Child Protective Services

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Centennial Office Building, 658 Cedar Street, St. Paul, MN 55155 • 612/296-4708

STATE OF MINNESOTA
OFFICE OF THE LEGISLATIVE AUDITOR
JAMES R. NOBLES, LEGISLATIVE AUDITOR

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Members
Legislative Audit Commission

In May 1997, the Legislative Audit Commission directed us to evaluate Minnesota's child protection system. The Legislature has grown increasingly interested in the effectiveness of this county-administered system, yet it has had limited information due to the privacy of county child protection records.

We found that Minnesota counties have widely varying child protection practices, partly reflecting the lack of common definitions of maltreatment in state laws and rules. Minnesota's child protection system relies on local property taxes far more than most states, and the Minnesota Department of Human Services plays a more limited role in the system than its counterparts elsewhere. Many of the professionals required to report cases of suspected maltreatment do not believe they adequately understand the decision-making criteria used by child protection agencies, and many lack confidence in the system's ability to intervene effectively in children's lives. We think the child protection system can be improved, and we offer suggestions for making the system more accountable to the public.

This report was researched and written by Joel Alter (project manager), David Chein, and Carrie Meyerhoff, with research assistance from Josh Halverson. We received the full cooperation of the Department of Human Services, county child protection agencies, and many others who work closely with the child protection system.

Sincerely,

James Nobles
Legislative Auditor

Roger Brooks
Deputy Legislative Auditor

1ST FLOOR SOUTH, CENTENNIAL BUILDING • 658 CEDAR STREET • ST. PAUL, MN 55155
TELEPHONE 612/296-4708 • TDD RELAY 612/297-5353 • FAX 612/296-4712 • WEB SITE http://www.auditor.leg.state.mn.us

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SUMMARY

Minnesota's child protective services system makes important decisions about whether (and how) government should intervene in families' lives to protect maltreated children. For example, child protection agencies decide which allegations of child maltreatment to investigate, whether maltreatment occurred, and whether protective services should be offered. They also decide whether to initiate court actions that may lead to out-of-home placement or termination of parental rights. These are difficult decisions, and they are often made with minimal public scrutiny because the records of child protection agencies are private.

In May 1997, the Legislative Audit Commission asked us to examine child protective services in Minnesota. In our research, we asked:

- **How much variation is there among counties in the incidence of child maltreatment investigations, determinations, and services? To what extent do county policies and practices explain these variations?**

- **Do people who work closely with Minnesota's child protection system believe that it works effectively?**

- **To what extent does maltreatment occur repeatedly within the same families? Are there additional steps that child protection agencies could take to reduce the incidence of repeated maltreatment?**

- **How large are the caseloads of child protection workers? What types of education and experience do these workers have, and how much staff turnover is there?**

- **How could the child protection system be made more accountable to the public?**

An effective child protection system relies on the efforts of many people and agencies, including "mandated reporters" of child maltreatment, county child protection agencies, county attorneys, the courts, law enforcement agencies, and providers of services to families. In addition, relatives, neighbors, and the community at large bear a responsibility for reporting instances of suspected

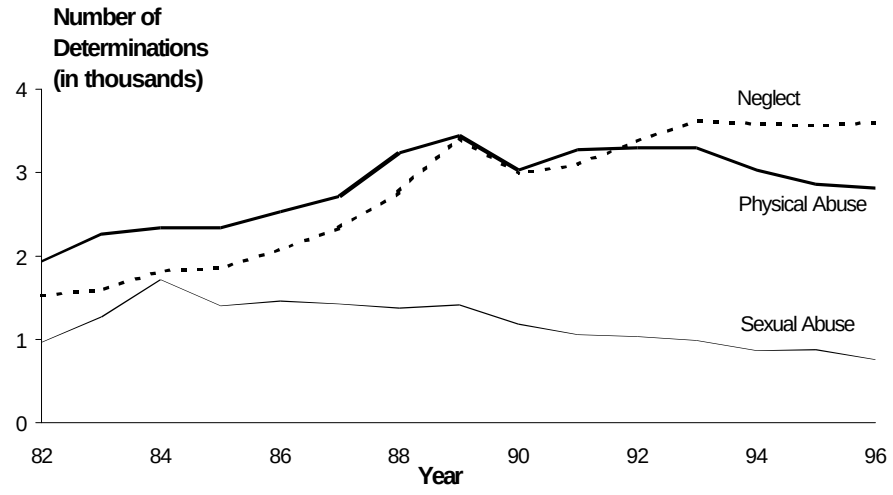
maltreatment and providing support to families in trouble. In response to legislative concerns, our study focused primarily on the role of county agencies in screening, investigating, and responding to reports of child maltreatment.

In 1996, Minnesota child protection agencies conducted 16,684 investigations and determined that maltreatment occurred in 6,725 cases (40 percent). The total number of investigations and maltreatment determinations in Minnesota has declined since 1993. Figure 1 shows trends in various types of maltreatment. Child neglect is the most common type of maltreatment, accounting for 54 percent of maltreatment determinations in 1996.

Child neglect is the most common type of maltreatment.

We wanted to examine trends in maltreatment-related deaths, but we found that statewide child mortality data in the Department of Human Services' (DHS) maltreatment information system are unreliable. For example, the DHS information system indicated that 49 maltreatment-related child deaths occurred during 1994-96, but we found that half of these cases were erroneously reported as child deaths.[1]

Figure 1: Cases of Determined Maltreatment, by Type, 1982-96



SOURCE: Department of Human Services.

1 Through reviews of county records, we verified that 24 deaths actually occurred in the 49 cases that DHS' system said involved a child death. Just as counties erroneously reported to DHS that some child injuries were child deaths, there might also have been instances in which actual child deaths were erroneously reported to DHS as other types of injuries. If so, there would have been more than 24 maltreatment-related deaths during 1994-96. Unfortunately, documenting whether any child deaths were incorrectly reported to DHS as child injuries would require a more extensive verification of the county-submitted data than we were able to conduct.

