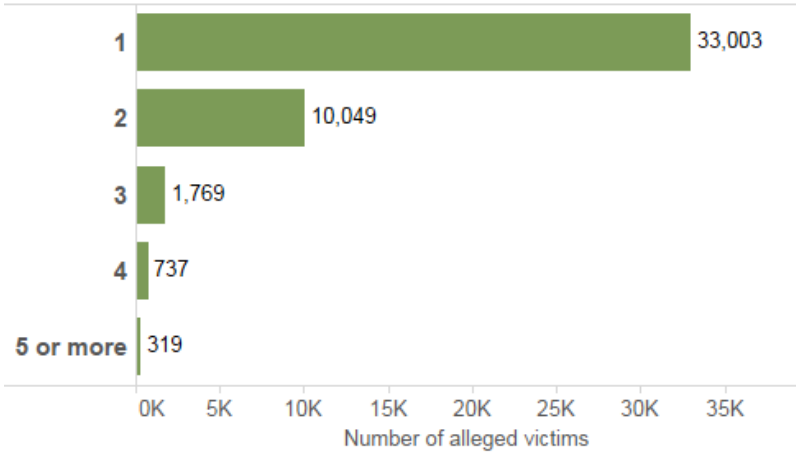
- Just over **15** percent of children who had screened in maltreatment reports in 2016 had a known disability (some disabilities may be undiagnosed). This rate of disability is **five** times more frequent than in the general population of children. [Sedlak et al., 2010]

Figure 8. Number and percent of alleged victims by disability status in 2016



- In each report of maltreatment, a child can have multiple allegations that relate to different types of possible maltreatment. Although changes were made in August 2016 to include threatened injury as its own type of maltreatment, this report will include the five main categories of maltreatment used previously as the new category wasn't used for the majority of the year. These are: Medical neglect (e.g., not providing medical care for a child deemed necessary by a medical professional); mental injury (e.g., behavior of a caregiver that causes emotional or mental injury to a child); neglect (e.g., not adequately providing for the physical, mental or behavioral needs of a child); physical abuse (e.g., behavior that is intended to and/or results in physical harm to a child); and sexual abuse (e.g., any behavior towards or exploitation of children by a caregiver that is sexual in manner). For more exact definitions, consult the Minnesota Child Maltreatment Screening Guidelines and Minn. Stat. § 626.556, Reporting of Maltreatment of Minors.
- Figure 9 shows the number of victims with one or more allegations per screened in maltreatment report in 2016. The vast majority of children (**71.9** percent) had one allegation of maltreatment within each screened in maltreatment report.

Figure 9. Number of alleged victims by number of allegations per report in 2016



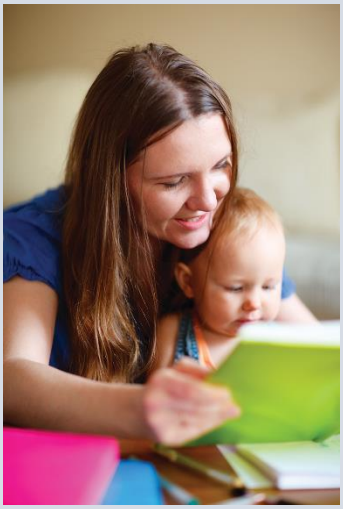
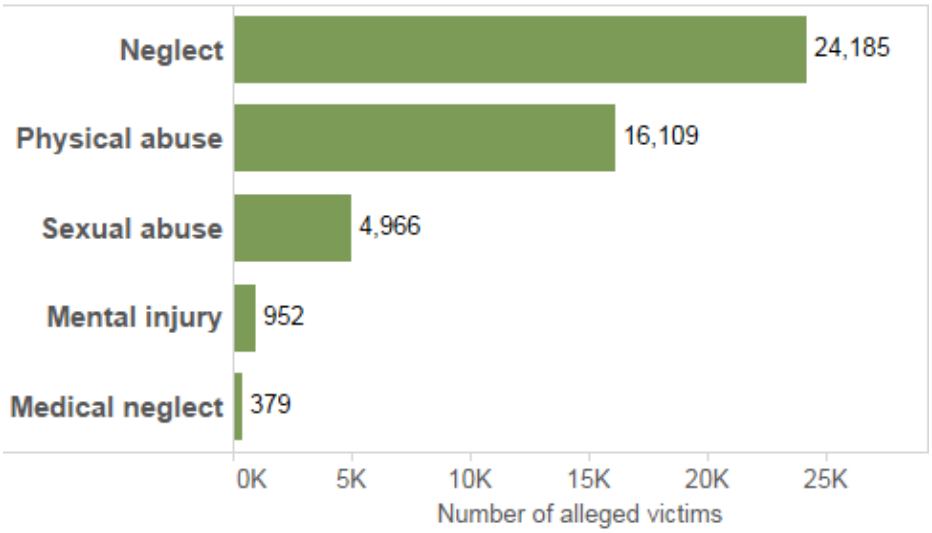


Figure 10. Number of alleged victims by maltreatment type in 2016



- Alleged victims with allegations of neglect constituted the largest group of children by far, with approximately **60** percent of all children who experienced maltreatment in 2016 experiencing neglect (see Figure 10).
- The relative frequency of the different types of maltreatment is changing. The percentage of all alleged victims with an allegation of physical abuse was on the rise in 2016, with nearly 40 percent of children having allegations of physical abuse compared to 32 percent of children in 2015.

The percentage of all alleged victims with an allegation of physical abuse was on the rise in 2016, with nearly 40 percent of children having allegations of physical abuse compared to 32 percent of children in 2015.

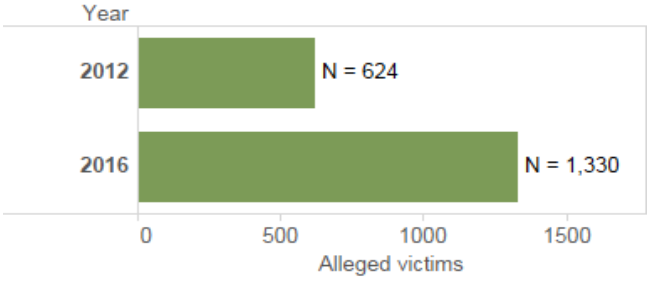
Sidebar: Prenatal exposure has been on the rise since 2012

Minnesota has not been immune to the nationwide increase in opiate-related substance use. For example, drug overdose death rates for adults in Minnesota have increased from three deaths per 100,000 in 2000 to more than 10 per 100,000 in 2015. [Minnesota Department of Health, 2016]

Nationally, an estimated 400,000 infants are affected by prenatal alcohol or prenatal substance exposure. [National Center of Substance Abuse and Child Welfare, ret. 2017] Exposure to harmful substances prenatally are known to have many adverse effects on newborns, including low birth weight, and long-term development and behavioral problems. [Behnke and Smith, 2013] Currently, 14 states and the District of Columbia, including Minnesota, have specific reporting procedures for infants who show evidence at birth of being exposed to drugs, alcohol, or other controlled substances, and classify prenatal exposure in their definitions of child abuse and neglect. [Children's Bureau, 2016] See Minnesota's Best Practice Guide for Responding to Prenatal Exposure here: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7605-ENG

As shown in Figure 11, there were **1,330** children prenatally exposed to substances and alcohol in 2016. This represents a **113** percent increase in the number of children with prenatal exposure since 2012. In 2016, African American/Black and American Indian infants were nearly **six** and **20 times** more likely to be identified as victims with prenatal exposure compared to White children respectively.

Figure 11: Increase in alleged victims with prenatal exposure, 2012 to 2016



The Minnesota Department of Human Services (department) has a variety of policies and programs that directly work with children and families to promote positive outcomes and reduce dependency on substances and alcohol. For example, the department currently supports the following initiatives:

1. Reducing substance misuse and substance disorder: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3765-ENG
2. Supporting funding efforts that seek to specifically address and reduce opioid availability and use: https://mn.gov/dhs/media/news/?id=1053-256523
3. Providing funding to community organizations working on disparities, some with respect to prenatal exposure: https://mn.gov/dhs/media/news/#/detail/appId/1/id/244639

Additionally, several tribes across Minnesota have programs that are addressing the needs of mothers and families addicted to substances. Two examples of these programs are the MOMs program through the White Earth Nation and the Tagwii Plus program through the Fond Du Lac Tribe. For more information on these programs, please see their websites: http://www.whiteearthculturaldivision.com/programs/moms-program and http://www.fdlrez.com/%5C/humanservices/index.htm

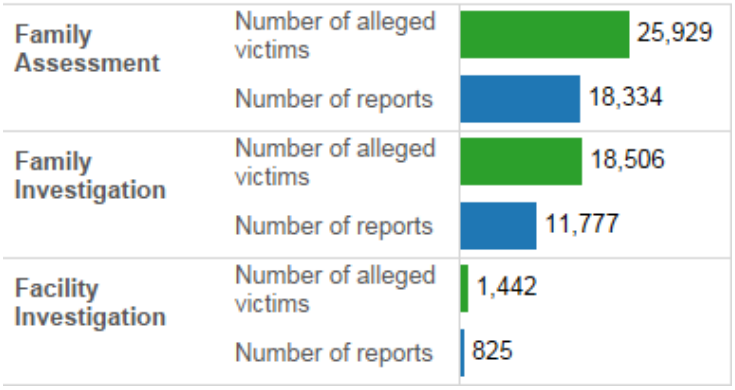
Child protection response path assignment

Once a report has been accepted and screened in, local agencies assigns a report to one of three child protection responses: Family Assessment, Family Investigation, or Facility Investigation. All response paths are involuntary and families must engage with child protection or face the possibility of court action. See the sidebar on the right for information about how reports are assigned to each of the tracks.

Assignment of child maltreatment reports to child protection response paths

- Figures 12 and 13 show approximately **60** percent of child maltreatment reports were assigned to the Family Assessment path, while the rest received either a Family or Facility Investigation.

Figure 12. Number of reports and victims by path assignment in 2016



- In all types of child protection responses to maltreatment reports, there are five shared goals in the assessment or investigative phase:
  - Identify and resolve immediate safety needs of children.
  - Conduct fact-finding regarding circumstances described in a maltreatment report.
  - Identify risk of ongoing maltreatment.

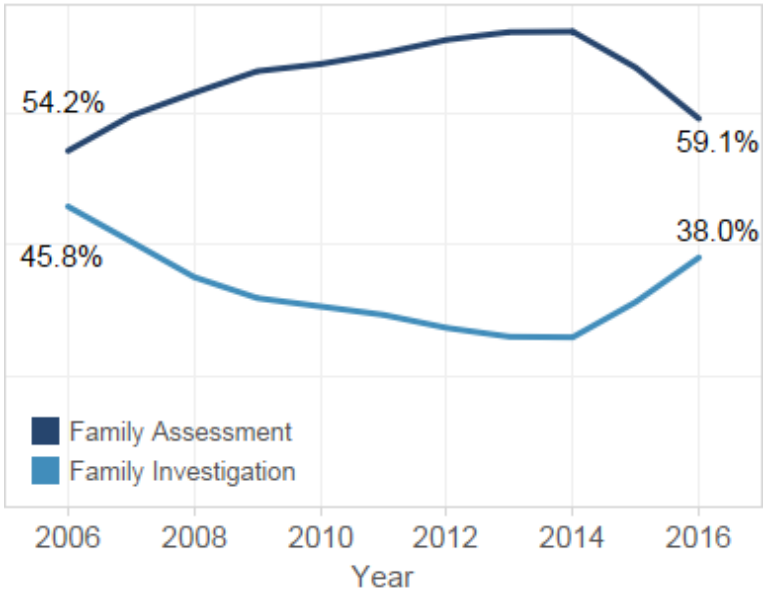
Assigning reports to child protection response paths:

- By law, reports that include allegations that indicate sexual abuse or substantial child endangerment (such as, egregious harm, homicide, felony assault, abandonment, neglect due to failure to thrive and malicious punishment), must be assigned to a **Family Investigation**.
- Maltreatment allegations reported to occur in family foster homes or family child care homes are assigned to a **Facility Investigation**. Maltreatment occurring in state-licensed residential facilities, institutions, and child care centers is investigated by the Minnesota Department of Human Services, Licensing Division, and is not included in this report.
- Reports not alleging substantial child endangerment or sexual abuse can either be assigned to **Family Assessment** or, if there are complicating factors associated with a report, such as frequent, similar, or recent history of past reports, or the need for legal intervention due to violent activities in the home, a local agency may, at its discretion, assign a report to a **Family Investigation** response.

