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DEPARTMENT OF HUMAN SERVICES

Minnesota's Child Maltreatment Report, 2017

Children and Family Services

November 2018

Minnesota Department of Human Services
Child Safety and Permanency Division
P.O. Box 64943
St. Paul, MN 55155
651- 431-4660
dhs.csp.research@state.mn.us
https://mn.gov/dhs/people-we-serve/children-and-families/services/child-protection/

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As required by Minn. Stat. 3.197: This report cost approximately $10,667.30 to prepare, including staff time, printing and mailing expenses.

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Contents

The 2017 annual Child Maltreatment Report summary

Purpose

The purpose of this annual report is to provide information on children involved in 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 information on all state and federal performance measures, see the Minnesota Child Welfare Data Dashboard.

Findings

The intake process

- In 2017, Minnesota child protection agencies received **84,148** reports of child maltreatment, representing a **4.8** percent increase from 2016.[1]

The screening process

- Of the **84,148** child maltreatment reports received in 2017, local agencies screened in **37,736**, **44.8** percent, of reports.
- For reports that were screened out, more than **nine of every 10** were screened out because allegations did not meet the statutory threshold for maltreatment.
- Mandated reporters made the vast majority of reports of maltreatment, nearly four of five reports (**67,101** of **84,148** reports or **79.7** percent).

Completed assessments and investigations

- There were **39,606** alleged victims involved in at least one completed assessment or investigation following a screened in child maltreatment report.
- The number of completed assessments/investigations and of alleged victims with at least one screened in and completed report has remained steady since the last year.
- Since 2008, there has been about a **75** percent increase in completed assessments/investigations; the increase in workload has greatly exceeded increases in funding for child welfare agencies.
- American Indian children were about **five** times more likely to be involved in completed maltreatment assessments/investigations than white children, while children who identify with

[1] The methodology for calculating the total number of reports was modified in 2017. See page 10 for description of methodology. Caution should be taken when comparing the 2017 total number of reports with numbers from previous publications.

two or more races and African-American children were both approximately **three** times more likely to be involved.

- Minnesota continues to struggle with opportunity gaps for families of color and American Indian families. The disproportionality seen in child protection cases is further evidence of a gap in services and opportunities for these families and children.
- Children age 8 and younger represented the majority involved in completed maltreatment assessments/investigations (**59.7** percent) in 2017.
- Alleged victims with allegations of neglect constituted the largest group of children by far, with approximately **62.2** percent of all children in 2017.
- Prenatal exposure to alcohol or substances is one form of neglect. In 2017, **1,672** children were prenatally exposed to alcohol or illegal substances. This represents a **26** percent increase since 2016, and a **121** percent increase since 2013.
- Maltreatment allegations of chronic and severe use of a controlled substance/alcohol have also seen a similar large increase. There were **2,681** children with this allegation identified in 2013, increasing to **6,321** alleged victims in 2017.

Child protection response path assignment

- The number and proportion of reports being assigned to Family Assessment (Minnesota's alternative response path) was essentially unchanged from 2016. This comes after a noticeable decrease in the number of Family Assessment responses from 2015 to 2016.
- Approximately **59** percent of the **30,927** completed maltreatment assessments/investigations were assigned to the Family Assessment path (N = **18,212**), while the rest received either a Family or Facility Investigation.

Assessment or investigation of safety, risk and service needs

- Improvements are essential in agency performance on the timeliness of first face-to-face contact with alleged victims in screened in maltreatment reports, critical for ensuring safety, with only **83.6** percent of victims seen within the time frames established in statute. This is a **2.5** percent increase from 2016, when **80.1** percent of victims were seen within time frames.
- A higher percentage of completed maltreatment assessments/investigations that were Family Investigations indicated families were at high risk of future maltreatment (**41.2** percent) than were Family Assessments (**20.7** percent).
- There were **18,660** children in completed maltreatment assessments/investigations who experienced a Family Investigation, with **46.5** percent having a determination of maltreatment; there were **1,610** children in completed assessments/investigations who received a Facility Investigation, with **25.8** percent having a maltreatment determination.
- There were **21** child deaths and **17** life-threatening injuries determined to be a result of maltreatment in 2017.

Outcomes after child maltreatment assessments/investigations conclude

- Minnesota met the federal maltreatment recurrence standard in 2017, with **8.9** percent of all children having a recurrence of maltreatment within 12 months of their first determination.

Child maltreatment appendix

The child maltreatment appendix has eight tables that break down data from 2017 by agency:

1. The number and percent of child maltreatment reports by screening status and agency
2. Number of completed child maltreatment assessments/investigations by response path and agency
3. Number of alleged victims in completed assessments/investigations by maltreatment type and rate per 1,000 children by agency
4. Number of alleged victims by age group and agency
5. Number of alleged victims by race and ethnicity and agency
6. Number of alleged and determined victims in completed assessments/investigations and rate per 1,000 children by agency
7. Number of social service agency referrals to early intervention for infants and toddlers involved in substantiated cases of maltreatment
8. Number of assessments/investigations by SDM risk assessment status and agency

Legislation

This report was prepared by the Minnesota Department of Human Services (department), Children and Family Services Administration, Child Safety and Permanency Division, for the Minnesota Legislature in response to a 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 out-of-home placement. The commissioner shall confer with county agencies, child welfare organizations, child advocacy organizations, courts, and other groups on how to improve the content and utility of the department's annual report. Regarding child maltreatment, the report shall include the number and kinds of maltreatment reports received, and other data that the commissioner determines appropriate in a child maltreatment report.

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 county agency progress in improving outcomes of vulnerable children and adults related to safety, permanency and well-being.

Minn. Stat. 626.556, subd. 10n: A child under age 3 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 that information to the legislature beginning Mar. 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, and an annual summary of reviews. It states: (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 county agencies 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 Sept. 30, 2015. (b) The commissioner shall produce an annual report of the summary results of the reviews. The report must only include 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.

Introduction

Caring for and protecting children is one of the critical functions of any society. Communities can only be successful when children have opportunities to grow, develop and thrive. [Annie E. Casey, 2017] No factor may be a stronger indicator of a poorly-functioning society than high rates of child maltreatment. It is widely considered to be a public health crisis in the U.S., with far-ranging negative consequences for not only developing children, but also for families and communities in which children live.

It is critical that the department monitors and reports on the experiences of children who are alleged to have been maltreated, and the work of child protection in ensuring those children are safe and reaching their full potential.

Minnesota children

After substantial increases in both the number of child maltreatment reports and alleged victims over the last few years, 2017 showed a leveling-off. The number of maltreatment reports made and investigated decreased by a few percentage points from 2016. The reason for the slight decrease is unknown. One explanation is that there has been sufficient time since a law was passed in 2015 requiring local agencies to follow revised screening and reporting guidelines to create consistency in practice over time.

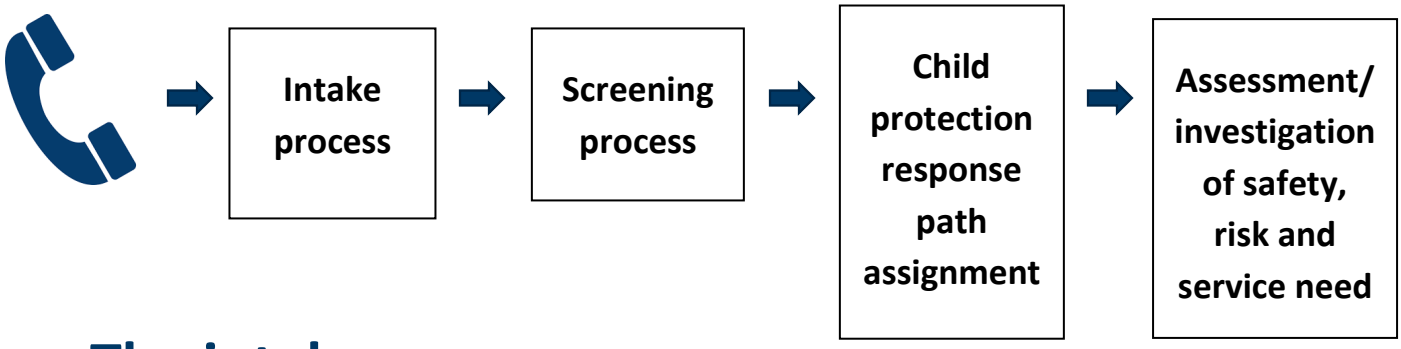
What is child maltreatment?

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.

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?



The intake process

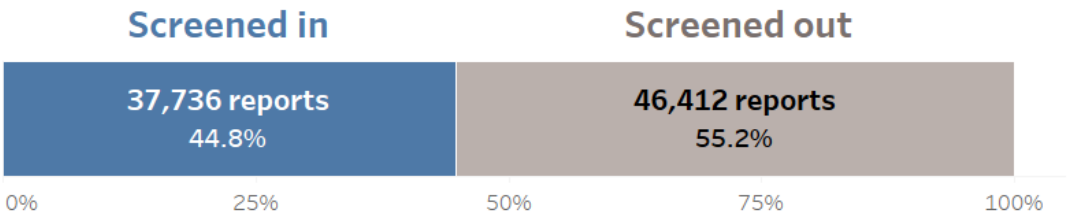
- When a community member has a concern that a child is being maltreated, they can (or must if they are a mandated reporter – see Minn. Stat. 626.556, subd. 3, for information about who is a mandated reporter) call their local child protection agency to report this concern. Local agencies document reports of maltreatment, including information about a reporter, children involved, alleged offenders, and specifics of alleged maltreatment.
- Over the past few years, data on the number of incoming child protection reports and screening rates have become more important to the overall picture of child welfare. Subsequently, attempts have been made to include this information, however, there have been several changes made to the methodology used. This, along with changes in requirements for local agency data entry, makes it difficult to compare the total number of reports from one annual report to the next.
- The 2017 report begins with information on the number of child maltreatment reports received and the screening rates for these reports at the time of intake. **All other information contained in the report will be based on assessments/investigations completed during the calendar year because it includes information not known until the assessment/investigation closes**. Although these two groups of reports are related, they aren't identical populations of reports or corresponding children. For example, some reports that were made to child protection in 2017 (i.e., reports at the intake phase) will not have an assessment or investigation of allegations completed until 2018 and will be included in that year's annual report (e.g., reports received in December 2017). Likewise, some assessments/investigations that were completed in 2017 were based on maltreatment reports received later in 2016.
- Minnesota child protection agencies received **84,148** reports of maltreatment in 2017, representing a **4.8** percent increase from 2016.

The screening process

Once a report of maltreatment has been received, local agency staff reviews the information in the report and determines if allegation(s) meet 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 further assessment or investigation. 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 (**46,412** reports or **55.2** percent) and screened in for assessment or investigation (**37,736** reports or **44.8** percent).

Figure 1. Screening decisions of child maltreatment reports received in 2017

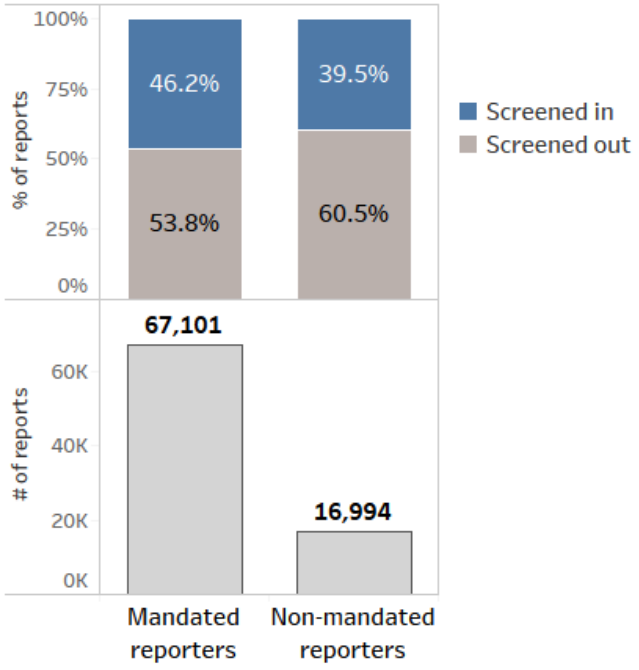


Screened out maltreatment reports

- In 2017**, 42,065** of the **46,412** screened out reports (**90.6** percent) were screened out because allegations did not meet the statutory threshold for maltreatment. The rest of the reports (**4,347** or **9.4** percent) were screened out for various reasons, including the following:
  - Report did not include enough identifying information (**2.6** percent)
  - Allegations referred to an unborn child (**4.1** 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 **41,554** of the **46,412** screened out reports (**89.5** 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 is completed by a team and is appraised both for screening decisions and also for the quality of information in reports. The review team requested further consultation with local agencies regarding their screening decisions in **170** of **2,934** reports reviewed (**5.7** percent) in 2017. Of those **170**, the consultation resulted in the agency screening in the report **70** times and an upholding of the screening decision **100** times.