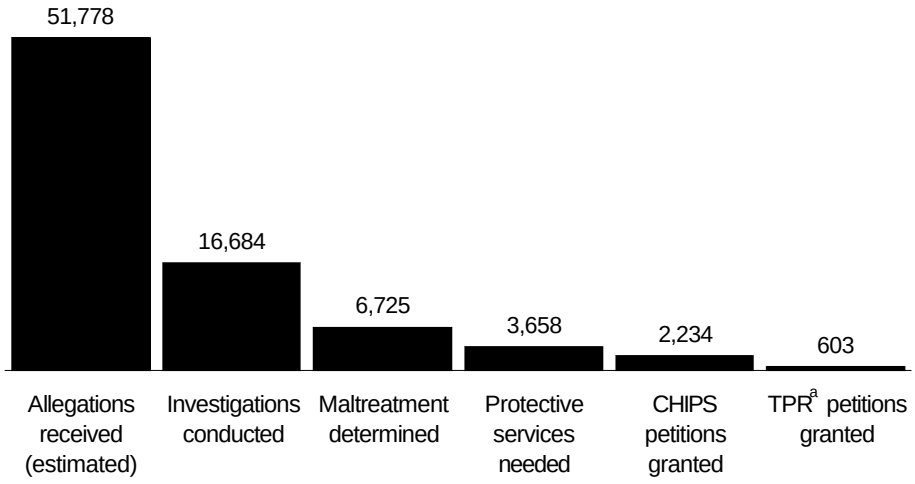
VARIATIONS IN COUNTY PRACTICES

Minnesota relies on counties more than most states to staff and pay for child protective services.

State agencies administer child protective services in most states, but in Minnesota these services are primarily administered by 84 county human services agencies.[2] In fact, Minnesota is one of only 10 states with a county-administered child protection system. Furthermore, local property tax revenues pay for the majority of Minnesota's $300 million in annual child welfare expenditures, while they pay for a much smaller percentage of child welfare costs nationwide. Minnesota laws and rules provide a framework for county services, but state definitions of maltreatment are broadly-stated and leave considerable room for county discretion.

Based on a survey of county human services directors, we estimated that Minnesota counties received about 50,000 allegations of child maltreatment in 1996. Figure 2 shows that counties investigated about one-third of these allegations statewide and "screened out" the remainder. According to our survey, the percentage of allegations investigated ranged from 20 percent or less in five county agencies to more than 90 percent in nine agencies.

Figure 2: 1996 Maltreatment Allegations, Investigations, Determinations, and Petitions



[a] Termination of parental rights.

SOURCE: Program Evaluation Division analysis of DHS and Minnesota Supreme Court data; September 1997 survey of county human services directors.

Some counties have developed written screening criteria to help articulate local interpretations of state maltreatment laws, improve consistency in decision making, and inform the public and professionals about what types of cases will be investigated. But we found that:

2 There are 87 counties in Minnesota, but one agency administers services in Lincoln, Lyon, and Murray counties, and one agency administers services in Faribault and Martin counties.

- **Fifty-two county child protection agencies (62 percent) have no written screening criteria that supplement the broad maltreatment definitions in state law.**

Counties that used screening criteria reported to us that they investigated 28 percent of the allegations they received in 1996, while counties without criteria investigated 51 percent of the allegations.

Most counties do not have written criteria that supplement the broad maltreatment definitions in state law.

During 1994-96, there were 14 reports of maltreatment investigated annually in Minnesota per 1,000 children under age 18. The rates of individual counties varied from 3 investigations per 1,000 children in Itasca County to 29 per 1,000 in neighboring Hubbard County. Variation in rates of investigation may partly reflect underlying differences in the incidence of maltreatment, but it was apparent from our interviews with county staff that variation also reflects differences in county philosophies and criteria about the types of reports that warrant investigations.

State rules require counties to begin all investigations within three days of receiving a report of maltreatment, and investigations must start sooner when children are alleged to be (1) in imminent danger or (2) victims of infant medical neglect. Information submitted by counties to DHS indicated that the state's most populous county (Hennepin) started only 44 percent of its 1994-96 investigations within three days, while the remaining counties started 91 percent of their investigations within three days.

At the conclusion of an investigation, the law requires county agencies to determine whether maltreatment occurred. Table 1 shows that counties varied considerably in their number of determined maltreatment victims per 1,000 children in the population. This partly reflects the fact that:

- **County child protection agencies differ somewhat in their definitions of what constitutes maltreatment.**

For example, some county agencies require evidence of an injury—such as a bruise—before determining that maltreatment has occurred, while other agencies do not. Some county agencies think it is acceptable for children ages seven or older to be left unsupervised, while others do not. Some counties rarely if ever determine that caregivers have caused "mental injuries," while other counties frequently—and sometimes without psychiatric or psychological diagnoses—justify maltreatment determinations on the basis of mental injury.

Following an investigation, county agencies are also required by law to determine whether the investigated family needs protective services. Families determined to need protective services must be monitored regularly by counties, and they may be offered services such as counseling, treatment, or placement of the children away from home. Statewide,

Rates of maltreatment determinations vary considerably among counties.

Table 1: Annual Determinations of Child Maltreatment Per 1,000 Children by Type of Maltreatment, 1994-96

Type of Maltreatment	Statewide Rate	Counties With Highest Rates	Counties With Lowest Rates
Physical Abuse	2.7	8.5 (Cottonwood) 8.1 (McLeod) 7.7 (Blue Earth)	0.6 (Itasca) 1.2 (Wright) 1.3 (Washington)
Sexual Abuse	0.8	2.1 (Cottonwood) 2.1 (Hubbard) 1.9 (Faribault)	0.2 (Swift) 0.3 (Scott) 0.3 (Wright)
Mental Injury	0.2	3.3 (Cottonwood) 3.0 (Blue Earth) 2.2 (Polk)	0.0 (Clay) 0.0 (Lyon) 0.0 (Mower) 0.0 (Watonwan)
Neglect	5.3	14.0 (Polk) 12.3 (Swift) 10.0 (Faribault)	1.5 (Sherburne) 2.0 (Itasca) 2.2 (Wright)

NOTE: Thirty-nine counties with fewer than 100 victims in the three-year period are excluded. Rates are based on 1995 child population estimates provided by Minnesota Planning.