- Identify needs and circumstances of children (and families).
- Determine whether child protective services that ensure ongoing safety, permanency and well-being for children should be provided.

- In Investigations (both family and facility), there is an additional goal: To use the evidence gathered through fact-finding to determine if allegations of maltreatment occurred. If a determination is made, the information is maintained for a minimum of 10 years.

Figure 13. Trend of percent of reports assigned to FA and FI paths, 2006 – 2016*



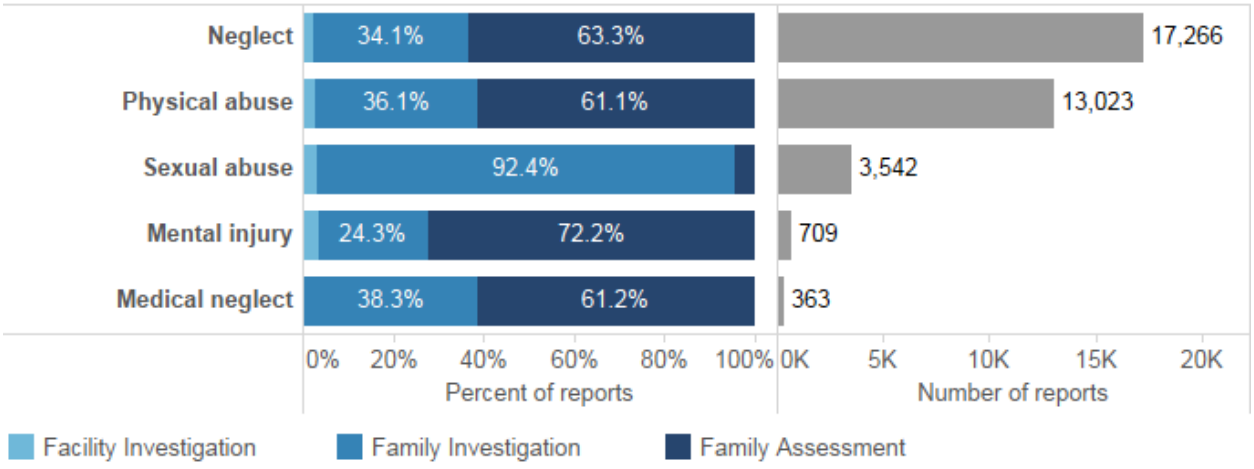
- After a pilot and evaluation of the Family Assessment model of child protection in 2000, statewide implementation was completed in 2005, leading to a decline in use of Family Investigations to make determinations of maltreatment.
- From 2015 to 2016, there was a **52.7** percent increase in the number of reports assigned to Family Investigation. There are several reasons that might explain the increase in reports assigned a Family Investigation response. A few possibilities are:
  - Updated guidance was provided on intake, screening and assignment decisions to county and tribal agency staff in the beginning of 2015, and the Minnesota Legislature passed a law requiring local agencies to follow this guidance. This information provided additional clarification as to which type of reports should be assigned to each track, which improved both understanding and consistency statewide.
  - Following 2015 statutory changes, child welfare agencies must take into account any prior history of screened out maltreatment reports a child or family has when considering a new allegation of maltreatment. In 2016, almost **three-quarters** of reports indicated the frequency, similarity, or recentness of past reports as one of the reasons for assigning a report to a Family Investigation response.
  - In 2016, there was a **30** percent increase in the number of victims with at least one allegation of sexual abuse. Minnesota Statutes require that all sexual abuse allegations receive a Family Investigation response. The statutory definitions of sexual abuse were amended to include sex trafficked youth.

Maltreatment type and child protection response paths

- The majority of all reports including the different types of maltreatment allegations were assigned to the Family Assessment response path, with the exception of reports including sexual abuse allegations (see Figure 14).
- Despite statute indicating that all sexual abuse allegations should receive a Family Investigation response**, 4.5** percent of screened in maltreatment reports (N = **159** reports) having allegations of sexual abuse were closed as having received a Family Assessment response. However, **99** (or **62.3** percent) of those reports were initially assigned to a Family Investigation and were switched once further assessment indicated a Family Investigation was not needed, which is permissible under Minnesota Statutes. That leaves **60** reports**,** or **1.7** percent of all reports including sexual abuse allegations, that were closed as Family Assessment and had never been an Investigation. This is a decrease since 2014, when nearly **7.1** percent of reports having sexual abuse allegations were assigned to and closed as Family Assessment.

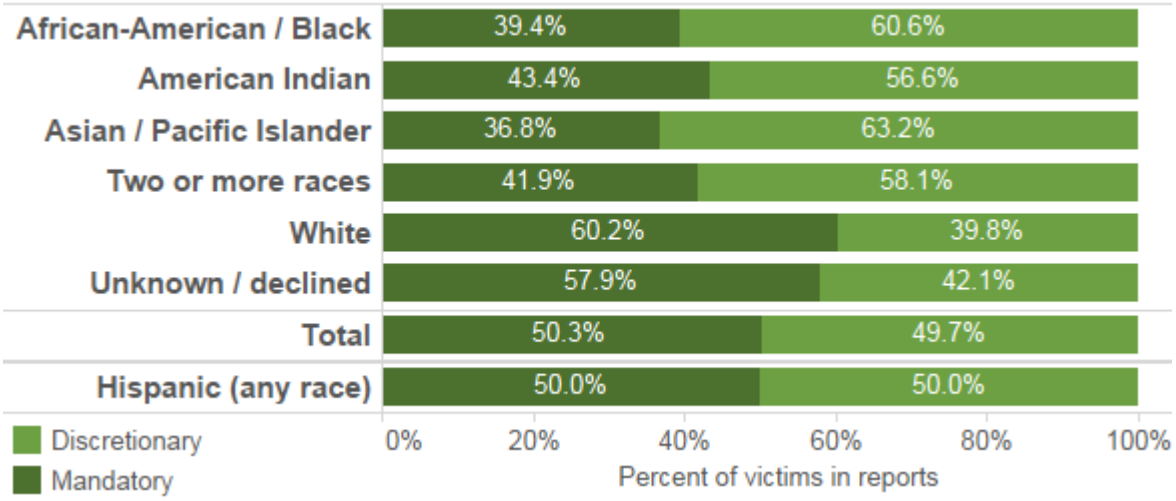
- Beginning in 2015, Child Safety and Permanency Division staff began reviewing every report that was assigned to Family Assessment and had a sexual abuse allegation, contacting local agencies to review this decision. This work will continue until there are no reports with sexual abuse allegations that were not initially assigned as Family Investigation.

Figure 14. The percent and number of reports by child protection response path and maltreatment type in 2016



- As mentioned in the assigning reports to child protection response paths explanation on p. 14, there are both mandatory and discretionary reasons that local child protection agency staff will assign a report to the Family Investigation response path.
- Figure 15 shows the percent of victims that were assigned to a Family Investigation by discretionary and mandatory reasons by race. White children received a Family Investigation for a discretionary reason by a much smaller margin than children from different racial and ethnic groups. The most frequent reason selected for discretionary assignment to a Family Investigation was frequency, similarity, or recentness of past reports (**73.3** percent).

Figure 15. The percent of alleged victims by race assigned to Family Investigation by discretionary versus mandatory reasons in 2016



Assessment or investigation of safety, risk and service need

After a report has been screened and assigned to the appropriate child protection response path, a child protection caseworker must make contact with alleged victims and all other relevant parties to assess the immediate safety of alleged victims. The specifics of how those meetings occur, when, and with whom are specific to each report and family. After the initial interviews and meetings in both the Family Assessment and Family Investigation response path, child protection caseworkers make an assessment of safety, based both on professional judgement and information provided from a safety assessment tool. If a safety threat is indicated, the caseworker, along with other partners, will determine whether a safety plan can keep a child safe, or if further intervention is warranted to place a child in out-of-home care.

During the assessment or investigation phase, caseworkers also determine the risk of future maltreatment and decide whether child protective services are needed to provide for ongoing safety, well-being and permanency. The assessment or investigation phase of all types of child protection responses is 45 days. If child protective services are needed, ongoing child protective case management services are provided to a family through opening child protection case management. At the closing of a Family Investigation or Facility Investigation, a determination is made as to whether or not maltreatment occurred. At any point during the assessment or investigation phase, if local agency staff feels a child is not safe, they may seek removal and place a child in out-of-home care and/or seek a Child in Need of Protection or Services (CHIPS) petition to provide court oversight and monitoring.

Timeliness of face-to-face contact with alleged victims of child maltreatment

- After screening a report, the first step in all child protection responses is to have face-to-face contact with alleged victims of maltreatment to determine if a child is safe or in need of protection. Occasionally, at the time a report is received, a child may already be placed on a 72-hour hold by local law enforcement. Regardless, a child protection caseworker must see all alleged victims in a report.
- There are two response time frames that align with assignment of the child protection response. Allegations that indicate risk of substantial child endangerment or sexual abuse require an Investigation and require local agencies to see all alleged victims within 24 hours.
- The majority of alleged victims did not have allegations that involved substantial child endangerment or sexual abuse (**80.1** percent) and, therefore, require face-to-face contact within five days. The five-day timeline applies to children named as alleged victims in

maltreatment reports assigned both to the Family Assessment response as well as those reports assigned to a Family Investigation at the discretion of local agency staff (rather than for mandatory reasons because of severity of the current allegation).

- While improvement has been made since 2015, **80.1** percent of victims were seen within the time frames established in statute for face-to-face contact with alleged victims in 2016 (see Figure 16), and continued efforts in this area are needed.