Referral source of child maltreatment reports

Figure 2. Reports screened in and out by source of reporter in 2017

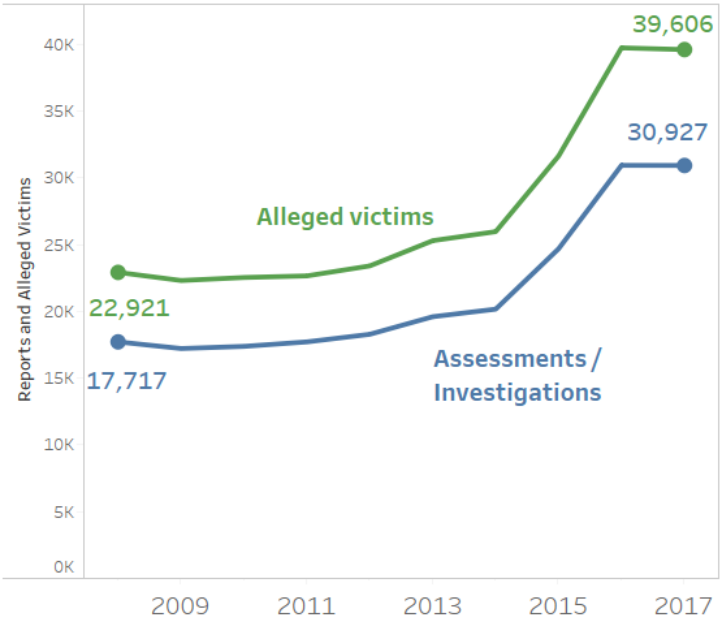


- Mandated reporters made the vast majority of reports of maltreatment to local agencies, with nearly four of five reports (**67,101** of **84,148** reports or **79.7** percent). There were 53 reports with an unidentified reporter.
- Mandated reporters include those in health care, law enforcement, mental health, social services, education and child care, among others who work with children.
- As shown in Figure 2, mandated reporters were more likely to have their reports accepted (**46.2** versus **39.5** percent). The difference in acceptance rates may be due to mandated reporters being better trained to identify maltreatment, therefore, more likely to report incidents that meet the threshold.

Completed assessments and investigations

- There were **30,927** assessments/investigations completed in 2017 after screened in reports of maltreatment; these reports involved **39,606** alleged victims.
- For the "Intake process" and "Screening process" sections, data provided are based on reports that were initially made to child welfare agencies in calendar year 2017. Beginning in this section, and for all subsequent sections, the information provided is based on maltreatment reports that led to an assessment/investigation that was completed in 2017. Therefore, the number of screened in reports shown in Figure 1 (i.e., **37,736** reports) is different than the number of completed assessments/investigations (which will also be referred to as "cases" throughout the rest of this report) in Figure 3 (i.e., 30,927 reports). All of the reports that were received in 2017, but not yet closed will be closed in the subsequent year and the outcomes will be reported in the 2018 annual Maltreatment Report.

Figure 3. Trends of completed assessments/ investigations and alleged victims, 2008 – 2017



- As shown in Figure 3, the number of completed assessments/investigations and alleged victims in at least one assessment/investigation has risen substantially over the past decade. Overall, since 2008, there has been a **74.6** percent and **72.8** percent increase in assessments/investigations and alleged victims, respectively.
- Possible explanations for the observed increases include a) an increase in opioid-related child protection cases as parental alcohol and substance use is a known risk factor for child maltreatment, [Children's Bureau, 2016] b) revisions made to maltreatment screening guidelines following the 2014 Governor's Task Force recommendations, which promoted consistency across agencies when responding to maltreatment reports, and c) increased scrutiny and tendency to report potential maltreatment following a high profile and highly publicized child death in 2013.
- While it isn't clear why this slight decline in the number of completed assessments/investigations occurred, the above mentioned changes to the guidelines and subsequent increases in consistency of screening decisions across agencies over time may be a partial explanation for this recent change.

- Some alleged victims had more than one completed assessment/investigation within the year. Table 1 provides information about how many victims had one or more completed assessment/investigation in 2017.
- There were **34,323** (86.7 percent) alleged victims who had a single completed assessment or investigation in 2017. Just over **13** percent had multiple assessments or investigations in the year.

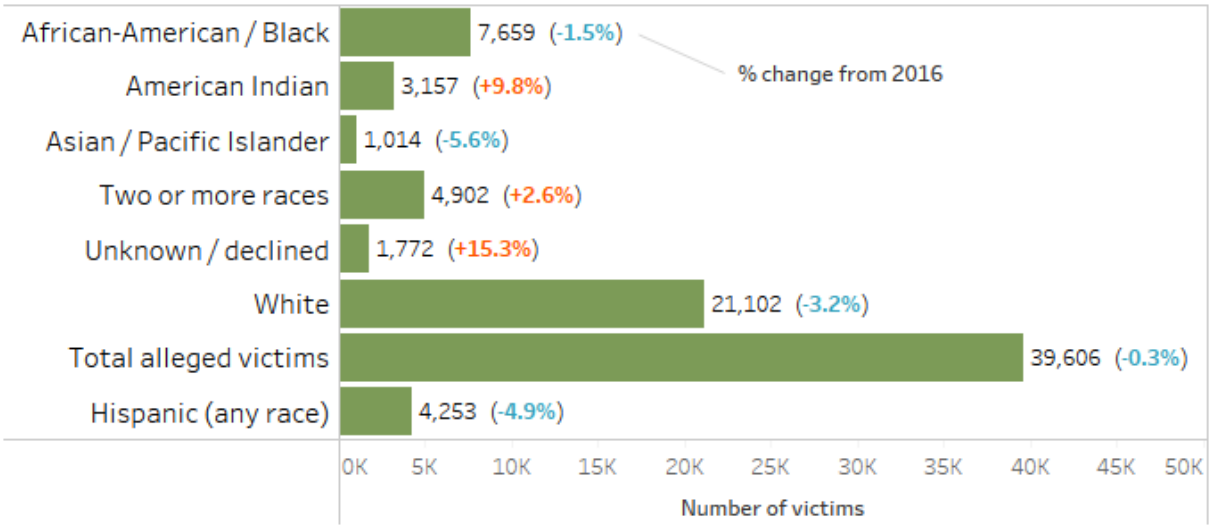
Table 1. Number of victims with one or more completed assessment/investigation in 2017

	Number	Percent
1 assmnt/inv	34,323	86.7%
2 assmnt/inv	4,322	10.9%
3 assmnt/inv	733	1.9%
4 or more assmnt/inv	228	0.6%
Total	39,606	100.0%

Characteristics of alleged victims in completed assessments/investigations

- Minnesota children involved in allegations of maltreatment live with all types of families in all parts of the state. However, there are communities that are disproportionately likely to be involved with the child protection system. Figures 5 and 6 provide information on the number of alleged victims and rates per 1000 by race.

Figure 5. Number of alleged victims with at least one completed assessment/investigation by race/ethnicity in 2017

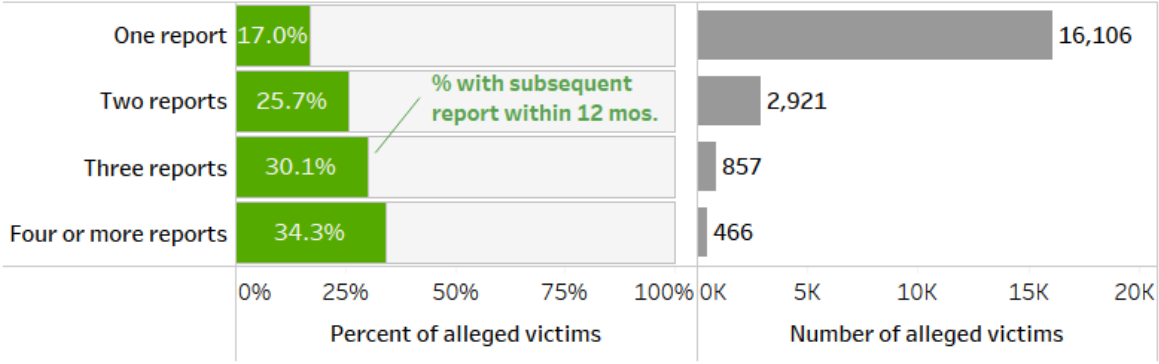


Were children who had a screened out maltreatment report in 2016 involved in a screened in report (and a subsequent completed assessment/investigation) maltreatment report within 12 months?

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 figure 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 2016 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 **20,350** children who had at least one screened out report in 2016 and no prior history in the previous four years. Of these children, **16,106** had one screened out report, **2,921** had two, **815** had three, and **466** had four or more screened out reports in 2016.
- Overall, **19.2** percent (N = **3,902**) 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.

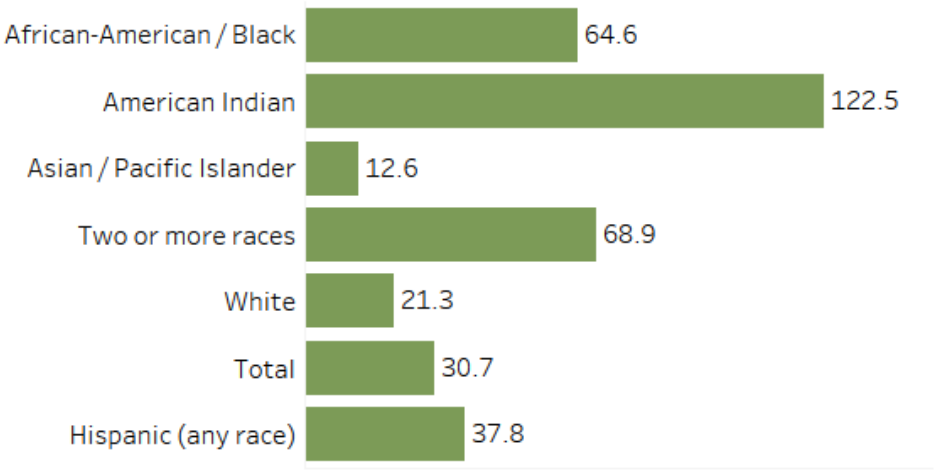
Figure 4: Percent and number of alleged victims with a screened in report by number of prior screened out reports



- Consistent with the Minnesota general population of children, the largest group with a screened in maltreatment report and a subsequent completed assessment or investigation are white (see Figure 5 below).
- Children who are African-American, American Indian, and those who identify with two or more races, were disproportionately involved in completed maltreatment assessments and investigations (see Figure 6).
- Adjusted to population rates, American Indian children were **5.8** times more likely to be involved in completed maltreatment assessments/investigations than white children, while children who identify with two or more races and African-American children were both about **three** times more likely.
- Between 2016 and 2017, the three groups increased their number of alleged victims in maltreatment assessments/investigations: Those who were identified as having two or more races and American Indian increased by **2.6** percent and **9.8** percent, respectively. The number of children with no identified race grew by **15.3** percent.
- Minnesota child welfare agencies are increasingly struggling with opportunity gaps for families of color and American Indian families across all systems serving children and families. The disproportionality seen in child protection is further evidence of this gap in services and opportunities.

Between 2016 and 2017, the number of children identified as American Indian and who were alleged victims in a screened in maltreatment report increased by about 10 percent.

Figure 6. The per 1000 rate of alleged victims in screened in reports by race/ethnicity in 2017



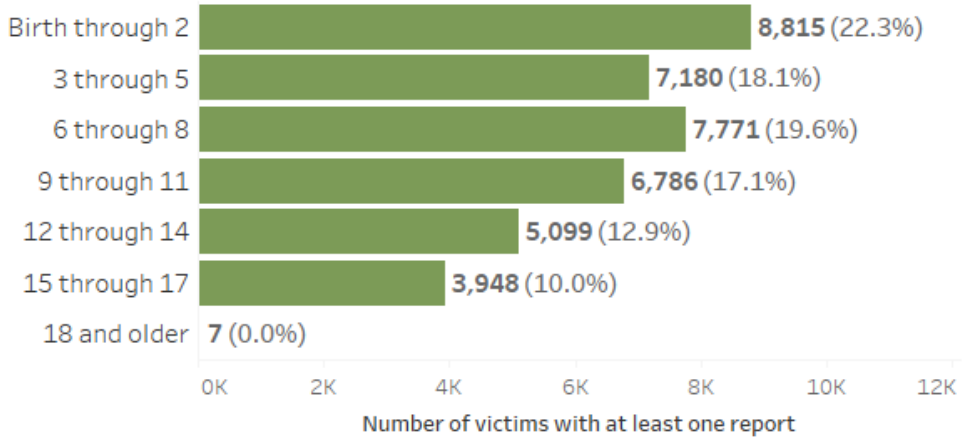
A closer look at the two or more race category

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 two or more races has more than doubled since 2012. Of children who identify with more than one race:

- **88.6** percent identified at least one race as white
- **64.6** percent identified at least one race as African-American/Black
- **45.2** percent identified at least one race as American Indian
- **7.3** percent identified at least one race as Asian, and less than **2** percent identified as Pacific Islander.

- Children age 8 and younger represented the majority of children involved in maltreatment assessments and investigations (**59.6** percent) in 2017. There were likely multiple reasons why this age group constituted the greatest 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] shows 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.