SOURCE: Program Evaluation Division analysis of child maltreatment data that counties submitted to the Department of Human Services.

- **Counties determined that 21 percent of investigated families needed protective services in 1994-96, but this percentage ranged from 7 to 57 percent among counties.**

While most county human services directors told us that budget considerations did not play a role in their decisions to provide services, 71 percent of district court judges responding to our survey said that they perceived that budget considerations have at least "sometimes" affected county recommendations and actions in the past two years.

Counties may petition the court if they want children placed out-of-home involuntarily or to require families to comply with recommended services. The petitions, commonly called "CHIPS" petitions, allege that the children are in need of protection or services. We found that counties varied in the number of CHIPS petitions filed in 1994-96. For example, there were 2.7 maltreatment-related CHIPS petitions filed in the seven-county Twin Cities metropolitan area per 1,000 children, compared with 4.3 CHIPS petitions per 1,000 children in other counties.[3] Some of the variation may reflect the

3 Our analysis included "dependency and neglect" CHIPS petitions. It did not include CHIPS petitions related to juvenile status offenses.

willingness of individual county attorney offices and child protection agencies to bring maltreatment-related cases before the court.

Counties also vary in the child protection records they keep. For example, only 58 percent of county child protection agencies (accounting for 30 percent of 1996 investigations) keep logs of all of the allegations they receive. In addition, counties vary in the length of time they keep records of investigations that did not result in determinations of maltreatment or services needed. Most counties told us that the vast majority of such records from 1996 investigations were still on file in mid-1997, but 10 of the 84 county child protection agencies told us that at least 75 percent of these 1996 records were already destroyed.

INCIDENCE OF REPEATED MALTREATMENT

According to state rules, "the purpose of child protective services is to protect children from maltreatment."[4] Thus, counties not only determine whether allegations of prior maltreatment are valid, but they also aim to reduce the likelihood of future abuse or neglect.

Many families were the subject of repeated investigations or determinations.

We used data reported by counties to the Minnesota Department of Human Services (DHS) to determine the incidence of repeated investigations or maltreatment determinations within the same family. Unfortunately, it is not possible to use the DHS information system to determine whether a family with a maltreatment determination in one Minnesota county subsequently had a determination in a different county. This is a serious weakness of this system, and it means that our analysis likely understates the true incidence of repeated maltreatment statewide. In addition, we found that Hennepin County has not assigned case numbers to families in the manner prescribed by DHS, making it impossible to use the state maltreatment information system to track that county's rates of repeated maltreatment.

As shown in Table 2, we found that:

- **Twenty-nine percent of families who were the subject of maltreatment investigations in 1993 were the subject of subsequent investigations in the same county within three years.**

- **Eighteen percent of families with maltreatment determinations in 1993 had subsequent determinations of maltreatment in the same county within three years.**

4 *Minn. Rules* 9560.0210.

Table 2: Subsequent Maltreatment Investigations and Determinations Over One-, Two-, and Three-Year Periods

Type of Maltreatment Originally Investigated	Percent of Investigated Families With Subsequent Investigations In the Same County Within: 12 months	24 months	36 months	Percent of Families With Determinations That Had Another Maltreatment Determination In the Same County Within: 12 months	24 months	36 months
Physical Abuse	17%	24%	27%	11%	14%	16%
Sexual Abuse	14	20	23	7	10	15
Mental Injury	19	23	28	13	14	21
Neglect	19	29	33	13	19	22
Any Maltreatment	18	25	29	11	15	18

NOTE: The "12-month" rate is based on families that were the subject of investigations or determinations in 1995, the "24-month" rate is based on such families in 1994, and the "36-month" rate is based on such families in 1993. All results exclude Hennepin County, and the 36-month results exclude Blue Earth County.

SOURCE: Program Evaluation Division analysis of child maltreatment data submitted by counties to the Department of Human Services.

The rates of repeated maltreatment (and repeated investigation) were higher for cases that originally involved child neglect than those that originally involved physical or sexual abuse.

When counties conduct investigations, they assess families' risks of subsequent maltreatment to help determine whether there is a need for protective services. All but one county agency use a DHS-recommended risk assessment instrument to classify families as "high," "intermediate", "low," or "no" risk. DHS has not validated its risk assessment instrument by examining whether rates of subsequent maltreatment correspond to the instrument's classifications. We found that low and no risk families had lower rates of repeated maltreatment than families with higher risk classifications. However, intermediate risk families had slightly higher rates of repeated maltreatment than high risk families, even among families determined to need services. It is possible that the *types* of services provided to high risk families accounted for their lower rates of repeated maltreatment, but it is also possible that Minnesota's risk assessment instrument is not sufficiently predictive. In addition, research in other states has indicated that other risk assessment instruments may be more reliable than the type Minnesota uses.

We reviewed county child protection records in detail for about 200 families in eight counties, including many families that were the subject of two or more maltreatment investigations or determinations. Our sample of cases was not statistically representative of cases statewide, but our reviews led us to conclude that some children might be more effectively protected from repeated maltreatment. For example, some chemically dependent parents

repeatedly received "second chances," sometimes with little ongoing monitoring of their chemical use and spotty compliance with case plan requirements.

Some families may need to be monitored by agencies for longer periods.

In general, we think it is possible that children could be more effectively protected if (1) counties had more predictive risk assessment approaches, (2) the behaviors of high-risk families were monitored by child protection agencies for longer periods, (3) child protection assessments were more comprehensive, rather than focusing solely on the incidents that initially prompted the investigations, and (4) counties petitioned the courts more quickly when families failed to comply with services. Recent changes in federal and state law are intended to expedite the process of finding permanent homes for children who have been removed from their families, and it is possible that these changes could reduce the opportunities for repeated maltreatment that some families have had.

PERCEPTIONS ABOUT THE CHILD PROTECTION SYSTEM

There are limited statewide data that can be used to evaluate the performance of Minnesota's child protection system. Lacking better measures, it is useful to consider whether the people who work closely with the system believe that it is operating effectively. We surveyed several groups of professionals required by law to report instances of suspected maltreatment—pediatricians, school social workers, and heads of local law enforcement agencies. We also surveyed district court judges, who hear CHIPS petitions, and county human services directors, who administer child protective services.