Figure 16. Timeliness to see alleged victims by timeliness response type

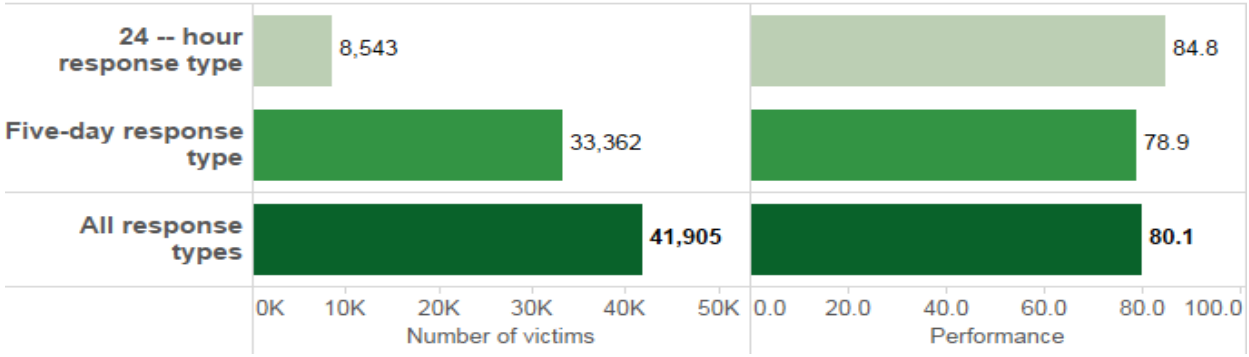
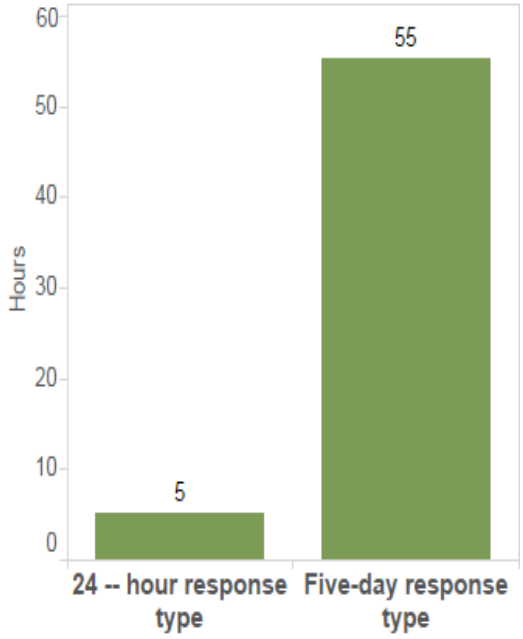


Figure 17. Median time to contact by timeliness response type



- Despite overall low performance, the median time of face-to-face contact between a child protection worker and alleged victims with allegations indicating substantial child endangerment was **five** hours, and the median time of contact for all other victims was **55** hours (see Figure 17).
- The 2015 Minnesota Legislature passed a bill providing increased funding to local agencies based on the number of families being served to assist agencies in hiring more child protection caseworkers. A percentage of the money is to be withheld and distributed at the end of the year based in part on a local agencies' performance on timely face-to-face contact with children who are subjects of a maltreatment report. This money was first distributed in February 2015 and continued in 2016; future years' data will provide further information regarding whether this funding provides local agencies with sufficient resources to see all alleged victims of maltreatment in a timely manner.
- Both the state and local child protection agencies recognize the urgent need to improve performance on this measure so that all children are seen in a timely manner, ensuring safety for Minnesota's alleged victims of maltreatment.

Assessment of safety and risk

- After making initial contact with alleged victims and the family, a child protection caseworker conducts a formal assessment tool regarding safety.
- A higher percentage of maltreatment reports that are assigned to Family Investigation are rated as unsafe (**15.6** percent versus **3.5** percent, respectively in Figure 18).
- Ratings of conditionally safe require caseworkers to create a safety plan to immediately address safety needs identified in the assessment tool for an alleged victim to remain in their home. Ratings of unsafe indicate removal of a child was necessary to achieve safety.

Figure 18. Number and percent of reports by safety levels and child protection response path

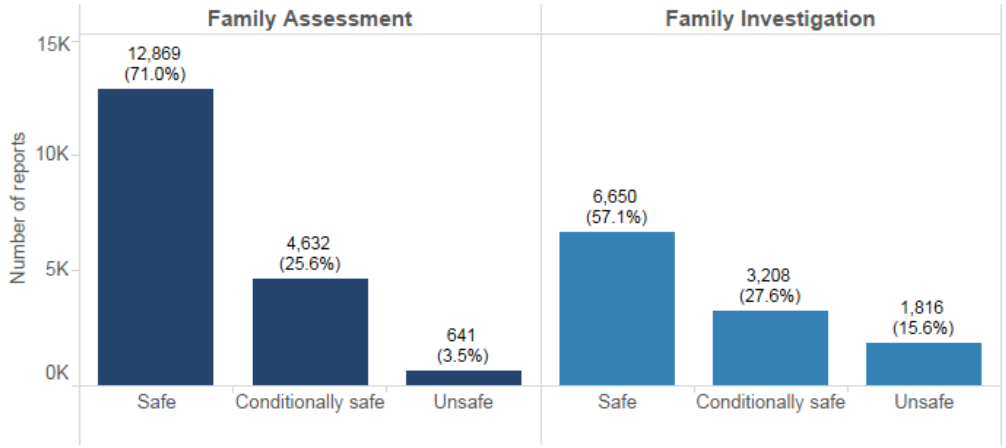
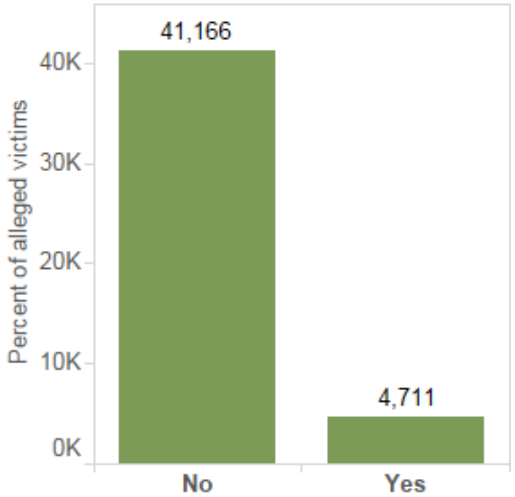


Figure 19. The number of alleged victims that have an out-of-home removal during the assessment or investigation phase

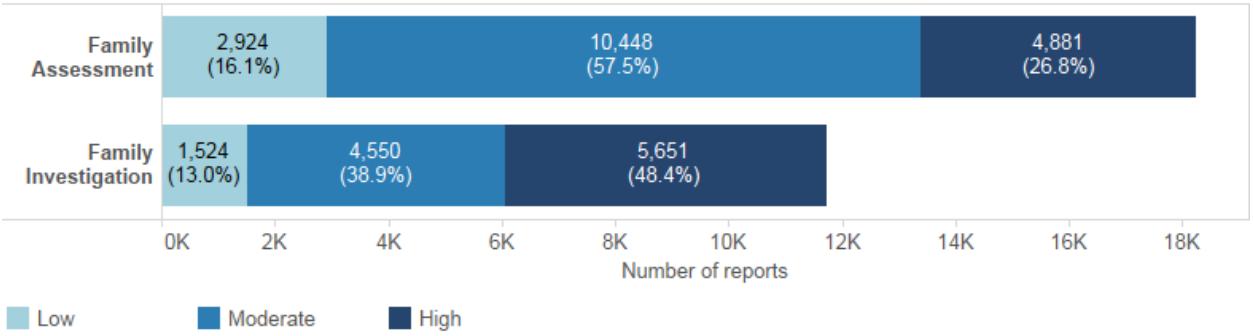


- When a child is found to be in an unsafe situation in which the adult(s) responsible for their care are unable or unwilling to make necessary changes to ensure their safety, a child can be removed by law enforcement or court order from their caregiver and placed in foster care.
- Sometimes removal of a child lasts only a few days, and sometimes they are in care for many months while their families work to ensure they are able to provide for their child's safety and well-being.
- Figure 19 shows a small proportion of all children who were involved in screened in child maltreatment reports in 2016 were placed in out-of-home care during an assessment or investigation (about

10 percent). Children may enter out-of-home care at other times as a result of being maltreated or for other reasons (e.g., children's mental health needs or developmental disabilities). See Minnesota's 2016 Out-of-home Care and Permanency report for more information.

- By the end of an assessment or investigation, child protection caseworkers must also complete a standardized assessment tool of risk of future maltreatment.
- Figure 20 provides information regarding the number of reports in which the current situation of alleged victims is at low, moderate or high risk of future maltreatment by child protection response path.
- As expected, a higher percentage of maltreatment reports that were Family Investigations were high risk (**48.4** percent) than were reports that were Family Assessments (**26.8** percent).

Figure 20. The number and percent of reports by risk assessment level and child protection response path

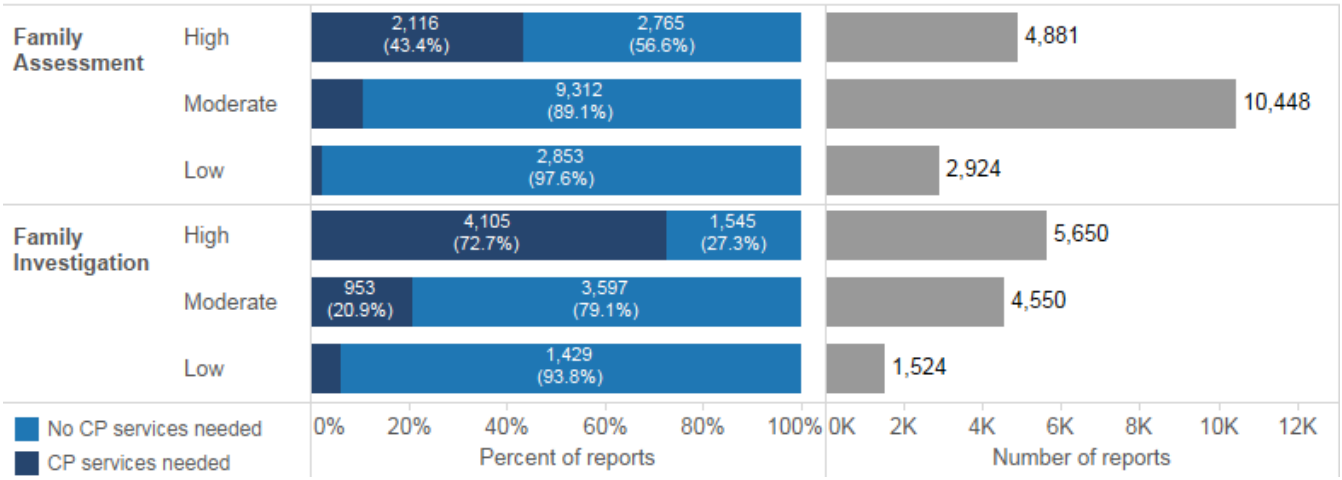


Assessing the need for ongoing child protection services post-assessment or investigation phase

- At the conclusion of a Family Assessment or Family Investigation, child protection caseworkers indicate whether an alleged victim and/or family needs ongoing child protective services to maintain safety, and promote permanency and well-being.
- Figure 21 provides information regarding whether the need for child protective services was indicated by risk levels identified through the risk assessment completed during the assessment or investigation phase.
- Reports that received a Family Investigation are more likely to indicate a need for post-investigation child protective services at all levels of risk.
- Although reports that are rated as high risk during an assessment or investigative phase were more likely to indicate a need for ongoing child protective services across both response paths, a majority of high risk reports that received a Family Assessment were not indicated as needing ongoing child protective services by caseworkers.

- The department revalidated the tool used for risk assessment during 2016. This included revisions to some of the item scores used to generate the overall risk level. Department staff will continue to monitor the relationship between risk assessments and the need for child protection case management.