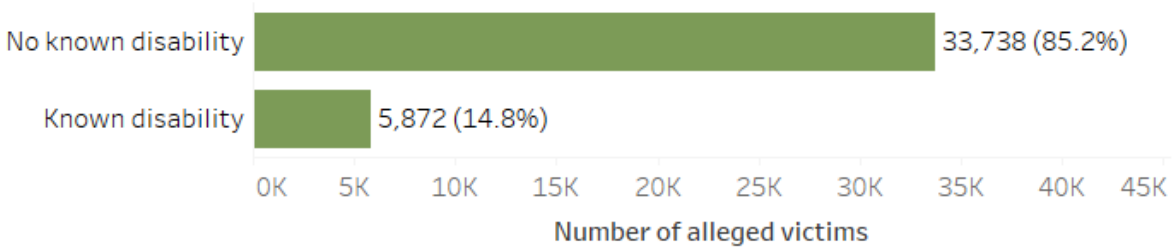
Figure 7. Number and percent of alleged victims with at least one completed assessment/investigation by age group in 2017



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.

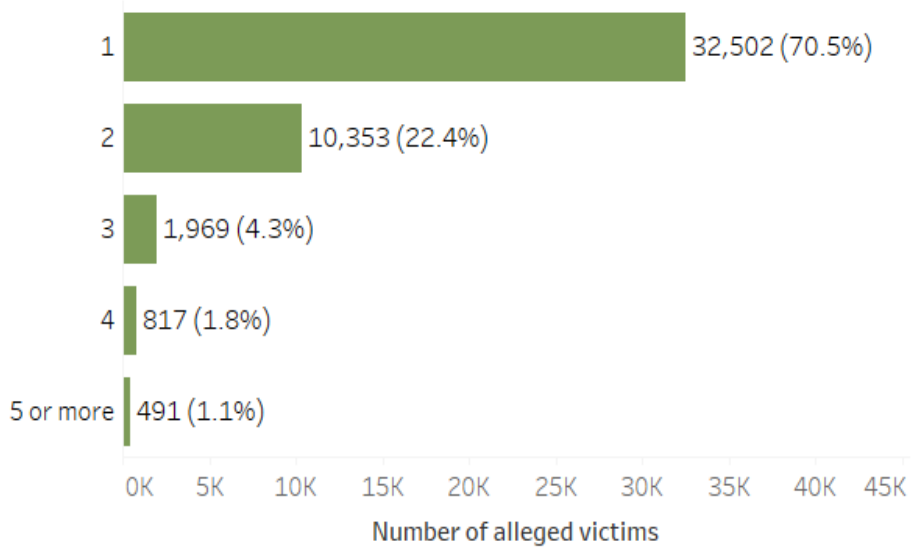
- Just under **15** percent of children who had screened in maltreatment reports in 2016 had a known disability (some disabilities may be undiagnosed). This rate of disability is **five** times more frequent than in the general population of children. [Sedlak et al., 2010]

Figure 8. Number and percent of alleged victims by disability status in 2017



- In any given report of maltreatment, a child may have one or more types of alleged maltreatment identified. There are six main categories of maltreatment: **Medical neglect** (i.e., not providing medical care for a child deemed necessary by a medical professional); **mental injury** (i.e., behavior of a caregiver that causes emotional or mental injury to a child); **neglect** (i.e., not adequately providing for the physical, mental or behavioral needs of a child); **physical abuse** (i.e., behavior that is intended to and/or results in physical harm to a child); **sexual abuse** (i.e., any behavior towards or exploitation of children by a caregiver that is sexual in manner); and **threatened injury** (i.e., attempting or threatening harm to a child or placing a child in a situation that puts them at risk for serious harm). 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 completed assessment/ investigation in 2017. The vast majority of children (**70.5** percent) had a single allegation of maltreatment within each completed assessment/ investigation.

Figure 9. Number and percent of alleged victims by number of allegations per assessment/investigation in 2017



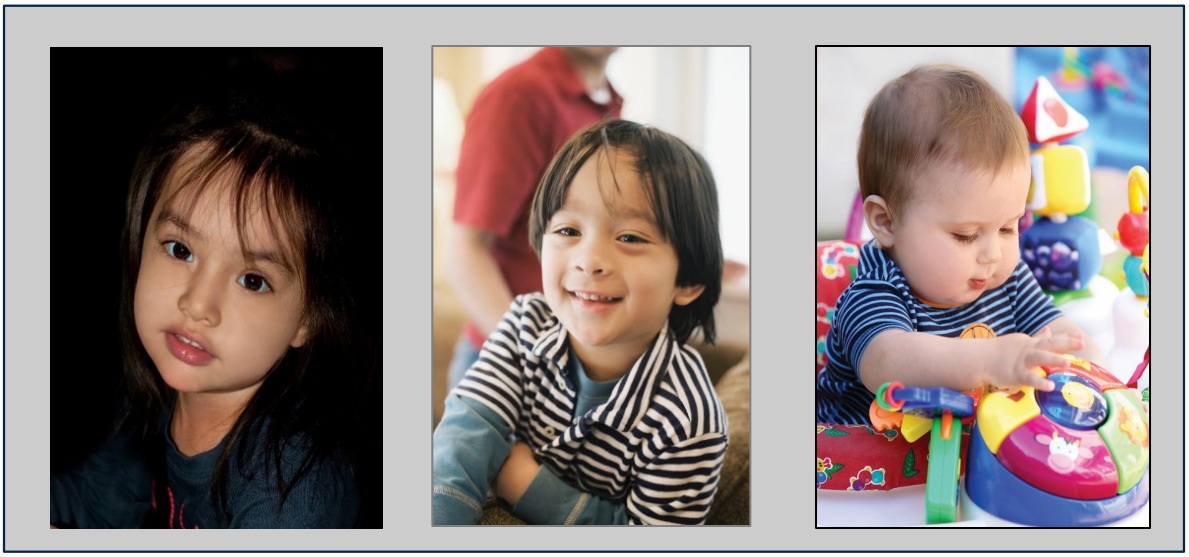
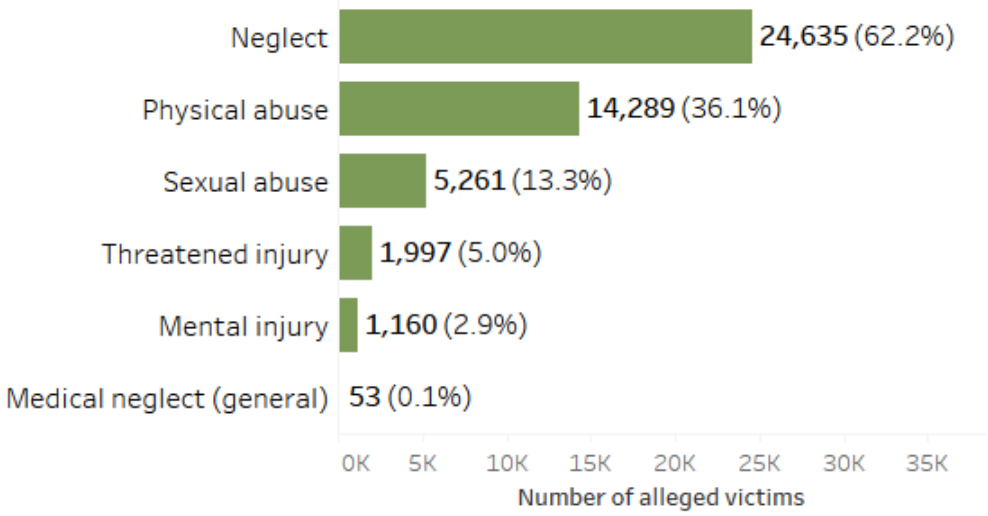


Figure 10. Number and percent of alleged victims by maltreatment type, 2017

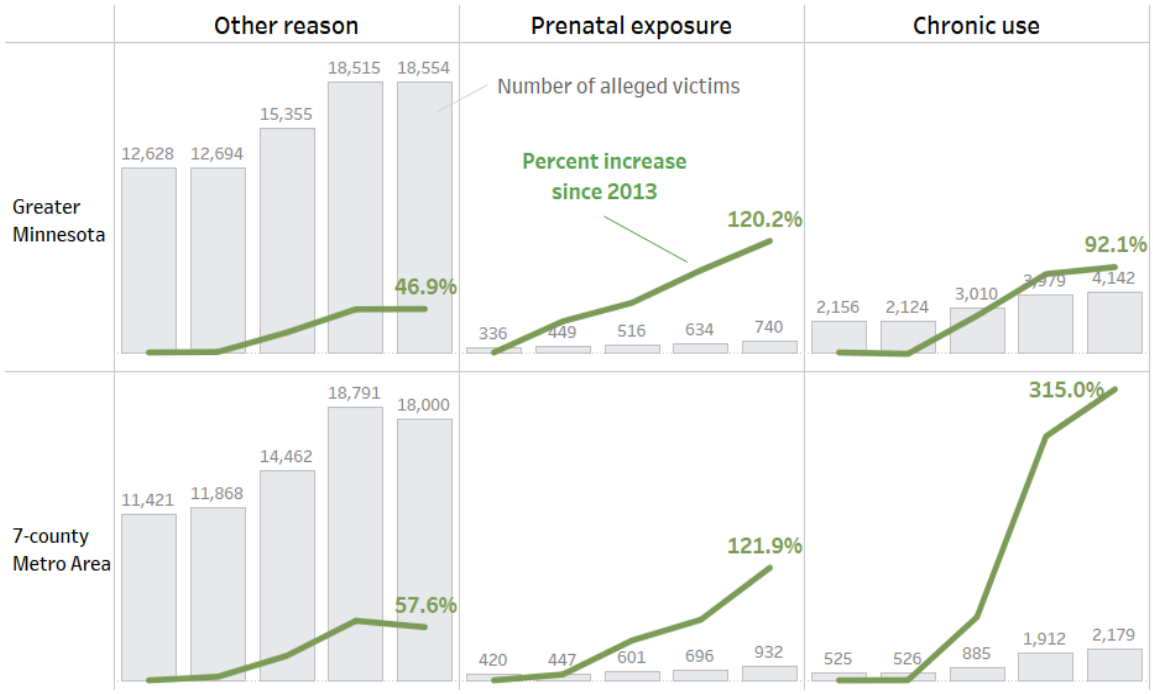


- Alleged victims with allegations of neglect was the largest group of children by far, about **62** percent of all children who experienced maltreatment in 2017 (see Figure 10).
- The relative frequency of the different types of maltreatment continues to shift. Threatened injury, a category added in 2016, was identified for 5 percent of all victims of maltreatment in 2017.

Threatened injury, a new category for maltreatment type, was identified for 5 percent of all alleged victims of maltreatment in 2017.

Drug-related maltreatment continues to climb

Figure 11. Increases in drug-related maltreatment allegations since 2013



Although the number of reports and alleged victims has risen substantially in recent years, 2016 and 2017 have seen a noticeably larger increase in drug-related allegations, including a) prenatal exposure to a controlled substance/alcohol, and b) chronic and severe use of alcohol/controlled substances. The seven-county metro area and greater Minnesota show similar increases for prenatal exposure (see Figure 11); however, the increase in documented allegations of chronic use of alcohol/controlled substances has been more dramatic in the seven-county metro. The number of alleged victims of chronic use increased to 6,321; the difference in increases for the seven-county metro compared to greater Minnesota is a pattern also seen in recent increases in opioid-related deaths in Minnesota. [Preliminary data from Minnesota Department of Health, 2018]

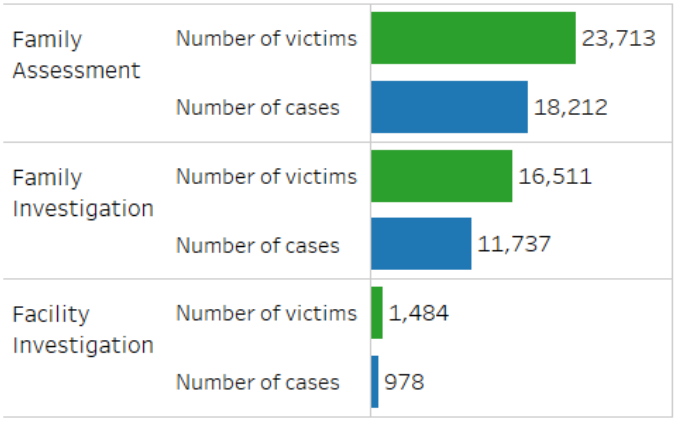
Child protection response path assignment

Once a report has been accepted and screened in, local agencies assign a case 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 cases are assigned to each of the tracks. (Note: A 'case' is used to mean an investigation or assessment that has been completed.)