"Mandated reporters" accounted for 62 percent of the reports investigated by child protection agencies in 1994-96. Consequently, it is especially important for child protection agencies to communicate effectively with these reporters and to have their confidence. We found that:

- **Large percentages of pediatricians and school social workers said they are not adequately informed about their county child protection agency's (1) criteria for investigating allegations of maltreatment, and (2) dispositions of the maltreatment reports they made.**

For example, 63 percent of pediatricians and 42 percent of school social workers statewide said that they were "sometimes, rarely, or never" adequately informed about county screening criteria for physical abuse. If the professionals who work regularly with the child protection system have limited knowledge about the criteria used by counties, we think it is safe to assume that the general public knows even less. In addition, state law requires counties to inform mandated reporters about the outcome of cases they report,

but 69 percent of pediatricians and 54 percent of school social workers said they were "sometimes, rarely, or never" informed about case dispositions.

Many pediatricians and school social workers lack confidence in the child protection system and would like child protection agencies to communicate with them more regularly.

Our surveys also indicated that:

- **Mandated reporters have concerns about the effectiveness of child protection interventions.**

About 45 percent of school social workers and 18 percent of pediatricians statewide said they have considered not reporting an instance of suspected maltreatment during the past two years because they thought the child protection agency would not respond appropriately. Failure to report suspected maltreatment is a misdemeanor under Minnesota law, so the qualms indicated by reporters reflect serious concerns.

While our surveys revealed concerns about the effectiveness of child protection interventions in various types of cases, respondents expressed particular concerns about cases involving child neglect. For instance, 54 percent of school social workers and 38 percent of pediatricians said that child protection agencies have "sometimes, rarely, or never" conducted thorough investigations of child neglect. Likewise, 41 percent of county human services directors said that law enforcement agencies "sometimes, rarely or never" give sufficient attention to investigations of child neglect. Also, 55 percent of school social workers and 45 percent of pediatricians said that child protection agencies have "sometimes, rarely, or never" taken appropriate steps to protect victims of child neglect from further harm.

Many mandated reporters also expressed concerns about inconsistent child protection decisions. Only 38 percent of school social workers and 26 percent of pediatricians said that child protection staff "always" or "usually" use consistent criteria to make decisions.

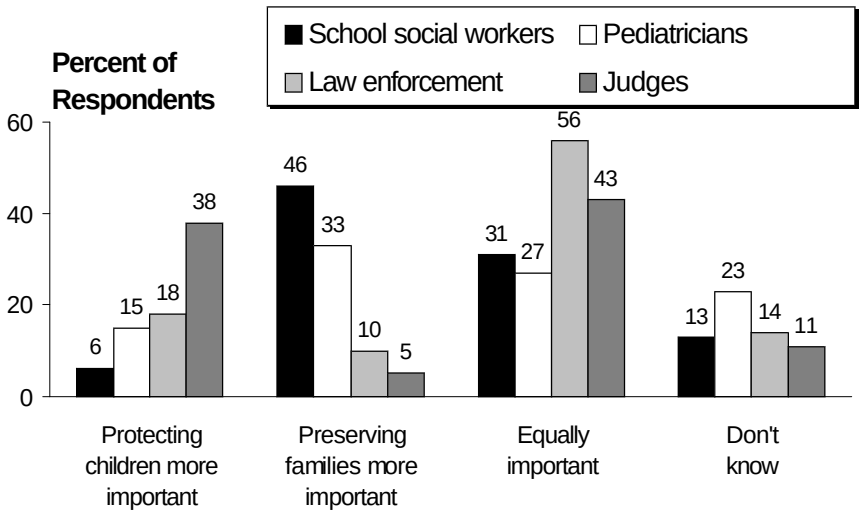
The heads of law enforcement agencies expressed greater satisfaction than pediatricians and school social workers with child protection agency investigations and interventions. For example, 91 percent of the police chiefs and sheriffs we surveyed said that child protection agencies "always" or "usually" conducted thorough investigations. Also, we found that the heads of law enforcement agencies and child protection agencies generally believe they have established cooperative working relationships with each other.

Most judges think that parents sometimes receive too many "second chances."

For the most part, Minnesota judges told us that they do not believe that child protection staff have been too intrusive in the lives of families, and they usually think that staff have pursued reasonable options before recommending child placements or terminations of parental rights. But the majority of judges told us that child protection staff "sometimes" (or more frequently) give parents too many "second chances." In other words, judges were more likely to think that child protection agencies have been too timid in their family interventions than to think they have been too aggressive.

Nationally and in Minnesota, there has been debate about the goals of the child protection system. While state rules direct child protection agencies to protect children from maltreatment, federal and state laws have also directed agencies to make "reasonable efforts" to prevent out-of-home placements and reunite placed children with their families. Our surveys asked people who work closely with county child protection agencies to characterize what they perceive to be the goals of those agencies in practice. As shown in Figure 3, school social workers and pediatricians were more likely than judges or law enforcement officials to cite family preservation, rather than protection of children, as the goal that is more important to child protection staff. Large percentages of law enforcement staff and judges said that the goals of family preservation and protection of children were equally important.

Figure 3: Perceptions About Child Protection Agencies' Goals



SOURCE: Program Evaluation Division surveys, August-September 1997 (N=385 school social workers, 225 pediatricians, 147 police chiefs/sheriffs, and 140 judges).

Finally, we asked county human services directors about the adequacy of services for families they serve. Their most often cited "unmet need" was for truancy and educational support services, with 60 percent of directors indicating that existing services have not met their needs and one-third of directors identifying it as one of their top three needs. Of the various types of maltreatment, directors most often cited child neglect (including educational neglect and other types of neglect) as the type for which services are the least adequate.

STAFFING ISSUES

The job of a child protection employee is a difficult one. Employees must make important judgments based on a wide variety of federal, state, and local laws and policies. They are also expected to work closely with the courts, law enforcement agencies, county attorneys, health professionals, school professionals, and others.