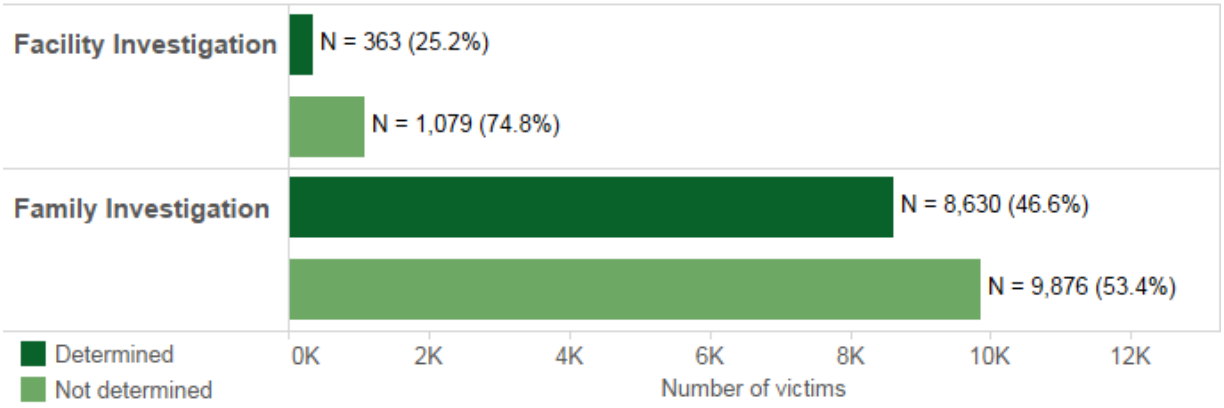
Figure 21. The percent and number of reports where child protective services were indicated by response category and risk level



Determining maltreatment

- For both family and facility investigations, there is a final step at the conclusion of a child maltreatment report that is not made in a Family Assessment. The final step is to make a determination of whether maltreatment occurred based on information gathered during an investigation.
- Figure 22 provides information about the number of determined reports and victims by family or facility investigation. There were **8,630** children in Family Investigations and **363** in facility investigations who had a maltreatment determination in 2016.
- For less than half of all victims in reports that were in either type of investigation, there was a determination that maltreatment occurred (**45.1** percent). However, the pattern is different for facility and family investigations, with **one quarter** of all victims in Facility Investigations, and less than **half** of victims in Family Investigations having a determination made.

Figure 22. The number of determined victims by Family Investigation and Facility Investigation response paths



Relationship of alleged offenders to alleged victims in screened in child maltreatment reports by determination

- The overwhelming majority of alleged and determined offenders in screened in reports of maltreatment were biological parents (see Table 2 below).
- Parents, unmarried partners of parents, and step-parents had the highest rate of being determined to have maltreated a child.
- Non-relative foster parents had the lowest determination rate, at **10.3** percent.
- There were **45** alleged offenders who had a relationship status entered in the data system that indicated they should have had an investigation but seem to have received a Family Assessment response. After further examination, this appears to be data entry errors in documentation of the relationship rather than inappropriate assignment of these cases to a Family Assessment response.

Sidebar: Minnesota is experiencing an increase in ongoing child protection

At closure of an assessment or investigation, a case may be opened to provide a child and family with ongoing services. Often, these services are provided in the home and community, however, services may include removing children from the home (see the Minnesota Out-of-home Care and Permanency Report for more information on children in out-of-home care).

Ongoing services are provided to help children and families address specific needs related to ensuring the safety and security of children in the home. This is achieved through a combination of regular assessment, case planning, face-to-face visitation, and referring children and families to additional supportive services in the community. Ongoing child protection work is demanding and requires additional resources from county and tribal agencies.

- The number of ongoing child protection cases has increased by **50** percent since 2012. In 2016, more than **6,000** ongoing child protection cases were opened, representing more than **30,000** children and adults.

Table 2. Number of alleged offenders by relationship to alleged victims, and child protection response and determination status in 2016

	Family Assessment	Investigations	Investigations determined	Percent determined
Biological parent	16,820	9,837	5,171	52.6%
Unmarried partner of parent	1,211	1,253	653	52.1%
Step parent	762	570	274	48.1%
Other relative (non-foster parent)	527	771	323	41.9%
Legal guardian	269	210	93	44.3%
Adoptive parent	243	196	80	40.8%
Other	190	462	209	45.2%
Sibling	207	617	233	37.8%
Friends or neighbors	35	89	34	38.2%
Unknown or missing	32	43	17	39.5%
Child daycare provider	24	200	68	34.0%
Non-relative foster parent	2	214	22	10.3%
Relative foster parent	16	201	60	29.9%
Other professionals	2	15	4	26.7%
Group home or residential facility staff	1	86	14	16.3%
Non-caregiver sex trafficker	0	4	1	25.0%

Child fatalities and near fatalities due to maltreatment

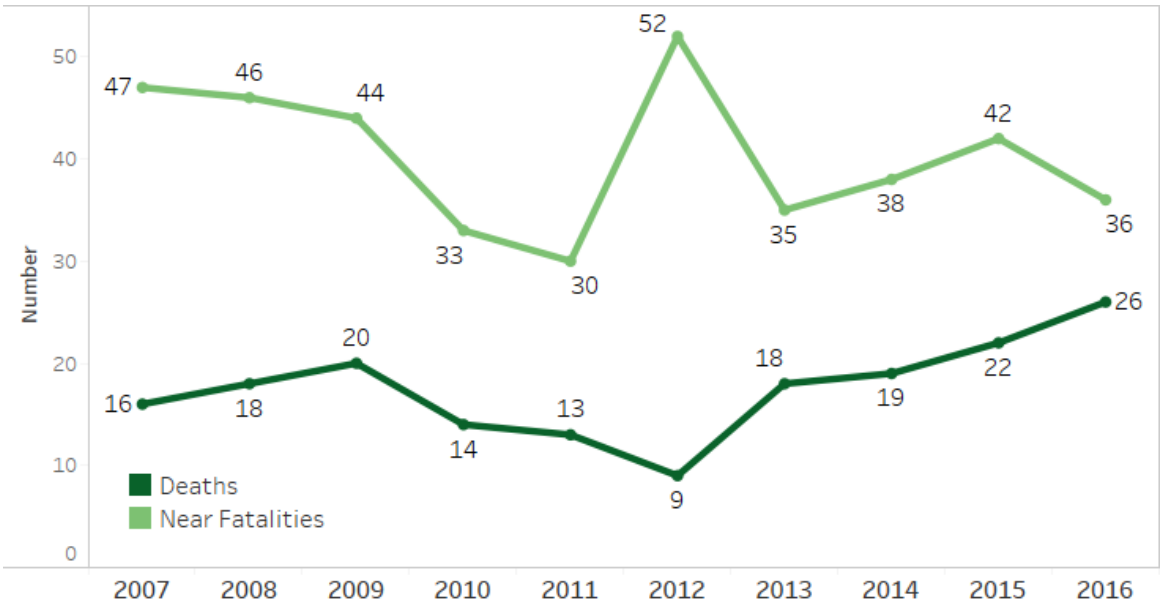
Local social service agencies and the department take the work of protecting children very seriously. In 2016, in response to recommendations from the Governor's Task Force on the Protection of Children and the final report from the National Commission to Eliminate Child Abuse and Neglect Fatalities, department staff began working with Collaborative Safety, LLC, to implement a trauma-informed, robust and scientific systemic critical incident review process for child fatalities and near fatalities due to maltreatment. The review process is designed to systemically analyze the child welfare system to identify opportunities for improvement, as well as address barriers to providing the best possible services to children and families. The model utilizes components from the same science used by other safety-critical industries, including aviation and health care; it moves away from blame and toward a system of accountability that focuses on identifying underlying systemic issues to improve Minnesota's child welfare system.

This approach [Collaborative Safety] has been shown to improve staff engagement and staff retention, and most important, to improve outcomes for children and families.

The revised review process will be implemented in 2017 in partnership with local agency staff and community partners. A significant component of the department's work with Collaborative Safety in early 2017 involves creating, advancing, and supporting development of a safety culture within Minnesota's child welfare system. This approach has been shown to improve staff engagement and retention, and most important, to improve outcomes for children and families. As a first step towards building a safety culture in Minnesota that will support learning after critical incidents and prevention of future incidents, events will be held across the state to provide information about safety science and the critical incident review process to the department's leadership, county and tribal agency leaders, front-line staff and other child welfare partners.

- Figure 23 provides trend information regarding both near fatalities and deaths that were determined to be a result of maltreatment from 2007 to 2016.
- There were **26** deaths and **36** near fatalities determined to be a result of maltreatment in 2016.

Figure 23. Victims who died or had a near fatality as a result of maltreatment, 2007 – 2016



- Tables 3 and 4 provide detailed information about victims who died as a result of maltreatment in 2016. Table 3 provides information for victims who died as a result of maltreatment and had at least one prior screened in maltreatment report; Table 4 provides information for victims who had no known prior involvement in a child maltreatment report.

- There are often a number of months, and sometimes even longer, between when a determination is finalized and when a death occurred. The delay often results from needing to wait until criminal investigations are completed before making a determination. The tables, therefore, provide information about when a death occurred; in all cases, the final determination about whether a death was a result of maltreatment was not made until 2016 which is why it is being included in the 2016 annual report.
- Other information included in the table are age at time of death, gender, the relationship of offender to the victim, and the type of maltreatment that resulted in death.
- Of the **26** children whose deaths were determined to be a result of maltreatment in 2016, **four** had been involved in prior screened in reports; **22** had not.

Table 3. Detailed information regarding deaths that were determined to be a result of maltreatment in 2016, and where children had a prior CP history

Year of Death	Age and gender	Type of maltreatment
2016	5 year(s) old, Male	Neglect
2015	2 years old, female	Neglect, physical abuse, sexual abuse
2016	2 years old, male	Neglect
2016	2 years old, female	Neglect

Table 4. Detailed information regarding deaths determined to be a result of maltreatment in 2016, where children had no prior CP history

Year of Death	Age and gender	Type of maltreatment
2016	5 years old, male	Neglect
2016	Less than 1 year old, male	Physical abuse
2015	1 year old, male	Physical abuse
2016	16 years old, male	Neglect
2016	Less than 1 year old, female	Neglect
2016	1 year old, male	Neglect, physical abuse
2015	1 year old, female	Neglect
2015	Less than 1 year old, female	Neglect
2015	Less than 1 year old, male	Physical abuse
2016	17 years old, male	Neglect
2016	15 years old, female	Neglect, physical abuse
2016	4 years old, male	Neglect
2015	Less than 1 year old, male	Neglect
2015	2 years old, female	Neglect, physical abuse, sexual abuse
2016	2 years old, male	Physical abuse
2016	Less than 1 year old, female	Neglect
2015	Less than 1 year old, male	Physical abuse
2015	6 years old, male	Neglect
2015	2 years old, female	Neglect
2015	5 years old, female	Neglect
2016	2 years old, female	Neglect
2014	Less than 1 year old, male	Neglect, physical abuse
2016	Less than 1 year old, female	Neglect
2016	Less than 1 year old, female	Neglect, physical abuse
2016	2 years old, male	Neglect
2016	Less than 1 year old, female	Neglect

Outcomes after child maltreatment reports have concluded

To determine how successfully child protection is assessing the needs of children and families and providing the appropriate services to meet those needs, local agency and Child Safety and Permanency Division staff monitor whether children who were alleged or determined victims in child maltreatment reports have another occurrence of being an alleged or determined victim in a screened in maltreatment report within 12 months.