Assignment of child maltreatment cases to child protection response paths

- Figures 12 and 13 show just under **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 cases and victims by path assignment in 2017



- In all types of child protection responses to maltreatment reports, there are five shared goals in the assessment or investigative phase:

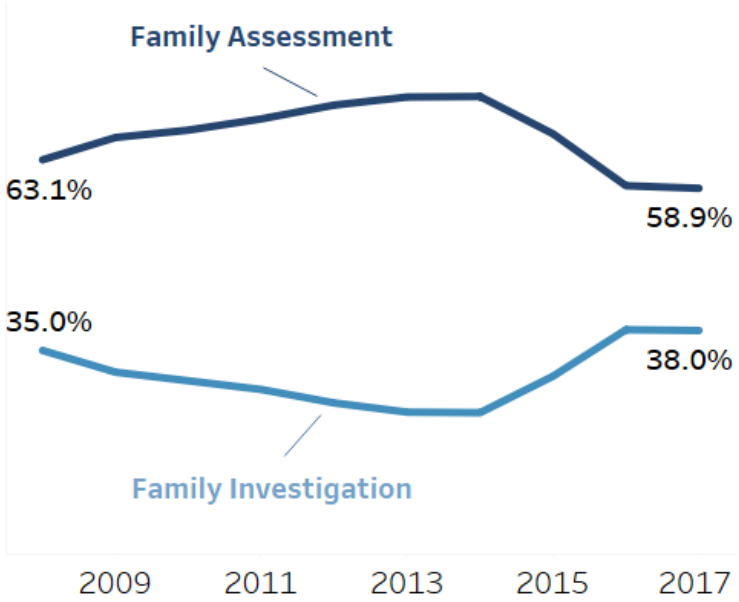
Assigning reports:

- By law, cases that include allegations of 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.
- Cases 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.

1. Identify and resolve immediate safety needs of children.
2. Conduct fact-finding regarding circumstances described in a maltreatment report.
3. Identify risk of ongoing maltreatment.
4. Identify needs and circumstances of children (and families).
5. Determine whether child protective services are focused on providing ongoing safety, permanency and well-being for children.

- 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 cases assigned to FA and FI paths, 2008 – 2017



- There was a pilot and evaluation of the Family Assessment model of child protection in 2000, and statewide implementation was completed in 2005, leading to a decline in use of Family Investigations to make determinations of maltreatment.
- After a long steady decline, there was a large increase in the percentage of reports being assigned to Family Investigation, which rose from 25 percent to 38 percent of cases from 2014 to 2016. This increase has been attributed to several factors, including but not limited to:

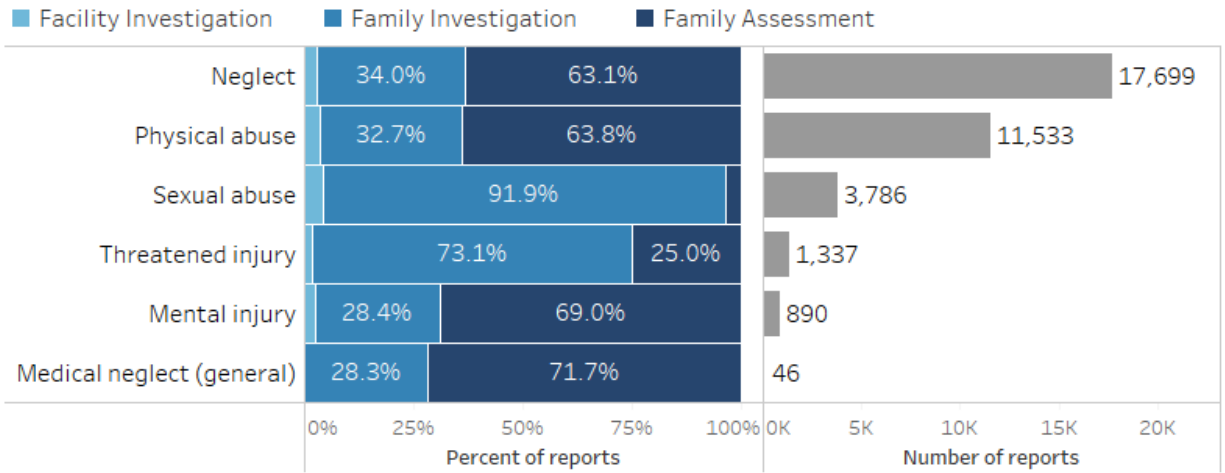
a) Updated guidance regarding intake, screening, and assignment decisions released in 2015.
b) State legislation requiring local agencies to follow this guidance.
c) Statutory changes requiring child welfare agencies to consider prior history of screened out maltreatment reports when assigning cases to a response path.
d) An increase in reporting sexual abuse, which now includes sex trafficked youth.
e) Hennepin County, which comprises about one-quarter of state cases, went from about 40 percent of its cases being assigned to Family Investigation in 2014 to almost 60 percent in 2017, meaning this agency had a strong influence on overall state trends. This steep increase has leveled off; 2017 shows almost identical rates of assignment to Family Assessment compared to Family Investigation.

Maltreatment type and child protection response paths

- Reports of neglect, physical abuse, mental injury, and medical neglect were most often assigned to the Family Assessment response path. Sexual abuse (which has a required Investigation response) and threatened injury were most often assigned to Family or Facility Investigations (see Figure 14).
- Despite a statute indicating that all sexual abuse allegations should receive a Family Investigation response**, 3.7** percent of screened in maltreatment reports (N = **140** reports) having allegations of sexual abuse were closed as having received a Family Assessment response. However, **100** (or **71.4** percent) of those reports were at some point prior to case closure assigned to a Family or Facility Investigation and were switched once further assessment indicated a Family Investigation was not needed, which is permissible under Minnesota Statutes. That leaves **40** reports**,** or about **1** percent of all reports including sexual abuse allegations, that were closed as Family Assessment and had never had an Investigation. This is down 1.7 percent of cases from 2016.

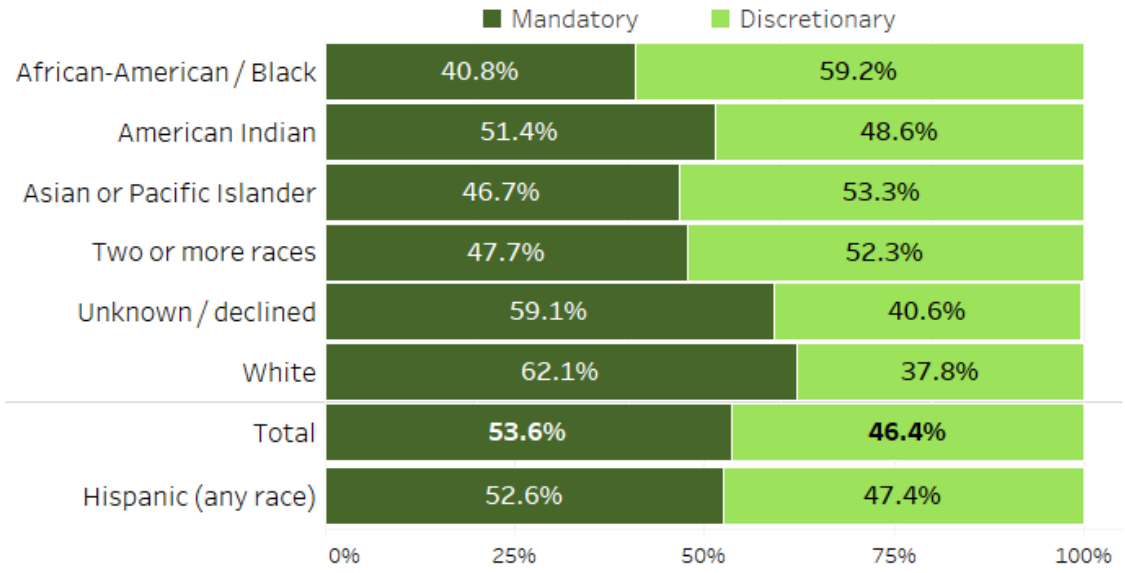
- Beginning in 2015, Child Safety and Permanency Division staff began reviewing every report that was assigned to Family Assessment and had a sexual abuse allegation, and contacting local agencies to review this decision. Beginning in September 2017, new cases that include an allegation of sexual abuse are forced by the electronic tracking system to be assigned to an investigation track.

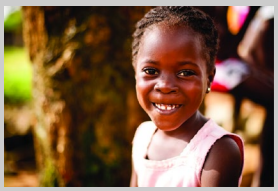
Figure 14. The percent and number of cases by child protection response path and maltreatment type in 2017



- As mentioned previously on p. 24, there are both mandatory and discretionary reasons that local child protection agency staff will assign a case 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 are assigned to a Family Investigation for a discretionary reason less frequently compared to children from other racial and ethnic groups. The most common reasons associated with discretionary assignment to a Family Investigation was frequency, similarity, or recentness of past reports (**71** percent), and need for legal intervention due to violent activities in the household (**15.8** percent).

Figure 15. The percent of alleged victims by race/ethnicity assigned to Family Investigation by discretionary versus mandatory reasons in 2017





Assessment or investigation of safety, risk and service need

After a maltreatment report has been screened in and a case has been 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 case and family. After 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, 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 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 case management services are provided to a family through opening child protection case management. At closing of a Family 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 them 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 (**78.1** percent), therefore, require face-to-face contact within five days. The five-day timeline applies to children named as alleged victims in child protection cases assigned both to the Family Assessment response as well as those assigned to a Family Investigation at the discretion of local agency staff (rather than for mandatory reasons because of severity of current allegation).
- While improvement has been made since 2015, **83.6** percent of victims were seen within the time frames established in statute for face-to-face contact with alleged victims in 2017 (see Figure 16); continued efforts in this area are underway.

Figure 16. Timeliness of face-to-face contact with alleged victims, 2017

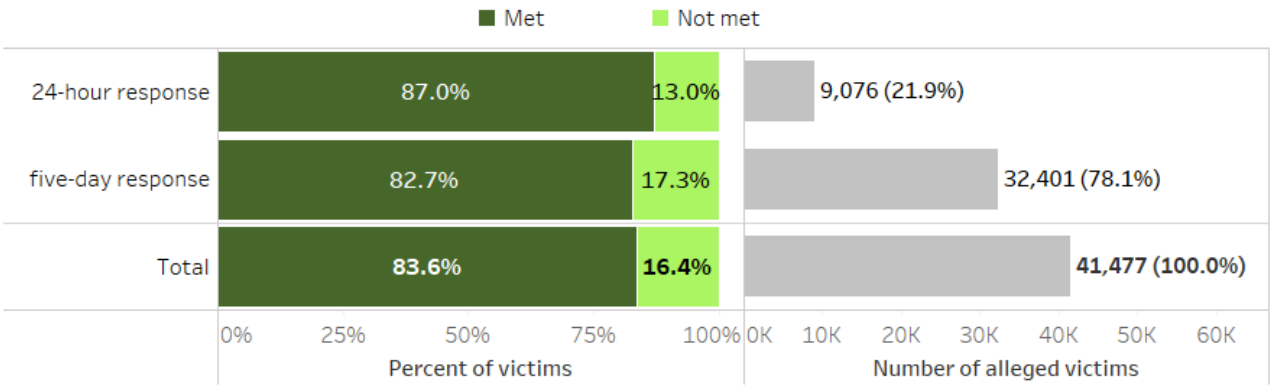
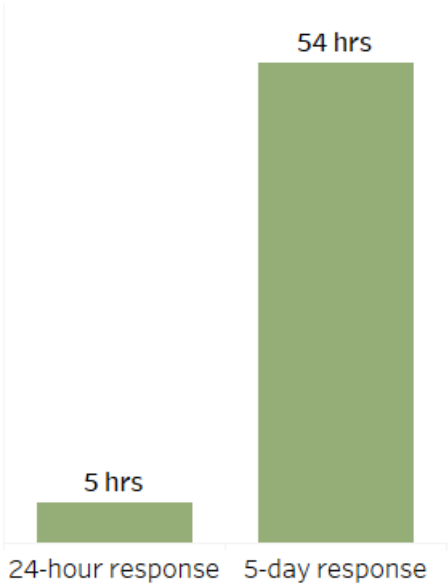


Figure 17. Median time of face-to-face contact by response type



- Despite not meeting the performance standard, the median time of face-to-face contact between a child protection worker and alleged victims with allegations indicating substantial child endangerment was just under **five** hours, and the median time of contact for all other victims was **54** 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 funding is 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 assessment/ investigation. Funding was first distributed in February 2015 and continued through 2018; recent increases in child protection reports and associated victims has far outpaced increases in funding allocated to social service agencies.

- Both department staff and local child protection agencies recognize the urgent need to improve performance on this measure so all children are seen in a timely manner, ensuring safety for alleged victims of maltreatment in Minnesota.