We collected information from counties in September 1997 to help us analyze child protection caseloads at that time. We examined the caseloads of staff who investigate allegations of child maltreatment, as well as the caseloads of staff who monitor families that have been determined to need protective services. We found that:

- **Statewide, there were 16 cases under investigation per full-time-equivalent (FTE) child protection investigator. Half of Minnesota counties had caseloads of 10 or more.**

- **Statewide, there were 15 cases open for protective services per FTE child protection caseworker. Half of Minnesota counties had caseloads of 18 or more.**

Child protection agencies may be understaffed.

It is possible that Minnesota child protection agencies are understaffed. A national child welfare organization has recommended that caseworkers not have more than 17 open cases and that investigators not have more than 12 cases.[5] Many of the mandated reporters we surveyed suggested to us that child protection agencies need additional staff—to work with families *before* serious crises arise and to monitor troubled families for longer periods of time following maltreatment determinations or family reunifications. In addition, we saw evidence that some child protection agencies have not fulfilled important duties, such as communicating regularly with mandated reporters and keeping up-to-date records.

We also examined the education and training of child protection staff. We found that about 32 percent of Minnesota's child protection staff have master's degrees, typically in social work. Another 67 percent have bachelor's degrees, and a majority of these employees had majored in social work. More than half (55 percent) of county child protection staff in the seven-county Twin Cities area have master's degrees, compared with only 12 percent in other counties. Twin Cities child protection staff also tend to have more experience with their current agencies, averaging about 10.6 years of experience compared with 6.5 years for child protection employees elsewhere in the state. Most county human services directors told us in a survey that they "always" or "usually" have adequate training opportunities for their staff.

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5 Child Welfare League of America, *Standards for Service for Abused or Neglected Children and Their Families* (Washington, D.C., 1988), 52.

ACCOUNTABILITY

Partly because counties' maltreatment-related records are private data, it has been difficult for the public, policy makers, and professionals who work with families to know whether the child protection system has been effective. We examined various options for improving the system's accountability.

There is little external review of child protection agencies' actions.

One option is external review of child protection agencies. State law requires DHS to "implement a method of monitoring and evaluating social services, including site visits that utilize quality control audits to assure county compliance with applicable standards, guidelines, and the county and state social services plans."[6] Although DHS reviews county social services plans, we found that DHS has not systematically monitored county compliance with state child protection regulations since 1991. An alternative type of external review could focus on the appropriateness of child protection decisions, rather than compliance with regulations. The only such state-level case review has occurred through Minnesota's child mortality review panel, which was created in 1989 but was inactive between 1995 and late 1997. External review of a county's child protection agency could be done by (1) staff from DHS or the child protection agency of a similar county, (2) citizen review boards, such as those required (but not yet implemented in Minnesota) in states by a 1996 federal law,[7] or (3) a special office created by the Legislature for this purpose—such as an ombudsman, case monitor, or inspector general. If such reviews are done, we think they should be conducted by people with a sufficient understanding of relevant laws, rules, and social work practices.

Another option for improving accountability is county agency self-monitoring and reporting. Since 1981, state law has required counties to prepare annual reports on "the effectiveness of the community social services programs in the county."[8] Counties have prepared information on the number and type of social service recipients, but most have not regularly evaluated program effectiveness. Some counties have developed useful performance measures of child welfare services for their biennial social services plans, but most counties' plans contain few measures and limited information on prior performance.

The 1997 Legislature considered but did not pass legislation to open CHIPS hearings to the public—another option for making the child protection system more accountable. Our study did not address the issue of open CHIPS hearings, but we did ask human services directors whether certain child protection agency records should be made public. Fifty-seven percent said they favor or might favor making records public in cases involving child deaths, and 39 percent said they favor or might favor opening records of cases involving serious injuries. Federal law requires states receiving federal grants

6 Minn. Stat. §256E.05, subd. 3 (e).

7 P.L. 104-235, sec 107 (c). Each state receiving more than $175,000 in federal funds annually under this act is required to establish at least three citizen review panels.

8 Minn. Stat. §256E.10, subd. 1.

to have methods of keeping child protection records confidential, but records may be released to persons "statutorily authorized by the State to receive such information pursuant to a legitimate State purpose" and states must publicly disclose "findings or information about" cases of maltreatment that result in child fatalities or near fatalities.[9]

There may be other ways to make child protection agencies more accountable, such as improved staff supervision or stronger oversight by county boards. For example, only about one-third of county human services directors said that their child protection supervisors "always or almost always" review case evidence before maltreatment determinations are made. In addition, county policies for screening child protection cases have usually not been a subject of public discussion.

RECOMMENDATIONS

State rules should have clearer maltreatment definitions.

Child protection agencies throughout the nation make critically important decisions in the lives of families. In Minnesota, however, they do so with limited guidance in state laws and rules, considerable reliance on local property taxes, and little oversight by state government or others. The result is a system of widely varying practices and standards, sometimes operating without the full confidence of the public or the professionals who make many reports of maltreatment.

County variation can reflect differences in community norms and differences in local willingness or ability to pay for services. But variation sometimes reflects different interpretations of state laws and rules. In our view, these laws and rules provide insufficient direction to counties, and the definitions of maltreatment should be a topic of greater public discussion. We recommend:

- **The Legislature should require DHS to adopt rules that define various types of maltreatment in more detail than current law. The Legislature should authorize individual counties to implement more detailed definitions or criteria that indicate which allegations to investigate, provided these policies are consistent with state rules and approved by the county board.**

Alternatively, the Legislature could require each county board to adopt its own maltreatment definitions to reflect local standards, without requiring definitions in state rules. But our survey of county human services directors indicated that 61 percent favored additional guidance in state rules about circumstances or evidence that justify a determination of maltreatment, and another 22 percent said they might favor such guidance. DHS should also consider developing training materials (and perhaps rules) that help child protection investigators evaluate the credibility of evidence and make decisions when evidence is conflicting.

9 P.L. 104-235, sec. 107 (b) (2) (A) (v, vi).

Counties should keep "mandated reporters" better informed.