Re-reporting for alleged victims

- Table 5 provides information on how many alleged victims in screened in maltreatment reports in 2015 had another screened in maltreatment report within 12 months of the first report by child protection response path.
- A slightly higher percentage of victims with a Family Assessment had a re-report within 12 months than did victims with a Family Investigation.

Table 5. The number and percent of alleged victims with a re-report of maltreatment within 12 months by child protection response path in 2016

	12-month re-report	
	Number	**Percent**
Family Assessment (N = 21,345)	4,476	21.0%
Family Investigation (N = 9,892)	1,823	18.4%
Facility Investigation (N = 645)	76	11.8%
Total (N = 31,879)	**6,373**	**20.0%**

Recurrence of maltreatment determinations for determined victims

- Table 6 provides information on how many children, by race, who were determined victims of maltreatment in 2015 had another maltreatment determination within 12 months of the first determination.
- Maltreatment recurrence is a federal performance measure that is examined annually by the Children's Bureau. It sets a federal performance standard that Minnesota must meet or face the possibility of a performance improvement plan with fiscal penalties. During 2015, the Children's Bureau revised the federal maltreatment performance indicator to follow victims with a determination for a full 12 months instead of only six months following their initial determination. The new federal performance standard for recurrence requires that less than **9.1** percent of children have a maltreatment determination recurrence within 12 months.
- In 2016, Minnesota met the maltreatment recurrence standard with **8.2** percent of all children having had a maltreatment determination.
- The recurrence rate for African-American/Black, American Indian, and children of two or more races is noticeably higher compared to other races at 12 months.

Table 6. The number and percent of victims with a maltreatment determination recurrence within 12 months by race in 2016

	12-month recurrence	
	Number	**Percent**
African-American / Black (N = 1,114)	131	11.8%
American Indian (N = 520)	52	10.0%
Asian / Pacific Islander (N = 172)	6	3.5%
Two or more races (N = 911)	110	12.1%
Unknown / declined (N = 131)	4	3.1%
White (N = 3,026)	181	6.0%
Total determined victims (N = 5,874)	484	8.2%
Hispanic (any race) (N = 680)	77	11.3%

Child maltreatment appendix

The number and percent of child maltreatment reports by screening status and agency, 2016

Agency	Screened in and completed N	Screened in and completed %	Screened in and unable to conclude N	Screened in and unable to conclude %	Screened out N	Screened out %	Total N	Total %
Aitkin	77	45.8%	1	0.6%	90	53.6%	168	100.0%
Anoka	1,277	41.5%	43	1.4%	1,757	57.1%	3,077	100.0%
Becker	239	43.5%	7	1.3%	303	55.2%	549	100.0%
Beltrami	332	38.6%	8	0.9%	521	60.5%	861	100.0%
Benton	177	24.0%	3	0.4%	558	75.6%	738	100.0%
Big Stone	18	45.0%	0	0.0%	22	55.0%	40	100.0%
Blue Earth	362	32.6%	17	1.5%	732	65.9%	1,111	100.0%
Brown	172	35.0%	0	0.0%	320	65.0%	492	100.0%
Carlton	286	33.9%	11	1.3%	546	64.8%	843	100.0%
Carver	364	53.9%	13	1.9%	298	44.1%	675	100.0%
Cass	172	46.1%	13	3.5%	188	50.4%	373	100.0%
Chippewa	48	62.3%	0	0.0%	29	37.7%	77	100.0%
Chisago	174	22.1%	13	1.7%	599	76.2%	786	100.0%
Clay	506	31.9%	45	2.8%	1,036	65.3%	1,587	100.0%
Clearwater	71	36.2%	2	1.0%	123	62.8%	196	100.0%
Cook	40	37.4%	0	0.0%	67	62.6%	107	100.0%
Crow Wing	272	25.4%	4	0.4%	794	74.2%	1,070	100.0%
Dakota	1,734	35.3%	20	0.4%	3,165	64.3%	4,919	100.0%
Douglas	244	44.6%	12	2.2%	291	53.2%	547	100.0%
Fillmore	68	50.4%	0	0.0%	67	49.6%	135	100.0%
Freeborn	136	24.3%	7	1.3%	417	74.5%	560	100.0%
Goodhue	230	38.9%	4	0.7%	357	60.4%	591	100.0%
Grant	105	47.7%	1	0.5%	114	51.8%	220	100.0%
Hennepin	8,258	55.5%	229	1.5%	6,389	42.9%	14,876	100.0%

Agency	Screened in and completed N	Screened in and completed %	Screened in and unable to conclude N	Screened in and unable to conclude %	Screened out N	Screened out %	Total N	Total %
Houston	91	82.0%	6	5.4%	14	12.6%	111	100.0%
Hubbard	264	53.0%	10	2.0%	224	45.0%	498	100.0%
Isanti	172	22.1%	5	0.6%	603	77.3%	780	100.0%
Itasca	325	28.2%	93	8.1%	736	63.8%	1,154	100.0%
Kanabec	113	40.1%	3	1.1%	166	58.9%	282	100.0%
Kandiyohi	206	27.5%	7	0.9%	537	71.6%	750	100.0%
Kittson	19	46.3%	1	2.4%	21	51.2%	41	100.0%
Koochiching	52	20.6%	0	0.0%	201	79.4%	253	100.0%
Lac qui Parle	30	68.2%	1	2.3%	13	29.5%	44	100.0%
Lake	52	55.3%	5	5.3%	37	39.4%	94	100.0%
Lake of the Woods	16	51.6%	0	0.0%	15	48.4%	31	100.0%
Le Sueur	171	27.9%	0	0.0%	442	72.1%	613	100.0%
McLeod	248	33.6%	4	0.5%	487	65.9%	739	100.0%
Mahnomen	34	44.2%	0	0.0%	43	55.8%	77	100.0%
Marshall	58	46.4%	0	0.0%	67	53.6%	125	100.0%
Meeker	89	35.0%	5	2.0%	160	63.0%	254	100.0%
Mille Lacs	306	30.0%	13	1.3%	702	68.8%	1,021	100.0%
Morrison	164	28.8%	0	0.0%	406	71.2%	570	100.0%
Mower	316	39.6%	4	0.5%	478	59.9%	798	100.0%
Nicollet	142	33.9%	4	1.0%	273	65.2%	419	100.0%
Nobles	88	23.2%	2	0.5%	290	76.3%	380	100.0%
Norman	52	38.8%	2	1.5%	80	59.7%	134	100.0%
Olmsted	674	42.2%	6	0.4%	919	57.5%	1,599	100.0%
Otter Tail	397	52.2%	7	0.9%	356	46.8%	760	100.0%
Pennington	75	55.1%	3	2.2%	58	42.6%	136	100.0%

Agency	Screened in and completed N	Screened in and completed %	Screened in and unable to conclude N	Screened in and unable to conclude %	Screened out N	Screened out %	Total N	Total %
Pine	373	28.7%	30	2.3%	896	69.0%	1,299	100.0%
Polk	175	27.6%	17	2.7%	441	69.7%	633	100.0%
Pope	102	45.3%	6	2.7%	117	52.0%	225	100.0%
Ramsey	2,567	41.6%	26	0.4%	3,572	57.9%	6,165	100.0%
Red Lake	18	52.9%	0	0.0%	16	47.1%	34	100.0%
Renville	93	38.4%	2	0.8%	147	60.7%	242	100.0%
Rice	417	36.7%	3	0.3%	717	63.1%	1,137	100.0%
Roseau	71	41.3%	1	0.6%	100	58.1%	172	100.0%
St. Louis	1,793	58.4%	104	3.4%	1,174	38.2%	3,071	100.0%
Scott	626	36.6%	7	0.4%	1,078	63.0%	1,711	100.0%
Sherburne	426	30.4%	3	0.2%	974	69.4%	1,403	100.0%
Sibley	83	35.0%	1	0.4%	153	64.6%	237	100.0%
Stearns	615	38.3%	9	0.6%	980	61.1%	1,604	100.0%
Stevens	54	42.9%	0	0.0%	72	57.1%	126	100.0%
Swift	69	26.4%	2	0.8%	190	72.8%	261	100.0%
Todd	100	24.9%	23	5.7%	278	69.3%	401	100.0%
Traverse	46	48.9%	2	2.1%	46	48.9%	94	100.0%
Wabasha	118	48.6%	3	1.2%	122	50.2%	243	100.0%
Wadena	110	35.5%	4	1.3%	196	63.2%	310	100.0%
Washington	795	40.7%	14	0.7%	1,144	58.6%	1,953	100.0%
Watonwan	71	52.6%	0	0.0%	64	47.4%	135	100.0%
Wilkin	62	48.8%	5	3.9%	60	47.2%	127	100.0%
Winona	283	29.1%	6	0.6%	683	70.3%	972	100.0%
Wright	552	27.3%	30	1.5%	1,440	71.2%	2,022	100.0%
Yellow Medicine	82	50.9%	1	0.6%	78	48.4%	161	100.0%

Agency	Screened in and completed N	Screened in and completed %	Screened in and unable to conclude N	Screened in and unable to conclude %	Screened out N	Screened out %	Total N	Total %
Southwest HHS	587	40.1%	25	1.7%	851	58.2%	1,463	100.0%
Des Moines Valley HHS	169	36.0%	1	0.2%	299	63.8%	469	100.0%
Faribault-Martin	253	37.6%	6	0.9%	414	61.5%	673	100.0%
Leech Lake Band of Ojibwe	132	30.8%	4	0.9%	293	68.3%	429	100.0%
White Earth Nation	165	42.9%	27	7.0%	193	50.1%	385	100.0%
MN Prairie	413	30.8%	24	1.8%	905	67.4%	1,342	100.0%
Total	**30,936**	**40.8%**	**1,020**	**1.3%**	**43,804**	**57.8%**	**75,760**	**100.0%**

N = number of reports

% = percentage of total reports for the given row

Number of alleged victims in screened in maltreatment reports by maltreatment type and rate per 1,000 children by agency, 2016

Agency	Medical neglect	Mental injury	Neglect	Physical abuse	Sexual abuse	Total unique victims*	2015 child population estimate	Children per 1,000
Aitkin	1	7	81	31	11	117	2,725	42.9
Anoka	14	15	860	561	200	1,528	83,424	18.3
Becker	5	18	242	121	53	332	8,227	40.4
Beltrami	5	5	395	102	53	513	11,516	44.5
Benton	2	12	137	106	18	236	9,729	24.3
Big Stone	0	1	22	6	1	27	1,028	26.3
Blue Earth	0	4	361	113	41	459	13,012	35.3
Brown	1	24	128	88	33	237	5,476	43.3
Carlton	8	18	290	144	26	389	8,059	48.3
Carver	2	34	315	177	40	505	27,222	18.6
Cass	2	11	160	70	16	218	6,102	35.7
Chippewa	1	0	49	21	9	71	2,800	25.4
Chisago	4	4	133	81	27	225	12,577	17.9
Clay	16	24	411	312	98	703	14,629	48.1
Clearwater	1	6	68	38	12	99	2,196	45.1
Cook	1	4	24	18	2	43	793	54.2
Crow Wing	2	14	218	171	74	401	13,940	28.8
Dakota	15	6	1,367	617	195	2,063	102,866	20.1
Douglas	5	14	248	100	47	335	7,878	42.5
Fillmore	0	1	42	57	6	90	4,998	18.0
Freeborn	2	1	135	60	26	200	6,685	29.9
Goodhue	1	2	172	89	56	291	10,438	27.9
Grant	2	12	80	52	11	116	1,298	89.4
Hennepin	95	209	5,767	5,709	1,428	10,562	271,399	38.9