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 cases that are assigned to Family Investigation compared to Family Assessment are rated as unsafe (**16.7** percent vs **3.4** percent; see 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 cases by safety levels and child protection response path

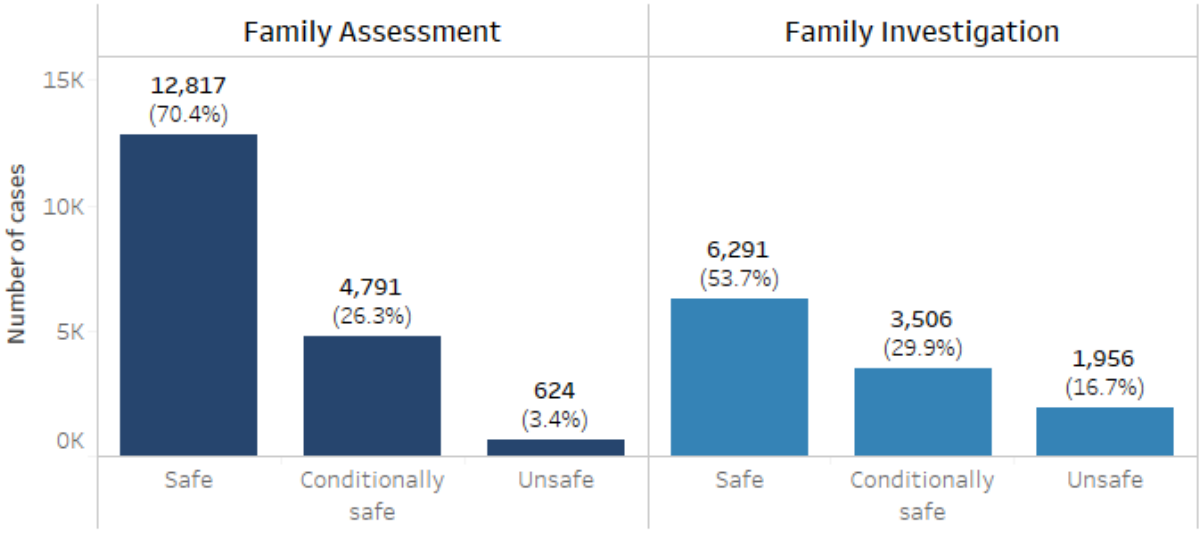
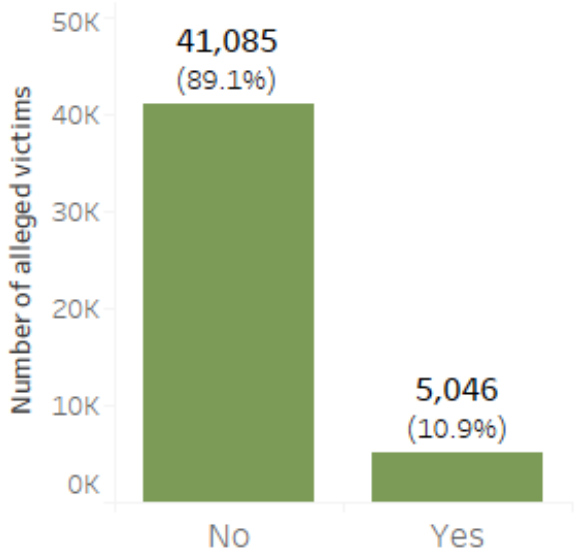
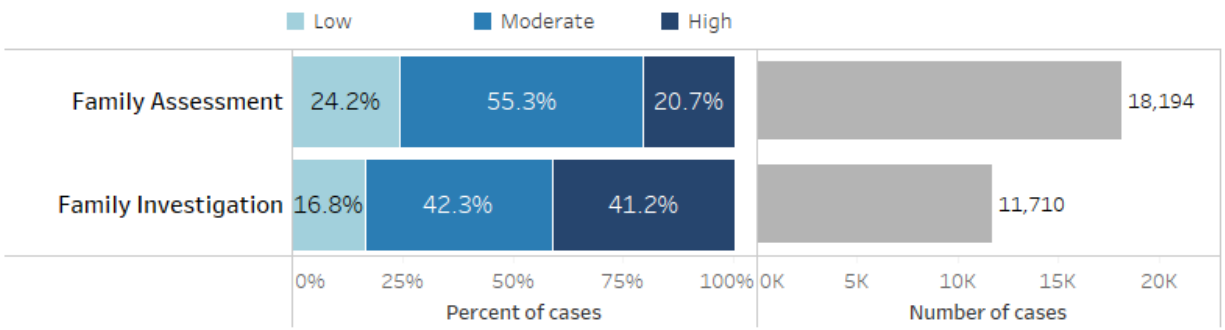


Figure 19. The number and percent of alleged victims who have an out-of-home placement during the assessment or investigation phase



- 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 2017 were placed in out-of-home care during an assessment or investigation (about **11** 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). For more information on children in out-of-home care, see **Minnesota's 2017 Out-of-home Care and Permanency report**.
- 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 assessments/investigations 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 child maltreatment cases assigned to Family Investigations were high risk (**41.2** percent) than reports that were Family Assessments (**20.7** percent).

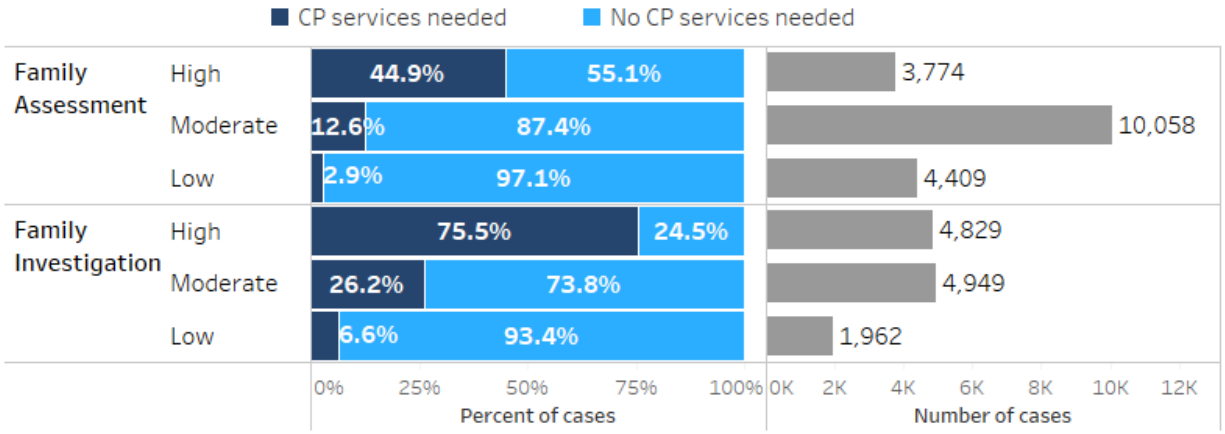
Figure 20. The number and percent of cases by risk assessment level and child protection response path



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.
- Cases that received a Family Investigation are more likely to indicate a need for post-investigation child protective services at all levels of risk.
- Although cases 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.
- In 2016, the department revalidated the tool used for risk assessment. 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.

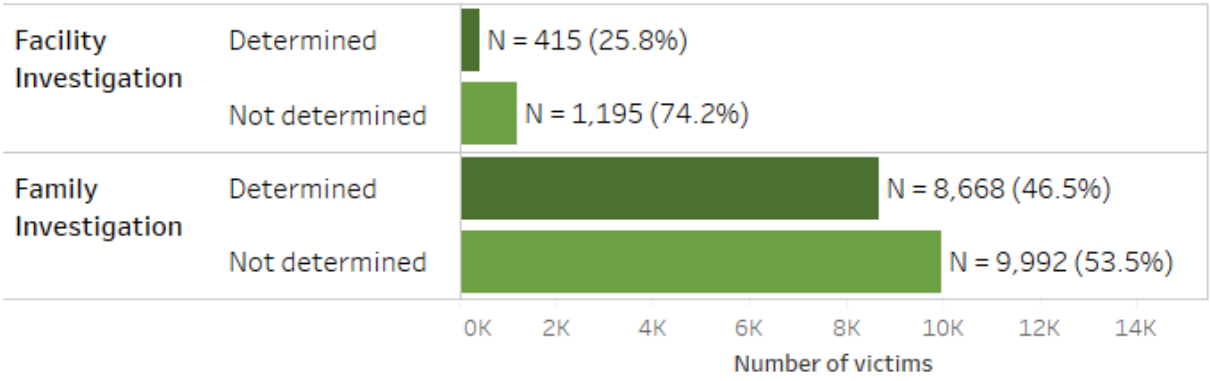
Figure 21. The percent and number of cases where child protective services were indicated by response category and risk level



Determining maltreatment

- For both Family and Facility Investigations, there is a final step at the conclusion of a child maltreatment case 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 the investigation.
- Figure 22 provides information about the number of determined reports and victims by Family or Facility Investigation. There were **8,668** children in Family Investigations and **415** in Facility Investigations who had a maltreatment determination in 2017.
- For less than half of all victims in reports that were in either type of investigation, there was a determination that maltreatment occurred (**44.8** percent). However, the pattern is different for Facility and Family Investigations, with about **one quarter** of all victims in Facility Investigations, and just under **half** of victims in Family Investigations having a determination.

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



Relationship of alleged offenders to alleged victims in completed assessments/ investigations by determination

- The overwhelming majority of alleged and determined offenders in child maltreatment cases 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 **18.1** percent.
- There were **32** 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. Upon review, this appears to be data entry errors in documentation of relationships, rather than inappropriate assignment of these cases to a Family Assessment response. There were fewer errors in 2017 than in previous years.

Table 2. Number of alleged offenders by relationship to alleged victims, and percent child protection response and determination status in 2017

Offender relationship	Family Assessment	Investigations	Investigations determined	Percent determined
Unmarried partner of parent	1,174	1,257	677	53.9%
Biological parent	16,605	9,810	5,196	53.0%
Unknown or missing	45	48	22	45.8%
Other	164	476	215	45.2%
Legal guardian	286	221	97	43.9%
Step-parent	767	536	232	43.3%
Friends or neighbors	47	84	35	41.7%
Other relative (non-foster parent)	483	766	318	41.5%
Non-caregiver sex trafficker	7	10	4	40.0%
Child daycare provider	15	204	79	38.7%
Sibling	215	680	249	36.6%
Adoptive parent	264	194	59	30.4%
Group home or residential facility staff	3	51	15	29.4%
Other professionals	1	21	6	28.6%
Relative foster parent	10	255	63	24.7%
Non-relative foster parent	3	260	47	18.1%

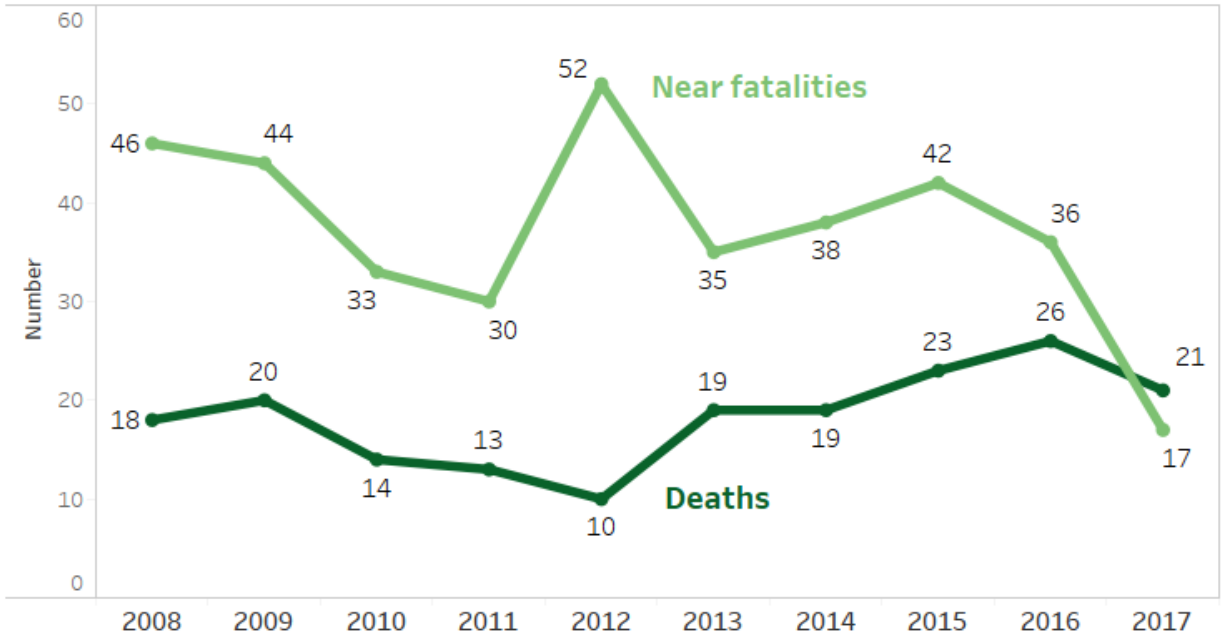
Child fatalities and near fatalities due to maltreatment

Local social service agencies and department staff 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.

The Department began utilizing this new review process in 2017 in partnership with local agency staff and community partners. A significant component of the department's work with Collaborative Safety over the past year has involved 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 improve outcomes for children and families. The first step towards building a safety culture in Minnesota that will support learning after critical incidents and prevention of future incidents included training more than 1600 individuals statewide over the past year to provide information about safety science and the critical incident review process. This included training department leadership, county and tribal agency leaders, frontline 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 2008 to 2017.
- There were **21** deaths and **17** near fatalities determined to be a result of maltreatment in 2017.
- The reduction in near fatality numbers in 2017 may be attributed to a number of factors. Language used to categorize these types of cases has changed from "Life threatening" to "Near fatality." This change was made to coincide with a Near Fatality Tip Sheet created by the department to assist agencies in determining whether a child's injury met established criteria. In addition, department staff worked with agencies statewide to ensure that coding is accurate and consistent. As a result of this effort, some cases were re-coded from "Near fatality" to something less severe (e.g., serious injury, moderate injury, etc.) as injuries in those cases did not meet criteria for near fatality.