We think steps should be taken to help mandated maltreatment reporters regain confidence in the child protection system. In general, counties should place a higher priority on keeping mandated reporters informed about the cases they initially reported and the counties' criteria for decisions. But we also recommend:

- **The Legislature should require each county child protection agency to periodically inform mandated reporters who work in the county about state maltreatment definitions, plus any supplemental definitions or screening policies adopted by the county board.**

We think there may be times when mandated reporters could better serve children and families if they received information from the child protection agency *in addition to* case disposition information. For instance, school social workers might be better able to help children if they knew the status of a county investigation involving a family, the county's assessment of a family's strengths and problems, or whether a family has been complying with case plan requirements. We recommend:

- **The Legislature should authorize county child protection agencies to provide certain mandated reporters with selected case information (other than case dispositions) that is classified as private data.**

To reduce the incidence of repeated maltreatment in Minnesota, it may be necessary to improve the way that child protection agencies assess families that are referred to them. Research has raised questions about whether the risk assessment instrument used by nearly all Minnesota counties is the most valid, reliable instrument available. We recommend that:

- **DHS should establish a task force of county and state officials to consider during 1998 whether to revise Minnesota's approach to child protection risk assessment.**

There is a need for better interventions in cases of child neglect.

We think there is a need for county human services agencies to respond more effectively to cases involving child neglect. Several states are experimenting with alternative ways to respond to maltreatment reports. For instance, "dual track" child protection systems are based on the philosophy that some allegations require "investigations" that focus on whether maltreatment occurred while others (such as neglect cases) require less adversarial "assessments" of families' needs and perhaps an offer of services. According to our survey, 85 percent of county human services directors favor or might favor such a system. The 1997 Legislature authorized county pilot projects to explore the feasibility of alternative methods of handling maltreatment allegations, and we think the Legislature should closely monitor their results. It is possible that these approaches could provide stronger assistance to families and perhaps allow counties to redirect some resources from investigations to services.

Earlier, we noted that there are probably steps that county agencies and courts could take to more effectively protect children from repeated maltreatment—such as longer home monitoring of parents with chemical problems who have neglected their children. In our view, these actions do not necessarily require changes in state law, although they would require continuing commitment and diligence by counties, the courts, and others. Improved case monitoring by counties and courts might also require additional resources.

Because the courts and counties sometimes terminate their involvement with families once the goals of case plans have been met, it might be helpful for state rules and laws to clarify the authority of counties to provide continued monitoring of certain families. For example, it may be reasonable to monitor for extended periods the behavior of caregivers with histories of repeated chemical abuse or maltreatment—as a way of better ensuring the children's safety. We recommend:

- **The Legislature should require the protective services case plans authorized by *Minn. Stat.* §260.191, subd. 1e (in CHIPS cases) and *Minn. Rules* 9560.0228 (in cases where counties have determined a need for protective services) to address the need for continued monitoring of families by child protection agencies once the families have completed the services required in their case plans.**

There is no way to guarantee that counties and courts will always make decisions that protect the best interests of children, but there are several options for improving accountability for these decisions. At a minimum, we recommend:

The Legislature and DHS should take steps to improve accountability.

- **The Department of Human Services should present to the Legislature by January 1999 a plan for periodic, external reviews of (1) county compliance with state requirements, and (2) the appropriateness of decisions made by county child protection agencies in selected individual cases.**

- **The Legislature should direct DHS to establish a "performance measurement task force" of state and county officials to identify by January 1999 (1) statewide measures of the performance of child welfare services, and steps needed to collect reliable information on these measures, and (2) potentially useful practices that individual counties could use to monitor and evaluate child welfare services.**

- **The Legislature should amend state law to require that the determinations made in all investigated cases be reviewed and approved by a county child protection supervisor.**

- **Consistent with federal requirements, the Legislature should require state and local child mortality review panels to review "near fatalities" in addition to child deaths. Also, the Legislature**

should amend the statutory purpose of the panels to include examining, to the extent possible, whether public agencies took appropriate actions in individual cases. The Legislature should adopt policies (perhaps with input from the state child mortality review panel) for making public the child protection records in cases involving death or near death, including policies that indicate types of information that should *not* be made public.

Some records are destroyed too quickly.

In our view, some records of child protection investigations are destroyed too quickly. In many investigations, county staff are unable to assemble the preponderance of evidence required to determine that maltreatment occurred, yet there remains the possibility that it did. A record of these investigations can help county agencies if new evidence on these cases emerges, or if they investigate the same family for subsequent allegations. Such records can also help external reviewers evaluate an agency's decisions. We think that records of cases that did not result in a determination of maltreatment should continue to be classified as private data, but we recommend that:

- **The Legislature should require counties to keep for four years the records of investigations that did not result in determinations of maltreatment or services needed. It should authorize counties to share these records with other counties conducting investigations of the same family members, upon the counties' request.**

In addition, we recommend that:

- **DHS should regularly audit the accuracy of maltreatment data reported by counties.**

- **Hennepin County should revise its case numbering system so that DHS and others can track instances of repeated maltreatment within families.**

Finally, we think the Legislature should consider whether state financial support has been adequate for child protective services. Some Minnesota counties have difficulty adequately serving families for which they have documented abuse or neglect, and many also have difficulty finding resources to serve troubled families *before* children are harmed. Most state governments have played a more direct role in providing and paying for these services than has Minnesota's. In light of Minnesota's unusually high reliance on property taxes to pay for child welfare services, the Legislature should consider ways that state government could financially help counties if it concludes that there is a need to expand child welfare services or reduce child protection caseloads.

Introduction

Minnesota's child protective services system makes important decisions about whether (and how) government should intervene in families' lives to protect the interests of children. For example, child protection agencies decide which allegations of child maltreatment to investigate, whether maltreatment occurred, and whether protective services should be offered. They also decide whether to initiate court actions that may lead to out-of-home placement or termination of parental rights.

There is limited public scrutiny of child protection decisions.

Despite the importance of these decisions, most are made with limited public scrutiny. The records of county child protection agencies are private, so staff from these agencies cannot publicly discuss details of cases that would identify the individuals involved. This can be frustrating for the public and elected officials, who want assurances that agencies are making appropriate decisions. It can also be frustrating for agency administrators, who want to explain the actions of their staff.