Agency	Medical neglect	Mental injury	Neglect	Physical abuse	Sexual abuse	Total unique victims*	2015 child population estimate	Children per 1,000
Houston	0	8	80	38	15	127	4,041	31.4
Hubbard	13	13	209	111	45	310	4,392	70.6
Isanti	3	7	160	67	35	248	9,259	26.8
Itasca	5	8	300	168	57	467	9,650	48.4
Kanabec	1	5	71	65	13	133	3,452	38.5
Kandiyohi	1	16	186	129	60	314	10,207	30.8
Kittson	0	1	8	6	9	19	968	19.6
Koochiching	5	1	30	15	12	58	2,474	23.4
Lac qui Parle	1	2	28	9	3	40	1,374	29.1
Lake	1	0	43	38	4	72	1,986	36.3
Lake of the Woods	0	0	20	6	0	24	732	32.8
Le Sueur	5	9	116	82	31	207	6,731	30.8
McLeod	9	4	238	99	39	348	8,479	41.0
Mahnomen	2	0	31	12	1	42	1,661	25.3
Marshall	1	13	54	37	6	79	2,177	36.3
Meeker	1	1	32	58	13	102	5,705	17.9
Mille Lacs	3	11	272	144	75	415	6,154	67.4
Morrison	0	4	124	63	35	207	7,707	26.9
Mower	2	8	255	109	53	380	9,633	39.4
Nicollet	0	28	97	43	11	152	7,265	20.9
Nobles	0	13	58	54	20	125	5,841	21.4
Norman	1	3	44	22	13	74	1,541	48.0
Olmsted	3	22	591	218	100	864	37,346	23.1
Otter Tail	4	37	316	151	52	435	12,383	35.1
Pennington	0	1	53	37	16	91	3,318	27.4
Pine	0	8	394	201	62	519	5,972	86.9
Polk	3	19	153	50	24	236	7,421	31.8

Agency	Medical neglect	Mental injury	Neglect	Physical abuse	Sexual abuse	Total unique victims*	2015 child population estimate	Children per 1,000
Pope	4	8	80	70	18	139	2,291	60.7
Ramsey	8	11	2,089	1,112	411	3,300	125,750	26.2
Red Lake	0	1	10	9	1	21	1,013	20.7
Renville	7	5	85	40	15	128	3,320	38.6
Rice	4	0	337	196	68	530	14,471	36.6
Roseau	0	0	76	15	6	95	3,892	24.4
St. Louis	16	36	1,410	956	284	2,298	38,344	59.9
Scott	5	24	360	335	146	761	40,341	18.9
Sherburne	1	33	327	228	67	567	24,829	22.8
Sibley	0	0	102	25	14	131	3,563	36.8
Stearns	4	20	461	344	96	789	35,283	22.4
Stevens	2	5	39	35	2	71	2,085	34.1
Swift	2	1	73	18	13	92	2,048	44.9
Todd	2	2	82	35	10	129	5,817	22.2
Traverse	2	1	35	36	12	62	700	88.6
Wabasha	0	4	88	40	11	136	4,698	28.9
Wadena	1	2	90	60	32	143	3,401	42.0
Washington	12	31	500	487	146	1,000	62,864	15.9
Watonwan	1	0	49	21	21	88	2,648	33.2
Wilkin	1	0	30	24	4	53	1,452	36.5
Winona	7	24	193	149	26	313	9,338	33.5
Wright	7	7	433	287	62	717	37,511	19.1
Yellow Medicine	0	3	61	30	16	95	2,270	41.9
Southwest HHS	13	31	441	233	77	683	18,009	37.9
Des Moines Valley HHS	2	9	128	73	31	224	4,984	44.9
Faribault-Martin	10	0	233	85	24	321	7,384	43.5
Leech Lake Band of Ojibwe	11	0	138	15	6	163	1,975	82.5

Agency	Medical neglect	Mental injury	Neglect	Physical abuse	Sexual abuse	Total unique victims*	2015 child population estimate	Children per 1,000
White Earth Nation	3	2	273	34	2	304	1,981	153.5
MN Prairie	5	4	294	241	58	535	19,195	27.9
Total	**379**	**952**	**24,185**	**16,109**	**4,966**	**39,736**	**1,284,387**	**30.9**

***Total unique victims can be less than the sum of victims in all maltreatment types as a child could be represented in multiple maltreatment types.*
Population estimates come from the U.S. Census estimates for 2014, except for Leech Lake Band of Ojibwe and White Earth Nation; the data for these two groups are 2010 Census numbers which represent children residing on the Leech Lake and White Earth reservations who indicated American Indian alone or as one of two or more races. There are no intercensal child population estimates for these groups. The Leech Lake reservation overlaps Cass, Itasca, Beltrami and Hubbard counties. The White Earth reservation overlaps Mahnomen, Becker and Clearwater counties.

Number of alleged victims by age group and agency, 2016

Agency	Birth to 2	Three through 5	Six through 8	Nine through 11	Twelve through 14	Fifteen through 17	Eighteen and older	Total
Aitkin	19	19	27	23	18	11	0	**117**
Anoka	295	246	313	297	218	159	0	**1,528**
Becker	80	61	62	47	38	44	0	**332**
Beltrami	135	84	111	78	58	47	0	**513**
Benton	51	48	43	51	23	20	0	**236**
Big Stone	10	4	2	6	2	3	0	**27**
Blue Earth	114	98	96	84	43	24	0	**459**
Brown	35	49	55	45	31	22	0	**237**
Carlton	71	70	85	75	48	40	0	**389**
Carver	86	83	106	90	79	61	0	**505**
Cass	46	38	39	43	33	19	0	**218**
Chippewa	15	10	14	11	10	11	0	**71**
Chisago	57	45	43	39	23	18	0	**225**
Clay	162	140	150	116	77	58	0	**703**
Clearwater	17	18	19	21	14	10	0	**99**
Cook	11	14	3	6	2	7	0	**43**
Crow Wing	101	93	81	61	37	28	0	**401**
Dakota	328	331	477	403	279	244	1	**2,063**
Douglas	77	67	75	56	34	26	0	**335**
Fillmore	17	20	21	13	10	9	0	**90**
Freeborn	59	45	35	27	20	14	0	**200**
Goodhue	74	49	64	43	35	26	0	**291**
Grant	22	22	23	22	18	9	0	**116**
Hennepin	2,185	1,760	2,190	1,826	1,407	1,191	3	**10,562**
Houston	32	24	28	18	14	11	0	**127**

Agency	Birth to 2	Three through 5	Six through 8	Nine through 11	Twelve through 14	Fifteen through 17	Eighteen and older	Total
Hubbard	65	50	54	54	47	40	0	**310**
Isanti	47	49	44	44	35	29	0	**248**
Itasca	100	93	83	81	58	52	0	**467**
Kanabec	22	20	25	21	21	23	1	**133**
Kandiyohi	71	49	78	52	33	31	0	**314**
Kittson	1	4	3	4	7	0	0	**19**
Koochiching	12	11	7	12	10	6	0	**58**
Lac qui Parle	8	4	15	7	4	2	0	**40**
Lake	12	11	18	19	8	4	0	**72**
Lake of the Woods	8	4	2	3	5	2	0	**24**
Le Sueur	42	38	33	35	32	27	0	**207**
McLeod	69	67	85	58	38	31	0	**348**
Mahnomen	12	11	6	7	5	1	0	**42**
Marshall	18	16	10	12	12	11	0	**79**
Meeker	8	18	21	22	18	15	0	**102**
Mille Lacs	108	67	66	74	61	39	0	**415**
Morrison	59	44	35	31	18	20	0	**207**
Mower	77	61	92	62	47	41	0	**380**
Nicollet	35	29	30	35	12	11	0	**152**
Nobles	23	27	21	22	13	19	0	**125**
Norman	12	17	16	15	8	6	0	**74**
Olmsted	220	158	174	132	105	75	0	**864**
Otter Tail	120	73	98	53	60	31	0	**435**
Pennington	32	24	13	12	6	4	0	**91**
Pine	118	81	99	92	67	61	1	**519**
Polk	42	38	62	49	30	15	0	**236**

Agency	Birth to 2	Three through 5	Six through 8	Nine through 11	Twelve through 14	Fifteen through 17	Eighteen and older	Total
Pope	33	23	28	27	15	13	0	**139**
Ramsey	738	545	714	551	414	338	0	**3,300**
Red Lake	10	2	1	2	2	4	0	**21**
Renville	18	32	21	21	13	23	0	**128**
Rice	96	110	116	86	70	52	0	**530**
Roseau	23	19	16	7	9	21	0	**95**
St. Louis	549	404	477	395	252	215	6	**2,298**
Scott	154	105	157	146	106	93	0	**761**
Sherburne	107	92	123	113	76	56	0	**567**
Sibley	33	20	28	24	17	9	0	**131**
Stearns	171	161	192	122	71	72	0	**789**
Stevens	17	8	17	7	14	8	0	**71**
Swift	25	25	17	14	8	3	0	**92**
Todd	34	22	24	22	12	15	0	**129**
Traverse	11	15	12	9	9	6	0	**62**
Wabasha	32	20	25	25	19	15	0	**136**
Wadena	23	31	28	26	22	13	0	**143**
Washington	203	180	203	172	147	95	0	**1,000**
Watonwan	23	10	14	21	10	10	0	**88**
Wilkin	11	10	13	7	7	4	1	**53**
Winona	71	59	60	48	39	36	0	**313**
Wright	118	126	153	130	94	96	0	**717**
Yellow Medicine	16	9	24	17	19	10	0	**95**
Southwest HHS	139	143	152	120	73	56	0	**683**
Des Moines Valley HHS	38	52	54	27	38	15	0	**224**
Faribault-Martin	76	65	51	63	33	33	0	**321**

Agency	Birth to 2	Three through 5	Six through 8	Nine through 11	Twelve through 14	Fifteen through 17	Eighteen and older	Total
Leech Lake Band of Ojibwe	43	28	45	26	13	8	0	**163**
White Earth Nation	69	56	58	51	45	25	0	**304**
MN Prairie	122	107	113	81	63	49	0	**535**
Total	**8,443**	**6,981**	**8,288**	**6,869**	**5,041**	**4,101**	**13**	**39,736**

***Some victims may be involved in more than one report during the report period. Victim's age is calculated based on the first maltreatment report they were an alleged victim in during the report period.*

Number of alleged victims by race and ethnicity and agency, 2016

Agency	African-American/ Black	American Indian	Asian/ Pacific Islander	Two or More Races	Unknown/ declined	White	Total	Hispanic (any race)
Aitkin	*	13	*	7	*	96	**117**	*
Anoka	258	42	21	202	57	948	**1,528**	153
Becker	8	69	*	42	*	204	**332**	7
Beltrami	9	281	*	44	*	173	**513**	23
Benton	29	*	*	22	*	176	**236**	16
Big Stone	*	*	*	*	*	24	**27**	*
Blue Earth	56	9	16	42	14	322	**459**	47
Brown	*	*	*	7	7	217	**237**	45
Carlton	*	116	*	68	*	197	**389**	*
Carver	42	10	*	39	*	391	**505**	72
Cass	*	39	*	15	7	157	**218**	*
Chippewa	*	*	*	*	*	57	**71**	17
Chisago	*	*	*	14	19	184	**225**	18
Clay	63	85	*	124	*	429	**703**	123
Clearwater	8	27	*	10	*	52	**99**	*
Cook	*	12	*	*	*	27	**43**	*
Crow Wing	10	14	*	18	*	359	**401**	8
Dakota	366	30	35	289	165	1,178	**2,063**	313
Douglas	10	*	*	38	17	267	**335**	18
Fillmore	*	*	*	10	*	78	**90**	*
Freeborn	14	*	*	29	*	153	**200**	35
Goodhue	23	*	*	23	*	243	**291**	23
Grant	*	*	*	*	*	104	**116**	11
Hennepin	4,491	567	353	1,747	287	3,117	**10,562**	1,479
Houston	*	*	*	*	18	98	**127**	*
Hubbard	*	35	*	22	*	246	**310**	11
Isanti	*	12	*	24	*	201	**248**	10