Figure 23. Victims who died or had a near fatality as a result of maltreatment, 2008 – 2017



- Tables 3 and 4 provide detailed information about victims who died as a result of maltreatment in 2017. Table 3 provides information on victims who died as a result of maltreatment and had at least one prior screened in maltreatment report; Table 4 provides information on victims who died and had no known prior involvement in a screened in child maltreatment report.
- There are often a number of months, and sometimes 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 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 2017, which is why it is included in the 2017 report.
- Other information included in the table are age at time of death, gender, and the type of maltreatment that resulted in death.
- Of the **21** children whose deaths were determined to be a result of maltreatment in 2017, **seven children** had been involved in prior screened in child protection reports, and **14** had not.

Table 3. Details regarding deaths that were determined to be a result of maltreatment in 2017, where children had a prior child protection history

Year of death	Age and gender	Type of maltreatment
2015	7 years old, male	Neglect
2016	8 years old, female	Physical abuse
2016	6 years old, male	Neglect
2016	Less than 1 year old, female	Neglect
2017	Less than 1 year old, female	Neglect, physical abuse
2017	Less than 1 year old, male	Neglect
2017	Less than 1 year old, female	Neglect

Table 4. Details regarding deaths determined to be a result of maltreatment in 2017, where children had no prior child protection history

Year of death	Age and gender	Type of maltreatment
2016	13 years old, male	Physical abuse
2016	10 years old, female	Physical abuse
2016	Less than 1 year old, female	Neglect
2016	Less than 1 year old, female	Physical abuse
2016	Less than 1 year old, female	Physical abuse
2016	Less than 1 year old, female	Physical abuse
2017	5 years old, male	Threatened injury
2017	2 years old, male	Neglect, physical abuse
2017	3 years old, male	Physical abuse
2017	1 year old, male	Physical abuse
2017	Less than 1 year old, male	Physical abuse
2017	Less than 1 year old, male	Neglect, physical abuse
2017	1 year old, male	Neglect, physical abuse
2017	Less than 1 year old, female	Neglect, threatened injury

Outcomes after child maltreatment assessments/investigations have concluded

To determine how successful child protection is in assessing the needs of children and families and providing 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 alleged victims

- Table 5 provides information on how many alleged victims in screened in maltreatment reports in 2017 had another screened in maltreatment report within 12 months of the first report by child protection response path.

Table 5. The number and percent of alleged victims with a re-report of maltreatment within 12 months by child protection response path in 2017

Response path	Total number of victims	Victims who had a re-report	Percent of victims with a re-report
Family Assessment	23,571	4,660	19.8%
Family Investigation	15,175	3,227	21.3%
Facility Investigation	1,120	180	16.1%
Total across response path	**39,862**	**8,063**	**20.2%**

Recurrence of maltreatment determinations

- Table 6 provides information on how many children, by race, who were determined victims of maltreatment in 2016 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. In 2015, the Children's Bureau revised the federal maltreatment performance indicator to follow victims with a determination for 12 months instead of 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.
- Minnesota met the maltreatment recurrence standard in 2017, with **8.9** percent of all children having a maltreatment determination. This is up from 8.2 in 2016.
- The recurrence rate for African-American/Black, American Indian, and children of two or more races is noticeably higher than recurrence for both white and Asian/Pacific Islander children.

Table 6. The number and percent of victims with a maltreatment determination recurrence within 12 months by race in 2017

Race/ethnicity	Determined victims	Determined victims with maltreatment recurrence within 12 months	Percent with maltreatment recurrence
African-American/Black	1,982	224	11.3%
American Indian	755	92	12.2%
Asian/Pacific Islander	272	14	5.1%
Unknown/declined	230	14	6.1%
Two or more races	1286	157	12.2%
White	3,892	252	6.5%
Total	**8,417**	**753**	**8.9%**
Hispanic (any race)	990	94	9.5%

Child maltreatment appendix

Table 7. Number and percent of child maltreatment reports by screening status and agency, 2017

Agency	Total child maltreatment reports received in 2017	Number of screened in reports	Number of screened out reports	Percent of reports screened in	Percent of reports screened out
Aitkin	210	104	106	49.5	50.5
Anoka	3,609	1,496	2,113	41.5	58.5
Becker	714	300	414	42.0	58.0
Beltrami	938	462	476	49.3	50.7
Benton	689	185	504	26.9	73.1
Big Stone	59	24	35	40.7	59.3
Blue Earth	1,108	369	739	33.3	66.7
Brown	526	205	321	39.0	61.0
Carlton	931	443	488	47.6	52.4
Carver	793	376	417	47.4	52.6
Cass	412	206	206	50.0	50.0
Chippewa	74	50	24	67.6	32.4
Chisago	908	319	589	35.1	64.9
Clay	1,735	498	1,237	28.7	71.3
Clearwater	245	136	109	55.5	44.5
Cook	108	46	62	42.6	57.4
Crow Wing	1,177	244	933	20.7	79.3
Dakota	4,810	1,917	2,893	39.9	60.1
Douglas	774	354	420	45.7	54.3
Fillmore	187	87	100	46.5	53.5
Freeborn	644	223	421	34.6	65.4
Goodhue	724	291	433	40.2	59.8
Grant	217	108	109	49.8	50.2
Hennepin	17,405	10,313	7,092	59.3	40.7
Houston	242	100	142	41.3	58.7
Hubbard	540	319	221	59.1	40.9

Agency	Total child maltreatment reports received in 2017	Number of screened in reports	Number of screened out reports	Percent of reports screened in	Percent of reports screened out
Isanti	857	217	640	25.3	74.7
Itasca	1,117	534	583	47.8	52.2
Kanabec	349	139	210	39.8	60.2
Kandiyohi	793	268	525	33.8	66.2
Kittson	41	14	27	34.1	65.9
Koochiching	330	112	218	33.9	66.1
Lac qui Parle	87	38	49	43.7	56.3
Lake	122	67	55	54.9	45.1
Lake of the Woods	40	24	16	60.0	40.0
Le Sueur	682	267	415	39.1	60.9
McLeod	695	253	442	36.4	63.6
Mahnomen	93	36	57	38.7	61.3
Marshall	121	42	79	34.7	65.3
Meeker	361	128	233	35.5	64.5
Mille Lacs	1,237	360	877	29.1	70.9
Morrison	659	145	514	22.0	78.0
Mower	873	338	535	38.7	61.3
Nicollet	470	191	279	40.6	59.4
Nobles	349	88	261	25.2	74.8
Norman	160	54	106	33.8	66.3
Olmsted	1,527	667	860	43.7	56.3
Otter Tail	843	471	372	55.9	44.1
Pennington	174	98	76	56.3	43.7
Pine	1,251	374	877	29.9	70.1
Polk	636	211	425	33.2	66.8
Pope	214	121	93	56.5	43.5
Ramsey	6,171	2,759	3,412	44.7	55.3
Red Lake	37	20	17	54.1	45.9
Renville	304	108	196	35.5	64.5

Agency	Total child maltreatment reports received in 2017	Number of screened in reports	Number of screened out reports	Percent of reports screened in	Percent of reports screened out
Rice	1,203	322	881	26.8	73.2
Roseau	106	52	54	49.1	50.9
St. Louis	3,773	2,419	1,354	64.1	35.9
Scott	1,838	762	1,076	41.5	58.5
Sherburne	1,403	503	900	35.9	64.1
Sibley	262	156	106	59.5	40.5
Stearns	1,878	809	1,069	43.1	56.9
Stevens	186	97	89	52.2	47.8
Swift	311	93	218	29.9	70.1
Todd	480	113	367	23.5	76.5
Traverse	112	50	62	44.6	55.4
Wabasha	266	116	150	43.6	56.4
Wadena	474	227	247	47.9	52.1
Washington	2,120	847	1,273	40.0	60.0
Watonwan	172	63	109	36.6	63.4
Wilkin	168	65	103	38.7	61.3
Winona	1,126	486	640	43.2	56.8
Wright	2,330	744	1,586	31.9	68.1
Yellow Medicine	223	104	119	46.6	53.4
Southwest HHS	1,697	745	952	43.9	56.1
Des Moines Valley HHS	563	200	363	35.5	64.5
Faribault-Martin	651	320	331	49.2	50.8
Leech Lake Band of Ojibwe	583	247	336	42.4	57.6
White Earth Nation	437	342	95	78.3	21.7
MN Prairie	1,414	535	879	37.8	62.2
Minnesota	**84,148**	**37,736**	**46,412**	**44.8**	**55.2**

Table 8. Number of completed maltreatment assessments/investigations by response path and agency, 2017

Agency	Family Assessment	Family Investigation	Facility Investigation	Total reports
Aitkin	75	17	3	95
Anoka	765	506	26	1,297
Becker	140	144	8	292
Beltrami	139	222	12	373
Benton	99	61	3	163
Big Stone	17	7	0	24
Blue Earth	321	58	11	390
Brown	142	27	2	171
Carlton	169	113	26	308
Carver	257	71	4	332
Cass	56	70	5	131
Chippewa	28	16	1	45
Chisago	142	111	9	262
Clay	264	75	14	353
Clearwater	39	47	3	89
Cook	32	8	2	42
Crow Wing	160	50	13	223
Dakota	1,085	707	25	1,817
Douglas	138	128	11	277
Fillmore	71	4	0	75
Freeborn	115	40	1	156
Goodhue	123	42	7	172
Grant	40	43	2	85
Hennepin	3,566	4,294	297	8,157
Houston	58	11	2	71
Hubbard	214	94	11	319
Isanti	133	42	5	180
Itasca	159	115	25	299

Agency	Family Assessment	Family Investigation	Facility Investigation	Total reports
Kanabec	71	62	3	136
Kandiyohi	89	88	2	179
Kittson	7	5	0	12
Koochiching	71	21	1	93
Lac qui Parle	25	12	1	38
Lake	24	9	2	35
Lake of the Woods	18	3	1	22
Le Sueur	139	41	1	181
McLeod	102	122	2	226
Mahnomen	26	9	0	35
Marshall	27	12	2	41
Meeker	89	32	3	124
Mille Lacs	156	143	17	316
Morrison	87	42	4	133
Mower	210	84	3	297
Nicollet	143	21	1	165
Nobles	62	14	1	77
Norman	27	12	3	42
Olmsted	513	100	6	619
Otter Tail	201	180	3	384
Pennington	47	40	4	91
Pine	154	125	15	294
Polk	117	49	4	170
Pope	40	43	6	89
Ramsey	1,328	947	68	2,343
Red Lake	14	2	1	17
Renville	57	39	7	103
Rice	224	79	3	306
Roseau	39	9	2	50
St. Louis	1,230	643	82	1,955
Scott	479	139	14	632

Agency	Family Assessment	Family Investigation	Facility Investigation	Total reports
Sherburne	307	154	14	475
Sibley	52	64	2	118
Stearns	404	193	25	622
Stevens	76	18	2	96
Swift	36	36	3	75
Todd	70	12	3	85
Traverse	21	21	0	42
Wabasha	80	20	1	101
Wadena	138	49	5	192
Washington	456	206	25	687
Watonwan	49	18	1	68
Wilkin	43	12	2	57
Winona	165	51	10	226
Wright	390	186	15	591
Yellow Medicine	68	25	2	95
Southwest HHS	392	201	23	616
Des Moines Valley HHS	128	42	4	174
Faribault-Martin	174	88	1	263
Leech Lake Band of Ojibwe	237	11	11	259
White Earth Nation	226	22	33	281
MN Prairie	337	58	6	401
Minnesota	**18,212**	**11,737**	**978**	**30,927**

Table 9. Number of alleged victims in completed assessments/investigations by maltreatment type and rate per 1,000 children by agency, 2017

Agency	Medical neglect	Threatened injury	Neglect	Sexual abuse	Mental injury	Physical abuse	Total alleged victims*	Child pop. est. (2016)	Rate per 1,000
Aitkin	1	5	91	17	2	34	127	2,630	48.3
Anoka	3	35	1,038	181	15	567	1,664	83,398	20
Becker	0	17	257	69	20	152	393	8,207	47.9
Beltrami	1	23	456	56	5	120	593	11,651	50.9
Benton	1	20	120	19	9	66	207	9,882	20.9
Big Stone	0	1	12	9	1	12	29	1,042	27.8
Blue Earth	0	18	336	56	4	111	474	13,013	36.4
Brown	0	10	139	23	27	71	216	5,563	38.8
Carlton	4	20	315	49	36	163	428	8,085	52.9
Carver	0	34	228	45	26	186	437	27,384	16
Cass	1	11	101	26	25	60	159	6,190	25.7
Chippewa	0	5	41	12	0	20	73	2,781	26.2
Chisago	1	12	188	48	7	98	317	12,543	25.3
Clay	0	55	291	56	14	177	496	15,053	33
Clearwater	0	8	95	27	16	29	131	2,194	59.7
Cook	0	0	34	3	8	14	52	820	63.4
Crow Wing	0	19	199	59	36	121	324	13,965	23.2
Dakota	2	43	1,435	212	7	605	2,143	102,983	20.8
Douglas	1	13	247	63	34	114	354	7,982	44.3
Fillmore	0	2	28	4	0	51	83	5,095	16.3
Freeborn	0	6	134	33	3	85	220	6,621	33.2
Goodhue	0	11	143	32	0	67	221	10,466	21.1
Grant	1	5	62	8	7	31	87	1,360	64
Hennepin	9	590	5,970	1,588	276	4,737	10,241	273,089	37.5
Houston	0	0	50	11	1	32	82	4,065	20.2
Hubbard	1	21	271	46	27	144	403	4,407	91.4