In May 1997, the Legislative Audit Commission asked us to evaluate child protective services in Minnesota. In our research, we asked:

- **How much variation is there among counties in the incidence of child maltreatment investigations, determinations, services, and court cases? To what extent do differences in county policies and practices explain these variations?**

- **To what extent do persons required by state law to report suspected maltreatment believe that Minnesota's child protection system responds appropriately to their concerns?**

- **To what extent does maltreatment occur repeatedly within the same families? Are there additional steps that child protection agencies could take to reduce the risk of repeated maltreatment?**

- **How large are the caseloads of child protection workers? What types of education and experience do these workers have, and how much staff turnover is there?**

- **Is Minnesota's child protection system sufficiently accountable to the public?**

An effective child protection system relies on many people and agencies.

An effective child protection system relies on the efforts of many people and agencies, including "mandated reporters" of child maltreatment, county child protection agencies, county attorneys, the courts, law enforcement agencies, and providers of support services. In addition, relatives, neighbors, and the community at large bear a responsibility for reporting instances of suspected maltreatment and providing support to families in trouble.

Our study focused considerable attention on the role of county child protection agencies, for several reasons. First, according to state rules, the purpose of these agencies is "to protect children from maltreatment."[1] Child protection agencies become involved with families from the earliest allegations of maltreatment, and they often remain involved if the families receive services or are brought to court. Second, at the outset of our study, legislators told us they were interested in finding out more about the practices of child protection agencies. Third, because a 1997 report by a Supreme Court task force addressed many issues related to child permanency planning, foster care, and adoption, we focused our research primarily on issues related to maltreatment reports, investigations, and services.[2]

We conducted several surveys and reviewed county records of child protection cases.

To document the perceptions of people who work closely with the child protection system, we surveyed five important groups of Minnesota professionals in the summer of 1997.[3] We surveyed all pediatricians, as well as a systematic sample of school social workers—two groups of professionals who are required by law to report suspected maltreatment. We also surveyed police chiefs and sheriffs of cities and counties with over 10,000 residents because law enforcement staff work closely with child protection agencies on case investigations. In addition, we surveyed those district court judges whose cases in the previous two years included at least five petitions involving children in need of protection or services (also known as "CHIPS" petitions). We asked all of the surveyed professionals to respond on the basis of their own experiences during the previous two years.

In addition, we conducted two surveys of county human services directors—in June and September 1997. We used these surveys to obtain information about county policies and practices, as well as staff training, experience, and job duties. In addition, we asked respondents for their opinions about service availability and ways to better protect children.

We visited eight counties (Beltrami, Blue Earth, Dakota, Hennepin, Olmsted, Polk, Ramsey, and St. Louis) and reviewed the child protection files of about 200 families. The cases we reviewed did not comprise a statistically

1 *Minn. Rules* 9560.0210.

2 *Final Report: Minnesota Supreme Court Foster Care and Adoption Task Force* (St. Paul, January 1997).

3 A summary of the survey responses is available upon request from the Office of the Legislative Auditor.

representative sample of cases statewide, but they provided us with a useful indication of the types of cases handled, the basis for decisions, and the services provided.[4] We also interviewed supervisors and line staff during our site visits, and we examined employee training records. We made numerous other contacts with child protection agency staff by phone, and we also discussed child protection issues with state officials, advocacy groups, guardians *ad litem*, researchers, and others.

To help us evaluate variations in county practices, we used information from the statewide child maltreatment database maintained by the Minnesota Department of Human Services (DHS). Data in this system are supplied to DHS by counties and are not systematically verified for accuracy. While conducting our research, we found errors in some of the data—of particular importance, see our discussion of child deaths in Chapter 1.[5]

We hope this report provides a useful overview of child protective services in Minnesota. Chapter 1 describes how the system works and outlines recent trends in the number of maltreatment cases. Chapter 2 discusses variation in county practices and maltreatment determinations. Chapter 3 examines the rates of repeated maltreatment of children and discusses cases in which repeated maltreatment occurred. Chapter 4 documents perceptions of mandated reporters, judges, law enforcement officials, and county administrators about the child protection system. Chapter 5 examines child protection caseloads, as well as staff training and experience. Chapter 6 discusses options for improving public accountability of the child protection system, and Chapter 7 offers recommendations for system improvements.

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4 For each of the counties we visited, we identified random samples of cases investigated in 1995 in each of the following categories: (1) families with two or more determinations of maltreatment or services needed during 1995; (2) families with at least two maltreatment investigations during 1995—the first not resulting in a determination of maltreatment and a subsequent investigation resulting in a determination of maltreatment or services needed; (3) families for which maltreatment was determined but the county did not find a need for protective services; (4) families for which the county determined that services were needed but did not find that maltreatment occurred; (5) families in which court-ordered out-of-home placements were made; and (6) cases investigated due to the death of a child. We reviewed 1995 to 1997 records for these cases, and we usually reviewed at least some records prior to 1995, where applicable. In addition to these cases, we reviewed several cases that had been the subject of recent public concern.

5 We observed that much of the information in the case files of counties we visited was consistent with data in DHS' maltreatment database, but we did not systematically verify data consistency for a representative sample of cases.

Background

CHAPTER 1

Child physical abuse did not receive widespread attention in the United States until a 1962 medical journal article discussed patterns of suspicious injuries in children.[1] By 1966, all 50 states had passed laws requiring certain professionals to report cases of suspected child maltreatment. As reporting of maltreatment increased, states developed systems to support their child protection responsibilities. We asked:

- **What federal laws have affected the development of states' child protection systems?**
- **How does Minnesota's system of maltreatment reporting, investigating, and services operate? What are the roles of county child protection agencies, and how is the system funded?**
- **Have investigations and determinations of child maltreatment increased in recent years? What is known about the characteristics of maltreatment victims and perpetrators?**

KEY FEDERAL LAWS

Federal law establishes a framework for state child protection systems.

The first major federal legislation addressing child maltreatment was the Child Abuse Prevention and Treatment Act of 1974. A noteworthy feature of the act was a definition of maltreatment that included more than physical abuse. Specifically, it defined child abuse and neglect as "the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of 18 by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby."[2] The act required states to develop procedures for receiving and investigating reports of abuse and neglect and providing immunity from prosecution for persons who were mandated by state laws to report maltreatment. The act also provided federal funding for state projects related to maltreatment prevention, identification, and services.