Agency	African-American/ Black	American Indian	Asian/ Pacific Islander	Two or More Races	Unknown/ declined	White	Total	Hispanic (any race)
Itasca	*	43	*	47	15	360	**467**	7
Kanabec	*	*	*	7	*	117	**133**	17
Kandiyohi	19	*	*	11	*	276	**314**	115
Kittson	*	*	*	*	*	16	**19**	*
Koochiching	*	*	*	*	*	56	**58**	*
Lac qui Parle	*	*	*	*	*	34	**40**	*
Lake	*	*	*	9	*	58	**72**	*
Lake of the Woods	*	*	*	*	*	23	**24**	*
Le Sueur	*	*	*	12	7	180	**207**	38
McLeod	*	*	*	32	12	295	**348**	50
Mahnomen	*	26	*	*	*	11	**42**	8
Marshall	*	*	*	7	*	66	**79**	10
Meeker	*	*	*	*	*	92	**102**	*
Mille Lacs	7	154	*	28	*	208	**415**	10
Morrison	*	*	*	37	*	159	**207**	8
Mower	42	*	16	34	*	280	**380**	76
Nicollet	15	*	*	18	*	116	**152**	17
Nobles	8	10	20	*	*	77	**125**	41
Norman	*	9	*	*	*	58	**74**	15
Olmsted	128	*	21	143	*	570	**864**	109
Otter Tail	12	16	*	20	*	363	**435**	27
Pennington	*	*	*	8	*	77	**91**	13
Pine	13	95	*	31	*	358	**519**	7
Polk	15	22	*	17	*	179	**236**	52
Pope	*	*	*	15	*	121	**139**	*
Ramsey	1,234	145	439	441	90	951	**3,300**	374
Red Lake	*	*	*	*	*	20	**21**	*
Renville	*	*	*	*	*	117	**128**	30

Agency	African-American/ Black	American Indian	Asian/ Pacific Islander	Two or More Races	Unknown/ declined	White	Total	Hispanic (any race)
Rice	46	*	*	20	105	354	**530**	119
Roseau	*	10	*	9	*	67	**95**	*
St. Louis	234	266	*	283	*	1,438	**2,298**	81
Scott	82	31	35	100	36	477	**761**	70
Sherburne	36	*	*	71	59	391	**567**	30
Sibley	*	*	*	*	*	121	**131**	50
Stearns	114	13	*	65	*	562	**789**	64
Stevens	*	9	*	*	*	54	**71**	8
Swift	13	*	*	18	*	60	**92**	20
Todd	*	*	*	12	*	111	**129**	15
Traverse	*	20	*	*	*	36	**62**	*
Wabasha	10	*	*	9	*	108	**136**	15
Wadena	*	*	*	19	*	112	**143**	7
Washington	132	25	31	103	204	505	**1,000**	72
Watonwan	*	*	*	*	*	80	**88**	36
Wilkin	*	*	*	*	*	45	**53**	*
Winona	47	*	*	26	8	227	**313**	21
Wright	29	*	*	38	25	617	**717**	42
Yellow Medicine	*	19	*	17	*	53	**95**	17
Southwest HHS	27	53	14	65	35	489	**683**	111
Des Moines Valley HHS	*	*	9	17	*	189	**224**	23
Faribault-Martin	*	*	*	23	9	280	**321**	52
Leech Lake Band of Ojibwe	*	159	*	*	*	*	**163**	*
White Earth Nation	*	284	*	19	*	*	**304**	7
MN Prairie	26	*	*	40	7	456	**535**	79
Total	**7,773**	**2,847**	**1,071**	**4,775**	**1,501**	**21,769**	**39,736**	**4,461**

Number of screened in child maltreatment reports by response path and agency, 2016

Agency	Family Assessment	Family Investigation	Facility Investigation	Total
Aitkin	62	15	0	77
Anoka	774	466	37	1,277
Becker	117	120	2	239
Beltrami	143	161	28	332
Benton	112	58	7	177
Big Stone	14	2	2	18
Blue Earth	274	84	4	362
Brown	142	28	2	172
Carlton	187	84	15	286
Carver	259	96	9	364
Cass	88	76	8	172
Chippewa	33	14	1	48
Chisago	94	76	4	174
Clay	325	163	18	506
Clearwater	35	31	5	71
Cook	33	6	1	40
Crow Wing	202	65	5	272
Dakota	1,035	672	27	1,734
Douglas	119	124	1	244
Fillmore	60	8	0	68
Freeborn	91	39	6	136
Goodhue	163	57	10	230
Grant	58	43	4	105
Hennepin	3,492	4,528	238	8,258
Houston	80	11	0	91
Hubbard	183	70	11	264
Isanti	124	46	2	172
Itasca	205	109	11	325
Kanabec	88	23	2	113
Kandiyohi	115	88	3	206
Kittson	11	7	1	19
Koochiching	43	9	0	52
Lac qui Parle	22	8	0	30
Lake	41	9	2	52
Lake of the Woods	15	1	0	16
Le Sueur	135	35	1	171
McLeod	122	121	5	248
Mahnomen	30	4	0	34
Marshall	48	9	1	58
Meeker	75	14	0	89
Mille Lacs	151	149	6	306

Agency	Family Assessment	Family Investigation	Facility Investigation	Total
Morrison	116	42	6	164
Mower	255	56	5	316
Nicollet	119	21	2	142
Nobles	70	18	0	88
Norman	37	15	0	52
Olmsted	523	140	11	674
Otter Tail	228	165	4	397
Pennington	46	25	4	75
Pine	218	134	21	373
Polk	135	38	2	175
Pope	55	43	4	102
Ramsey	1,432	1,078	57	2,567
Red Lake	16	1	1	18
Renville	54	37	2	93
Rice	298	116	3	417
Roseau	58	11	2	71
St. Louis	1,137	585	71	1,793
Scott	462	149	15	626
Sherburne	270	139	17	426
Sibley	46	37	0	83
Stearns	414	194	7	615
Stevens	46	8	0	54
Swift	40	28	1	69
Todd	91	6	3	100
Traverse	20	25	1	46
Wabasha	102	13	3	118
Wadena	80	29	1	110
Washington	503	263	29	795
Watonwan	41	30	0	71
Wilkin	43	18	1	62
Winona	230	50	3	283
Wright	363	179	10	552
Yellow Medicine	55	27	0	82
Southwest HHS	422	146	19	587
Des Moines Valley HHS	124	37	8	169
Faribault-Martin	164	86	3	253
Leech Lake Band of Ojibwe	123	3	6	132
White Earth Nation	148	0	17	165
MN Prairie	350	56	7	413
Total	**18,334**	**11,777**	**825**	**30,936**

Number of alleged and determined victims in screened in maltreatment reports and rate per 1,000 children by agency, 2016

Agency	Unique alleged victims	Unique determined victims	2015 child population estimate	Determined victims per 1,000
Aitkin	117	14	2,725	5.14
Anoka	1,528	330	83,424	3.96
Becker	332	93	8,227	11.30
Beltrami	513	172	11,516	14.94
Benton	236	81	9,729	8.33
Big Stone	27	5	1,028	4.86
Blue Earth	459	69	13,012	5.30
Brown	237	16	5,476	2.92
Carlton	389	80	8,059	9.93
Carver	505	81	27,222	2.98
Cass	218	56	6,102	9.18
Chippewa	71	14	2,800	5.00
Chisago	225	40	12,577	3.18
Clay	703	118	14,629	8.07
Clearwater	99	14	2,196	6.38
Cook	43	4	793	5.04
Crow Wing	401	24	13,940	1.72
Dakota	2,063	303	102,866	2.95
Douglas	335	131	7,878	16.63
Fillmore	90	6	4,998	1.20
Freeborn	200	40	6,685	5.98
Goodhue	291	71	10,438	6.80
Grant	116	15	1,298	11.56
Hennepin	10,562	3,185	271,399	11.74
Houston	127	16	4,041	3.96
Hubbard	310	48	4,392	10.93
Isanti	248	62	9,259	6.70
Itasca	467	32	9,650	3.32
Kanabec	133	15	3,452	4.35
Kandiyohi	314	74	10,207	7.25
Kittson	19	4	968	4.13
Koochiching	58	6	2,474	2.43
Lac qui Parle	40	3	1,374	2.18
Lake	72	15	1,986	7.55
Lake of the Woods	24	1	732	1.37
Le Sueur	207	15	6,731	2.23

Agency	Unique alleged victims	Unique determined victims	2015 child population estimate	Determined victims per 1,000
McLeod	348	63	8,479	7.43
Mahnomen	42	2	1,661	1.20
Marshall	79	9	2,177	4.13
Meeker	102	13	5,705	2.28
Mille Lacs	415	112	6,154	18.20
Morrison	207	34	7,707	4.41
Mower	380	33	9,633	3.43
Nicollet	152	14	7,265	1.93
Nobles	125	12	5,841	2.05
Norman	74	12	1,541	7.79
Olmsted	864	66	37,346	1.77
Otter Tail	435	72	12,383	5.81
Pennington	91	9	3,318	2.71
Pine	519	79	5,972	13.23
Polk	236	22	7,421	2.96
Pope	139	31	2,291	13.53
Ramsey	3,300	936	125,750	7.44
Red Lake	21	0	1,013	0.00
Renville	128	24	3,320	7.23
Rice	530	96	14,471	6.63
Roseau	95	5	3,892	1.28
St. Louis	2,298	431	38,344	11.24
Scott	761	68	40,341	1.69
Sherburne	567	159	24,829	6.40
Sibley	131	23	3,563	6.46
Stearns	789	191	35,283	5.41
Stevens	71	6	2,085	2.88
Swift	92	27	2,048	13.18
Todd	129	2	5,817	0.34
Traverse	62	18	700	25.71
Wabasha	136	7	4,698	1.49
Wadena	143	9	3,401	2.65
Washington	1,000	166	62,864	2.64
Watonwan	88	13	2,648	4.91
Wilkin	53	1	1,452	0.69
Winona	313	43	9,338	4.60
Wright	717	111	37,511	2.96
Yellow Medicine	95	15	2,270	6.61

Agency	Unique alleged victims	Unique determined victims	2015 child population estimate	Determined victims per 1,000
Southwest HHS	683	114	18,009	6.33
Des Moines Valley HHS	224	31	4,984	6.22
Faribault-Martin	321	82	7,384	11.11
Leech Lake Band of Ojibwe†	163	4	1,975	2.03
White Earth Nation†	304	5	1,981	2.52
MN Prairie	535	23	19,195	1.20
Total	**39,736**	**8,446**	**1,284,387**	**6.58**

†Note: The data for these two groups are 2010 Census numbers which represent children residing on the Leech Lake and White Earth reservations who indicated American Indian alone or as one of two or more races. There are no intercensal child population estimates for these groups. The Leech Lake reservation overlaps Cass, Itasca, Beltrami and Hubbard counties. The White Earth reservation overlaps Mahnomen, Becker, and Clearwater counties.