Agency	Medical neglect	Threatened injury	Neglect	Sexual abuse	Mental injury	Physical abuse	Total alleged victims*	Child pop. est. (2016)	Rate per 1,000
Isanti	0	7	154	35	8	92	249	9,312	26.7
Itasca	1	13	297	74	8	134	424	9,563	44.3
Kanabec	0	15	101	25	15	64	166	3,394	48.9
Kandiyohi	0	11	176	48	6	88	261	10,193	25.6
Kittson	0	0	15	3	2	7	22	925	23.8
Koochiching	0	2	63	7	6	17	88	2,350	37.4
Lac qui Parle	0	5	31	7	3	10	50	1,322	37.8
Lake	0	0	36	6	0	14	50	1,947	25.7
Lake of the Woods	0	0	21	2	0	11	28	687	40.8
Le Sueur	0	12	128	23	10	87	213	6,623	32.2
McLeod	0	9	223	35	10	82	328	8,379	39.1
Mahnomen	0	3	21	8	1	13	35	1,710	20.5
Marshall	0	9	41	20	0	17	64	2,124	30.1
Meeker	2	14	70	27	0	54	146	5,612	26
Mille Lacs	1	9	306	90	16	137	463	6,180	74.9
Morrison	0	4	98	50	4	50	186	7,732	24.1
Mower	0	3	245	66	7	101	361	9,793	36.9
Nicollet	0	8	120	22	29	57	200	7,425	26.9
Nobles	0	2	51	15	3	46	107	5,842	18.3
Norman	0	3	32	10	3	14	57	1,511	37.7
Olmsted	0	11	545	86	13	212	820	37,756	21.7
Otter Tail	1	11	306	44	40	150	436	12,591	34.6
Pennington	0	7	94	13	4	47	137	3,291	41.6
Pine	0	14	259	85	8	132	415	5,799	71.6
Polk	0	10	169	33	3	47	234	7,543	31
Pope	0	9	67	13	8	43	108	2,292	47.1
Ramsey	0	423	1,807	353	25	825	3,106	126,468	24.6
Red Lake	0	0	16	1	0	4	21	983	21.4
Renville	0	5	113	12	9	43	148	3,248	45.6
Rice	0	15	220	48	0	204	428	14,302	29.9

Agency	Medical neglect	Threatened injury	Neglect	Sexual abuse	Mental injury	Physical abuse	Total alleged victims*	Child pop. est. (2016)	Rate per 1,000
Roseau	0	1	54	7	0	10	71	3,792	18.7
St. Louis	1	118	1,492	250	39	877	2,315	38,252	60.5
Scott	0	18	397	113	11	265	729	40,371	18.1
Sherburne	2	20	341	99	49	254	645	25,074	25.7
Sibley	0	1	99	23	1	54	153	3,509	43.6
Stearns	0	36	520	92	14	249	781	35,620	21.9
Stevens	0	10	78	23	4	40	106	2,037	52
Swift	0	2	70	3	4	41	107	2,150	49.8
Todd	0	1	92	14	0	25	127	5,783	22
Traverse	0	6	46	7	3	25	63	686	91.8
Wabasha	0	1	59	16	1	43	116	4,693	24.7
Wadena	1	3	187	46	6	81	253	3,355	75.4
Washington	0	17	456	145	13	396	888	62,865	14.1
Watonwan	0	6	30	11	0	27	70	2,622	26.7
Wilkin	0	6	36	4	2	19	61	1,420	43
Winona	0	11	178	34	46	106	291	9,300	31.3
Wright	2	19	456	73	51	363	789	37,621	21
Yellow Medicine	0	11	85	12	8	32	119	2,289	52
Southwest HHS	2	53	480	107	34	267	759	18,037	42.1
Des Moines Valley HHS	0	13	149	43	8	58	234	4,929	47.5
Faribault-Martin	0	10	255	39	1	99	370	7,349	50.3
Leech Lake Band of Ojibwe†	11	1	295	31	1	43	344	1,975	174.2
White Earth Nation†	1	4	365	12	5	72	411	1,981	207.5
MN Prairie	2	11	309	44	12	174	499	19,213	26
Minnesota	**53**	**1,997**	**24,635**	**5,261**	**1,160**	**14,289**	**39,606**	**1,288,333**	**30.7**

† 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.

* 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.

Table 10. Number of alleged victims by age group and by agency, 2017

Agency	Birth – 2	3 – 5	6 – 8	9 – 11	12 – 14	15 – 17	18 and older
Aitkin	32	25	20	18	27	7	0
Anoka	373	308	375	288	176	154	0
Becker	100	74	65	70	59	34	0
Beltrami	149	117	109	94	74	55	0
Benton	54	37	40	31	23	23	0
Big Stone	6	7	7	4	3	2	0
Blue Earth	118	111	100	96	45	20	0
Brown	36	43	44	35	28	31	0
Carlton	81	79	82	91	60	42	0
Carver	66	76	101	87	61	52	0
Cass	26	25	27	41	30	13	0
Chippewa	16	15	17	15	6	4	0
Chisago	63	60	56	63	48	29	0
Clay	123	105	106	81	67	26	0
Clearwater	24	31	25	24	17	12	0
Cook	14	12	10	9	5	3	0
Crow Wing	101	55	52	48	34	37	1
Dakota	387	349	510	380	292	248	0
Douglas	75	79	68	53	50	38	0
Fillmore	12	16	10	19	17	10	0
Freeborn	59	43	36	31	35	19	0
Goodhue	63	47	42	34	24	12	0
Grant	16	15	22	12	13	9	0
Hennepin	2,312	1,793	2,011	1,775	1,344	1,180	2
Houston	23	20	17	7	10	7	0
Hubbard	75	68	75	84	67	43	0
Isanti	53	53	50	49	27	20	0
Itasca	84	87	80	68	69	44	1

Agency	Birth – 2	3 – 5	6 – 8	9 – 11	12 – 14	15 – 17	18 and older
Kanabec	35	41	27	27	17	19	0
Kandiyohi	77	43	47	34	37	23	0
Kittson	2	2	3	9	2	4	0
Koochiching	17	18	17	18	15	6	0
Lac qui Parle	5	10	13	13	4	5	0
Lake	10	6	9	9	8	8	0
Lake of the Woods	7	5	5	6	3	3	0
Le Sueur	51	39	39	31	32	24	0
McLeod	72	59	70	56	51	22	0
Mahnomen	9	8	6	1	6	6	0
Marshall	17	17	11	9	5	6	0
Meeker	39	16	26	27	21	21	0
Mille Lacs	115	97	84	75	61	38	0
Morrison	45	44	40	28	16	14	0
Mower	72	72	70	80	44	29	0
Nicollet	28	48	33	44	29	18	0
Nobles	12	26	22	18	17	13	0
Norman	14	10	16	8	8	1	0
Olmsted	196	160	154	135	88	95	1
Otter Tail	105	88	88	67	58	40	0
Pennington	41	32	27	20	13	5	0
Pine	89	62	80	82	66	47	0
Polk	60	51	51	45	23	7	0
Pope	12	29	22	25	13	9	0
Ramsey	770	491	636	548	364	319	0
Red Lake	6	6	2	2	4	1	0
Renville	29	34	25	23	27	11	0
Rice	102	71	91	81	45	47	0
Roseau	14	16	15	12	10	4	0
St. Louis	584	446	447	408	287	193	2
Scott	162	137	149	116	95	80	0

Agency	Birth – 2	3 – 5	6 – 8	9 – 11	12 – 14	15 – 17	18 and older
Sherburne	125	85	143	113	110	76	0
Sibley	25	27	25	33	24	21	0
Stearns	171	164	136	126	112	79	0
Stevens	14	20	23	21	19	14	0
Swift	24	25	16	19	14	10	0
Todd	26	32	22	22	18	8	0
Traverse	15	19	10	7	11	3	0
Wabasha	25	27	21	23	14	8	0
Wadena	49	46	43	53	43	22	0
Washington	176	166	174	149	138	92	0
Watonwan	7	14	17	17	5	10	0
Wilkin	11	18	9	9	9	5	0
Winona	66	64	62	44	33	25	0
Wright	126	139	165	151	115	106	0
Yellow Medicine	35	18	22	22	14	11	0
Southwest HHS	151	153	166	124	100	74	0
Des Moines Valley HHS	50	57	53	30	27	20	0
Faribault-Martin	91	67	64	67	39	42	0
Leech Lake Band of Ojibwe	81	62	86	78	37	12	0
White Earth Nation	110	81	82	54	54	37	0
MN Prairie	103	89	107	92	68	47	0
Minnesota	**8,819**	**7,307**	**7,928**	**6,918**	**5,184**	**4,014**	**7**

Note: Some victims may be involved in more than one report during the report period.

Table 11. Number of alleged victims by race, ethnicity, and agency, 2017

Agency	African-American/ Black	American Indian	Asian/ Pacific Islander	Two or more races	Unknown/ declined	White	Total alleged victims	Hispanic (any race)
Aitkin	*	32	*	*	*	85	127	*
Anoka	281	28	39	191	87	1,038	1,664	130
Becker	15	73	*	57	*	240	393	21
Beltrami	12	374	*	41	*	158	593	16
Benton	22	*	*	31	*	145	207	9
Big Stone	*	*	*	*	*	25	29	*
Blue Earth	82	14	*	62	*	288	474	46
Brown	*	*	*	*	13	191	216	31
Carlton	*	134	*	66	*	221	428	*
Carver	57	8	*	46	*	302	437	54
Cass	*	14	*	*	12	126	159	*
Chippewa	*	7	*	7	*	56	73	14
Chisago	*	*	*	34	24	250	317	14
Clay	42	59	*	78	*	314	496	88
Clearwater	*	22	*	11	7	89	131	*
Cook	*	16	*	11	*	24	52	*
Crow Wing	*	20	*	25	*	272	324	*
Dakota	347	42	41	307	276	1,130	2,143	326
Douglas	19	*	*	30	9	290	354	11
Fillmore	*	*	*	*	*	78	83	*
Freeborn	9	*	*	12	10	182	220	51
Goodhue	16	*	*	18	*	175	221	19
Grant	*	*	*	*	*	76	87	8
Hennepin	4,361	544	365	1,761	321	2,889	10,241	1,433
Houston	*	*	*	*	10	64	82	*
Hubbard	8	50	*	45	*	297	403	13
Isanti	*	*	*	24	*	212	249	*
Itasca	7	49	*	53	*	310	424	*

Agency	African-American/ Black	American Indian	Asian/ Pacific Islander	Two or more races	Unknown/ declined	White	Total alleged victims	Hispanic (any race)
Kanabec	*	*	*	8	9	147	166	*
Kandiyohi	15	*	7	9	*	224	261	95
Kittson	*	*	*	*	*	22	22	*
Koochiching	*	*	*	*	*	80	88	*
Lac qui Parle	*	*	*	*	*	40	50	9
Lake	*	*	*	*	*	43	50	*
Lake of the Woods	*	*	*	*	*	21	28	*
Le Sueur	*	*	*	16	10	179	213	37
McLeod	*	*	*	19	*	292	328	62
Mahnomen	*	16	*	*	*	14	35	*
Marshall	*	*	*	*	*	51	64	8
Meeker	*	*	*	*	*	130	146	16
Mille Lacs	10	155	*	37	*	229	463	16
Morrison	*	*	*	32	*	140	186	7
Mower	48	*	17	33	*	254	361	68
Nicollet	25	*	*	17	7	151	200	27
Nobles	9	*	*	*	11	74	107	46
Norman	*	8	*	*	*	42	57	12
Olmsted	114	*	37	130	*	537	820	116
Otter Tail	17	11	*	32	*	346	436	20
Pennington	7	*	*	13	*	114	137	21
Pine	9	69	*	29	*	287	415	9
Polk	7	10	*	19	*	194	234	69
Pope	*	*	*	7	*	97	108	*
Ramsey	1,194	115	362	412	101	922	3,106	366
Red Lake	*	*	*	*	*	18	21	*
Renville	*	*	*	10	*	131	148	25
Rice	44	*	*	31	78	269	428	88
Roseau	7	*	*	11	*	45	71	*
St. Louis	241	298	*	309	*	1,409	2,315	70

Agency	African-American/ Black	American Indian	Asian/ Pacific Islander	Two or more races	Unknown/ declined	White	Total alleged victims	Hispanic (any race)
Scott	72	18	22	85	44	488	729	86
Sherburne	51	*	*	83	85	419	645	24
Sibley	*	*	*	13	8	132	153	46
Stearns	149	9	*	70	*	530	781	46
Stevens	*	10	*	*	*	81	106	16
Swift	14	*	*	15	*	77	107	21
Todd	*	*	*	8	*	114	127	11
Traverse	*	28	*	*	*	32	63	*
Wabasha	16	*	*	*	8	85	116	*
Wadena	12	*	*	23	7	205	253	*
Washington	94	19	31	114	199	431	888	77
Watonwan	*	*	*	*	*	69	70	43
Wilkin	*	9	*	7	*	45	61	*
Winona	28	*	*	27	14	218	291	19
Wright	49	8	7	51	30	644	789	32
Yellow Medicine	*	28	*	23	*	63	119	14
Southwest HHS	19	52	17	86	57	528	759	109
Des Moines Valley HHS	*	*	10	12	11	198	234	30
Faribault-Martin	*	*	*	34	9	319	370	58
Leech Lake Band of Ojibwe	*	330	*	13	*	*	344	7
White Earth Nation	*	380	*	31	*	*	411	10
MN Prairie	51	*	*	45	*	394	499	64
Minnesota	**7,659**	**3,157**	**1,014**	**4,902**	**1,772**	**21,102**	**39,606**	**4,253**

* The number of children is omitted to prevent identification of individuals. Totals include the omitted data.

Table 12. Number of alleged and determined victims in completed assessments/ investigations and rate per 1,000 children by agency, 2017

Agency	Unique alleged victims	Unique determined victims	Child pop. est. (2016)	Determined victims per 1,000
Aitkin	127	24	2,630	9.1
Anoka	1,664	349	83,398	4.2
Becker	393	123	8,207	15.0
Beltrami	593	247	11,651	21.2
Benton	207	56	9,882	5.7
Big Stone	29	5	1,042	4.8
Blue Earth	474	33	13,013	2.5
Brown	216	16	5,563	2.9
Carlton	428	107	8,085	13.2
Carver	437	49	27,384	1.8
Cass	159	38	6,190	6.1
Chippewa	73	20	2,781	7.2
Chisago	317	68	12,543	5.4
Clay	496	30	15,053	2.0
Clearwater	131	39	2,194	17.8
Cook	52	9	820	11.0
Crow Wing	324	32	13,965	2.3
Dakota	2,143	330	102,983	3.2
Douglas	354	135	7,982	16.9
Fillmore	83	2	5,095	0.4
Freeborn	220	50	6,621	7.6
Goodhue	221	59	10,466	5.6
Grant	87	17	1,360	12.5
Hennepin	10,241	3,210	273,089	11.8
Houston	82	1	4,065	0.2
Hubbard	403	37	4,407	8.4
Isanti	249	44	9,312	4.7
Itasca	424	55	9,563	5.8
Kanabec	166	44	3,394	13.0
Kandiyohi	261	77	10,193	7.6
Kittson	22	1	925	1.1
Koochiching	88	17	2,350	7.2
Lac qui Parle	50	6	1,322	4.5
Lake	50	11	1,947	5.6
Lake of the Woods	28	4	687	5.8
Le Sueur	213	23	6,623	3.5
McLeod	328	61	8,379	7.3
Mahnomen	35	5	1,710	2.9
Marshall	64	8	2,124	3.8
Meeker	146	13	5,612	2.3
Mille Lacs	463	69	6,180	11.2
Morrison	186	53	7,732	6.9
Mower	361	63	9,793	6.4
Nicollet	200	15	7,425	2.0

Agency	Unique alleged victims	Unique determined victims	Child pop. est. (2016)	Determined victims per 1,000
Nobles	107	8	5,842	1.4
Norman	57	6	1,511	4.0
Olmsted	820	32	37,756	0.8
Otter Tail	436	87	12,591	6.9
Pennington	137	18	3,291	5.5
Pine	415	70	5,799	12.1
Polk	234	44	7,543	5.8
Pope	108	30	2,292	13.1
Ramsey	3,106	815	126,468	6.4
Red Lake	21	2	983	2.0
Renville	148	28	3,248	8.6
Rice	428	79	14,302	5.5
Roseau	71	3	3,792	0.8
St. Louis	2,315	413	38,252	10.8
Scott	729	80	40,371	2.0
Sherburne	645	131	25,074	5.2
Sibley	153	42	3,509	12.0
Stearns	781	159	35,620	4.5
Stevens	106	19	2,037	9.3
Swift	107	53	2,150	24.7
Todd	127	9	5,783	1.6
Traverse	63	23	686	33.5
Wabasha	116	7	4,693	1.5
Wadena	253	7	3,355	2.1
Washington	888	94	62,865	1.5
Watonwan	70	7	2,622	2.7
Wilkin	61	1	1,420	0.7
Winona	291	55	9,300	5.9
Wright	789	96	37,621	2.6
Yellow Medicine	119	13	2,289	5.7
Southwest HHS	759	203	18,037	11.3
Des Moines Valley HHS	234	19	4,929	3.9
Faribault-Martin	370	72	7,349	9.8
Leech Lake Band of Ojibwe†	344	2	1,975	1.0
White Earth Nation†	411	22	1,981	11.1
MN Prairie	499	43	19,213	2.2
Minnesota	**39,606**	**8,447**	**1,288,333**	6.6

† 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.

Table 13. Number of social service agency referrals to early intervention for infants and toddlers involved in substantiated cases of maltreatment, 2017

Agency	Children with a referral	Children required to be referred	Referral rate
Aitkin	3	4	75.0
Anoka	90	102	88.2
Becker	25	35	71.4
Beltrami	74	80	92.5
Benton	9	11	81.8
Big Stone	0	0	--
Blue Earth	4	7	57.1
Brown	3	4	75.0
Carlton	27	31	87.1
Carver	10	11	90.9
Cass	4	7	57.1
Chippewa	4	4	100.0
Chisago	5	15	33.3
Clay	9	12	75.0
Clearwater	5	13	38.5
Cook	0	3	0.0
Crow Wing	3	5	60.0
Dakota	98	112	87.5
Douglas	32	39	82.1
Fillmore	0	0	--
Freeborn	8	11	72.7
Goodhue	5	14	35.7
Grant	4	5	80.0
Hennepin	793	823	96.4
Houston	0	1	0.0
Hubbard	8	11	72.7
Isanti	8	9	88.9
Itasca	6	8	75.0
Kanabec	10	12	83.3
Kandiyohi	20	24	83.3
Kittson	0	0	--
Koochiching	0	1	0.0
Lac qui Parle	0	0	--
Lake	1	2	50.0
Lake of the Woods	0	1	0.0
Le Sueur	4	5	80.0
McLeod	9	11	81.8
Mahnomen	0	2	0.0
Marshall	0	0	--

Agency	Children with a referral	Children required to be referred	Referral rate
Meeker	3	4	75.0
Mille Lacs	16	23	69.6
Morrison	6	14	42.9
Mower	15	18	83.3
Nicollet	1	1	100.0
Nobles	0	0	--
Norman	2	3	66.7
Olmsted	5	6	83.3
Otter Tail	28	41	68.3
Pennington	4	6	66.7
Pine	13	16	81.3
Polk	9	13	69.2
Pope	0	1	0.0
Ramsey	249	270	92.2
Red Lake	0	0	--
Renville	4	4	100.0
Rice	16	16	100.0
Roseau	0	1	0.0
St. Louis	72	94	76.6
Scott	18	25	72.0
Sherburne	32	35	91.4
Sibley	9	12	75.0
Stearns	28	38	73.7
Stevens	3	4	75.0
Swift	10	17	58.8
Todd	1	2	50.0
Traverse	6	13	46.2
Wabasha	0	0	--
Wadena	0	2	0.0
Washington	23	26	88.5
Watonwan	0	1	0.0
Wilkin	0	0	--
Winona	6	16	37.5
Wright	15	19	78.9
Yellow Medicine	1	2	50.0
Southwest HHS	37	47	78.7
Des Moines Valley HHS	0	0	--
Faribault-Martin	17	18	94.4
Leech Lake Band of Ojibwe	0	0	--
White Earth Nation	2	4	50.0
MN Prairie	5	9	55.6
Minnesota	**1,937**	**2,256**	**85.9**

Table 14. Number of assessments/investigations by SDM risk assessment status and by agency, 2017

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	9	0	9	34	13	47	16	20	36
Anoka	341	12	353	540	66	606	199	114	313
Becker	28	3	31	109	15	124	30	103	133
Beltrami	31	9	40	108	81	189	39	93	132
Benton	15	1	16	56	7	63	4	77	81
Big Stone	5	2	7	10	3	13	1	3	4
Blue Earth	72	0	72	175	13	188	87	31	118
Brown	33	2	35	74	14	88	22	24	46
Carlton	46	1	47	131	29	160	24	52	76
Carver	98	6	104	140	26	166	22	36	58
Cass	15	3	18	40	13	53	20	35	55
Chippewa	8	0	8	16	7	23	2	11	13
Chisago	63	1	64	109	18	127	21	41	62
Clay	31	1	32	145	15	160	81	74	155
Clearwater	22	2	24	31	7	38	8	16	24
Cook	2	0	2	9	6	15	13	10	23
Crow Wing	36	3	39	85	22	107	26	38	64
Dakota	494	8	502	914	63	977	132	183	315
Douglas	27	0	27	117	18	135	31	75	106
Fillmore	28	1	29	36	1	37	8	1	9
Freeborn	20	3	23	53	15	68	23	43	66
Goodhue	13	2	15	61	16	77	40	34	74
Grant	19	3	22	20	15	35	9	19	28
Hennepin	1,454	21	1,475	3,055	570	3,625	904	1,836	2,740
Houston	13	0	13	20	1	21	21	14	35
Hubbard	51	3	54	117	32	149	62	43	105
Isanti	38	1	39	65	11	76	17	46	63

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
Itasca	65	2	67	111	25	136	22	49	71
Kanabec	19	3	22	36	19	55	23	33	56
Kandiyohi	29	3	32	67	13	80	20	46	66
Kittson	4	0	4	4	2	6	1	1	2
Koochiching	13	1	14	37	5	42	19	17	36
Lac qui Parle	4	0	4	21	2	23	3	7	10
Lake	1	0	1	8	7	15	4	13	17
Lake of the Woods	3	2	5	5	3	8	4	2	6
Le Sueur	38	1	39	76	19	95	19	27	46
McLeod	40	5	45	92	39	131	17	31	48
Mahnomen	8	0	8	14	5	19	2	4	6
Marshall	3	0	3	15	5	20	4	12	16
Meeker	28	5	33	43	10	53	19	16	35
Mille Lacs	70	6	76	124	49	173	18	35	53
Morrison	30	3	33	57	10	67	4	27	31
Mower	88	0	88	147	18	165	23	18	41
Nicollet	29	5	34	61	22	83	12	36	48
Nobles	15	3	18	34	9	43	12	3	15
Norman	8	0	8	16	7	23	3	5	8
Olmsted	106	0	106	298	63	361	48	100	148
Otter Tail	77	4	81	146	36	182	28	90	118
Pennington	12	0	12	32	11	43	21	9	30
Pine	58	3	61	132	30	162	18	38	56
Polk	19	1	20	72	5	77	25	52	77
Pope	14	1	15	36	14	50	11	11	22
Ramsey	596	29	625	1,061	281	1,342	81	231	312
Red Lake	6	0	6	7	1	8	1	1	2
Renville	13	3	16	39	11	50	13	17	30
Rice	58	7	65	120	38	158	39	42	81

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
Roseau	10	1	11	14	11	25	3	9	12
St. Louis	329	11	340	826	105	932	259	347	606
Scott	193	4	197	250	62	312	37	63	100
Sherburne	101	5	106	203	38	241	45	68	113
Sibley	14	6	20	36	35	71	1	24	25
Stearns	113	3	116	250	48	298	97	88	185
Stevens	14	5	19	27	17	44	9	23	32
Swift	1	1	2	18	10	28	7	35	42
Todd	14	5	19	26	10	36	11	16	27
Traverse	2	0	2	15	9	24	7	9	16
Wabasha	20	1	21	47	7	54	17	10	27
Wadena	35	4	39	64	41	105	16	27	43
Washington	186	5	191	311	37	348	45	84	129
Watonwan	15	1	16	33	7	40	2	9	11
Wilkin	6	0	6	18	6	24	5	20	25
Winona	33	1	34	117	3	120	33	32	65
Wright	160	3	163	256	49	305	66	41	107
Yellow Medicine	6	0	6	34	19	53	5	29	34
Southwest HHS	122	10	132	233	66	299	48	122	170
Des Moines Valley HHS	41	1	42	54	24	78	19	31	50
Faribault-Martin	60	0	60	111	17	128	39	35	74
Leech Lake Band of Ojibwe	54	10	64	86	25	111	43	30	73
White Earth Nation	39	5	44	81	33	114	28	62	90
MN Prairie	81	0	81	162	25	188	44	82	126
Minnesota	**6,115**	**257**	**6,372**	**12,453**	**2,560**	**15,015**	**3,262**	**5,341**	**8,603**

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

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