Number of social service agency referrals to early intervention for infants and toddlers involved in substantiated cases of maltreatment, 2016

Agency	Children with a referral	Children required to be referred	Referral rate
Aitkin	0	1	0.0
Anoka	70	77	90.9
Becker	14	17	82.4
Beltrami	57	62	91.9
Benton	8	20	40.0
Big Stone	1	3	33.3
Blue Earth	7	10	70.0
Brown	4	4	100.0
Carlton	14	19	73.7
Carver	3	15	20.0
Cass	9	13	69.2
Chippewa	1	2	50.0
Chisago	6	8	75.0
Clay	18	25	72.0
Clearwater	2	3	66.7
Cook	0	1	0.0
Crow Wing	3	4	75.0
Dakota	54	76	71.1
Douglas	34	34	100.0
Fillmore	2	2	100.0
Freeborn	9	11	81.8
Goodhue	13	21	61.9
Grant	4	4	100.0
Hennepin	698	736	94.8
Houston	3	3	100.0
Hubbard	5	14	35.7
Isanti	15	17	88.2
Itasca	1	2	50.0
Kanabec	2	2	100.0
Kandiyohi	12	16	75.0
Kittson	0	0	0.0
Koochiching	0	0	0.0
Lac qui Parle	0	0	0.0
Lake	2	2	100.0
Lake of the Woods	0	0	0.0
Le Sueur	2	3	66.7
McLeod	11	14	78.6

Agency	Children with a referral	Children required to be referred	Referral rate
Mahnomen	0	0	0.0
Marshall	0	1	0.0
Meeker	0	0	0.0
Mille Lacs	28	36	77.8
Morrison	10	10	100.0
Mower	6	6	100.0
Nicollet	7	7	100.0
Nobles	0	0	0.0
Norman	1	1	100.0
Olmsted	12	17	70.6
Otter Tail	17	22	77.3
Pennington	0	2	0.0
Pine	11	13	84.6
Polk	3	5	60.0
Pope	3	7	42.9
Ramsey	245	255	96.1
Red Lake	0	0	0.0
Renville	2	3	66.7
Rice	27	27	100.0
Roseau	0	1	0.0
St. Louis	78	106	73.6
Scott	10	14	71.4
Sherburne	25	34	73.5
Sibley	10	10	100.0
Stearns	28	40	70.0
Stevens	0	1	0.0
Swift	10	10	100.0
Todd	0	0	0.0
Traverse	4	4	100.0
Wabasha	1	1	100.0
Wadena	1	1	100.0
Washington	32	40	80.0
Watonwan	1	1	100.0
Wilkin	0	0	0.0
Winona	3	8	37.5
Wright	19	19	100.0
Yellow Medicine	0	0	0.0
Southwest HHS	21	27	77.8
Des Moines Valley HHS	3	3	100.0

Agency	Children with a referral	Children required to be referred	Referral rate
Faribault-Martin	18	18	100.0
Leech Lake Band of Ojibwe	0	1	0.0
White Earth Nation	0	2	0.0
MN Prairie	4	5	80.0
Total	**1,724**	**1,999**	**86.2**

Number of child maltreatment reports by SDM risk assessment status and agency, 2016

Agency	Low risk, no CP Services Needed	Low risk, CP Services Needed	Low Risk Total	Moderate risk, no CP Services Needed	Moderate risk, CP Services Needed	Moderate Risk Total	High risk, no CP Services Needed	High risk, CP Services Needed	High Risk Total
Aitkin	5	1	6	25	9	34	19	18	37
Anoka	197	11	208	569	68	637	240	158	398
Becker	10	3	13	63	9	72	48	105	153
Beltrami	25	1	26	94	45	139	60	79	139
Benton	8	0	8	67	5	72	4	86	90
Big Stone	1	0	1	9	1	10	1	4	5
Blue Earth	42	0	42	160	14	174	91	50	141
Brown	15	3	18	79	21	100	27	26	53
Carlton	42	1	43	143	10	153	41	35	76
Carver	73	6	79	178	19	197	34	46	80
Cass	8	0	8	62	20	82	25	51	76
Chippewa	9	0	9	11	12	23	1	14	15
Chisago	35	0	35	80	11	91	20	24	44
Clay	42	2	44	206	22	228	101	128	229
Clearwater	12	0	12	27	3	30	19	5	24
Cook	2	0	2	9	4	13	15	9	24
Crow Wing	35	3	38	117	21	138	42	49	91
Dakota	298	2	300	867	48	915	143	184	327
Douglas	21	1	22	110	10	120	37	64	101
Fillmore	21	0	21	27	2	29	11	7	18
Freeborn	12	2	14	59	10	69	20	35	55
Goodhue	21	3	24	92	11	103	52	46	98
Grant	8	2	10	36	9	45	15	33	48
Hennepin	1,103	19	1,122	3,186	470	3,656	1,159	2,044	3,203
Houston	13	0	13	26	8	34	35	9	44
Hubbard	34	2	36	99	14	113	59	46	105

Agency	Low risk, no CP Services Needed	Low risk, CP Services Needed	Low Risk Total	Moderate risk, no CP Services Needed	Moderate risk, CP Services Needed	Moderate Risk Total	High risk, no CP Services Needed	High risk, CP Services Needed	High Risk Total
Isanti	24	0	24	70	11	81	6	62	68
Itasca	42	7	49	123	37	160	50	55	105
Kanabec	14	4	18	40	20	60	10	23	33
Kandiyohi	20	0	20	70	21	91	24	70	94
Kittson	4	0	4	3	6	9	2	3	5
Koochiching	6	0	6	21	4	25	17	4	21
Lac qui Parle	6	0	6	12	0	12	4	8	12
Lake	1	0	1	16	10	26	6	18	24
Lake of the Woods	1	1	2	5	3	8	2	3	5
Le Sueur	29	1	30	78	14	92	24	24	48
McLeod	29	1	30	105	31	136	26	52	78
Mahnomen	4	0	4	16	4	20	4	6	10
Marshall	6	0	6	21	5	26	8	17	25
Meeker	17	0	17	42	5	47	13	12	25
Mille Lacs	43	2	45	128	37	165	45	46	91
Morrison	26	0	26	60	16	76	17	39	56
Mower	61	1	62	168	18	186	31	32	63
Nicollet	13	2	15	61	18	79	17	34	51
Nobles	16	2	18	36	9	45	14	11	25
Norman	2	0	2	23	5	28	4	18	22
Olmsted	60	0	60	350	37	387	93	123	216
Otter Tail	37	3	40	158	34	192	64	97	161
Pennington	11	4	15	30	7	37	4	15	19
Pine	62	2	64	169	28	197	43	48	91
Polk	24	0	24	90	5	95	25	39	64
Pope	19	2	21	37	5	42	6	29	35
Ramsey	489	25	514	1,114	237	1,351	208	439	647

Agency	Low risk, no CP Services Needed	Low risk, CP Services Needed	Low Risk Total	Moderate risk, no CP Services Needed	Moderate risk, CP Services Needed	Moderate Risk Total	High risk, no CP Services Needed	High risk, CP Services Needed	High Risk Total
Red Lake	2	0	2	5	3	8	4	2	6
Renville	4	0	4	38	15	53	12	21	33
Rice	82	1	83	184	28	212	59	61	120
Roseau	10	3	13	26	15	41	4	10	14
St. Louis	204	6	210	743	79	822	338	358	696
Scott	142	3	145	273	62	335	36	83	119
Sherburne	58	5	63	171	26	197	71	79	150
Sibley	19	0	19	34	7	41	5	19	24
Stearns	80	1	81	276	41	317	111	99	210
Stevens	5	0	5	18	6	24	14	11	25
Swift	2	0	2	16	10	26	4	36	40
Todd	5	0	5	33	12	45	10	37	47
Traverse	3	2	5	17	6	23	4	14	18
Wabasha	12	1	13	60	6	66	26	13	39
Wadena	8	1	9	49	21	70	11	19	30
Washington	145	4	149	355	56	411	78	137	215
Watonwan	8	0	8	35	5	40	5	18	23
Wilkin	7	0	7	27	13	40	4	9	13
Winona	18	0	18	147	5	152	71	41	112
Wright	90	4	94	246	31	277	100	71	171
Yellow Medicine	7	3	10	25	16	41	5	26	31
Southwest HHS	64	6	70	243	47	290	85	122	207
Des Moines Valley HHS	30	4	34	64	13	77	14	35	49
Faribault-Martin	34	0	34	99	11	110	61	44	105
Leech Lake Band of Ojibwe	12	2	14	36	11	47	34	33	67
White Earth Nation	19	1	20	48	21	69	13	46	59

Agency	Low risk, no CP Services Needed	Low risk, CP Services Needed	Low Risk Total	Moderate risk, no CP Services Needed	Moderate risk, CP Services Needed	Moderate Risk Total	High risk, no CP Services Needed	High risk, CP Services Needed	High Risk Total
MN Prairie	54	0	54	196	20	216	45	95	140
Total	**4,282**	**166**	**4,448**	**12,911**	**2,089**	**15,000**	**4,310**	**6,221**	**10,531**

Note: Across all agencies, there were 1,067 reports excluded from this table because they had no associated SDM Risk Assessment completed.

References

Behnke, M., Smith, V., Committee on Substance Abuse, Committee on Fetus and Newborn. (2013). *Prenatal Substance Abuse: Short and Long-term Effects on the Exposed Fetus.* Journal of the American Academy of Pediatrics.

Children's Bureau (2016). Parental Drug Use as Child Abuse. Retrieved from Children's Bureau

Collins, J. (2016, Apr. 18). Here's why Minnesota has a big problem with opioid overdoses. *Minnesota Public Radio News*. Retrieved from Minnesota Public Radio.

Harvard Center on the Developing Child (2007). *The impact of Early Adversity on Child Development (InBrief).* Retrieved from www.developingchild.harvard.edu

Morley, L., & Kaplan, C. (2011). *Formal public child welfare responses to screened out reports of alleged maltreatment*. Englewood, CO: National Quality Improvement Center on Differential Response in Child Protective Services. Retrieved from http://www.ucdenver.edu/academics/ colleges/medicalschool/departments/pediatrics/ subs/can/DR/qicdr/General%20Resources/ General%20Resources/docs/issue-3_10-31-11.pdf.

Minnesota Department of Health (2016). Drug overdose deaths among Minnesota residents, 2000 - 2015. Retrieved from Minnesota Department of Health

Sedlak, A.J., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A., & Li, S. (2010). *Fourth National Incidence Study of Child Abuse and Neglect (NIS–4): Report to Congress.* Washington, D.C.: U.S. Department of Health and Human Services, Administration for Children and Families.

U.S. Department of Health and Human Services. National Center on Substance Abuse and Child Welfare (2017, Jun. 16). *Substance-Exposed Infants.* Retrieved from National Center on Substance Abuse and Child Welfare

U.S. Census Bureau; American Community Survey, 2014 American Community Survey 1-Year Estimates, Table S1701; generated by Yer Chang; using American FactFinder; <http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk>; (21 July 2016).