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1 C. H. Kempe, F. N. Silverman, B. F. Steele, W. Droegemueller, and H. K. Silver, "The Battered Child Syndrome," *Journal of the American Medical Association* 18, no. 1 (1962): 17-24.

2 *Child Abuse Prevention and Treatment Act of 1974 (CAPTA)*, P. L. 93-247, sec. 3.

In 1980, Congress passed the Adoption Assistance and Child Welfare Act.[3] As a condition of receiving expanded federal funding, the act required states to implement "permanency planning" for children placed out-of-home. Such planning was intended to ensure prompt decisions about whether the children should return to the homes of their natural parents or be placed permanently with other families. In addition, the act required that "reasonable efforts" be made in each case to (1) prevent or eliminate the need to remove children from their home, or (2) enable children to return home. Thus, the act placed an emphasis on preserving families, whenever possible. The 1980 act also provided financial incentives for states to implement procedural reforms (such as case planning and periodic case reviews) and develop improved information systems.

In 1993, Congress authorized nearly $1 billion over a five-year period for expanded family preservation and support services in states. "Family preservation" programs typically serve families in which children have been maltreated or have been identified as a danger to themselves or others. "Family support" programs include a broad array of community services that have the general goal of preventing child maltreatment.[4]

A 1997 law modified the federal government's prior emphasis on family preservation.

In late 1997, Congress passed legislation that significantly modified the policy framework that had been established in 1980.[5] The act declares that "in determining reasonable efforts [to preserve families], . . . the child's health and safety shall be the paramount concern."[6] The act cites various circumstances in which it is not necessary to make "reasonable efforts" to keep families intact, such as cases in which the parent has caused serious injury to the child through abandonment or torture or has had parental rights to the child's sibling involuntarily terminated. When a child has been in foster care for 15 of the previous 22 months, the act requires states to file petitions to terminate parental rights unless the state has placed the child with a relative, has not provided appropriate services to the family, or has determined that such a petition would not be in the child's best interest.

One other major federal law affecting child protective services is the Indian Child Welfare Act (ICWA). Congress passed this act in 1978 to address the specific needs of American Indian children involved in placement and custody proceedings. Congress felt that too many American Indian families were being broken up "by the removal, often unwarranted, of their children . . . by nontribal public and private agencies."[7] ICWA requires states to involve the tribe of which a child is a member (or eligible for membership) in court proceedings. It also requires social services agencies to meet different and arguably higher standards of effort and proof in cases recommending placement of American Indian children than is required in cases involving

3 *Adoption Assistance and Child Welfare Act of 1980,* P. L. 96-272.

4 U.S. General Accounting Office, *Child Welfare: States' Progress in Implementing Family Preservation and Support Services* (Washington, D.C., February 1997), 4.

5 P. L. 105-89, signed by President Clinton in November 1997.

6 P. L. 105-89, sec. 101.

7 *Indian Child Welfare Act of 1978 (ICWA),* P. L. 95-608, sec. 2 (4).

non-Indian children. In cases where an American Indian child is removed from the home, ICWA directs states to place the child in the following order of preference: (1) with a member of the child's extended family, (2) in a foster home approved by the child's tribe, (3) in an Indian foster home licensed by a non-Indian authority, or (4) in an institution approved by an Indian tribe or operated by an Indian organization.[8] A 1991 federal law was passed to improve the reporting of child abuse on Indian reservations and to provide funding to tribes for the treatment of victims of child abuse and the development of tribal child protection and family violence prevention programs.[9]

MINNESOTA'S CHILD PROTECTION SYSTEM

Minnesota law seeks to "protect children whose health or welfare may be jeopardized through physical abuse, neglect, or sexual abuse," and "to assure that all children live in families that offer a safe, permanent relationship with nurturing parents or caretakers."[10] In addition, state policy aims toward "preventing the unnecessary separation of children from their families by identifying family problems, assisting families in resolving their problems, and preventing breakup of the family if it is desirable and possible" and "restoring to their families children who have been removed, by continuing to provide services to the reunited child and the families."[11] To achieve these ends, Minnesota has developed a process for receiving and investigating reports of suspected child abuse and neglect, providing services when appropriate, and pursuing court involvement when necessary.

Receiving and Investigating Reports

The Legislature passed Minnesota's first maltreatment reporting law in 1963.

In 1963, the Minnesota Legislature passed a law requiring the reporting of child maltreatment. This law required health care professionals to report to law enforcement "injuries or evidence of injuries appearing to arise from the beating or similar maltreatment of any minor under the age of 16 years."[12]

Since that time, the Legislature has expanded the types of maltreatment covered by law and increased the number of professions required to report maltreatment. Today maltreatment includes physical abuse, sexual abuse, and neglect, as defined in Figure 1.1. Professionals identified as mandated reporters include those in the fields of health care, education, child care, law

8 A federal law was passed in 1996 to prevent discrimination in the placement of children based on race, color, or national origin, but it does not apply to ICWA cases. P. L. 104-188, sec. 1808.

9 *Indian Child Protection and Family Violence Prevention Act of 1991*, P.L. 101-630.

10 *Minn. Stat.* §626.556, subd. 1 and *Minn. Stat.* §256F.01.

11 *Minn. Stat*. §256F.01, (1) and (2).

12 *Minn. Laws* (1963), ch. 489. Professionals listed are, "every physician, every surgeon, every person authorized to engage in the practice of healing, every superintendent or manager of a hospital, every nurse and every pharmacist."

Figure 1.1: Definitions of Child Maltreatment

Physical abuse: "Any physical or mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's history of injuries, or any aversive and deprivation procedures that have not been authorized [in statute]." Mental injury is "an injury to the psychological capacity or emotional stability of a child as evidenced by an observable or substantial impairment in the child's ability to function within a normal range of performance and behavior with due regard to the child's culture."

Sexual abuse: "The subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child . . ., or by a person in a position of authority . . ." to sexual penetration, sexual contact, sexual performances, or prostitution. "Sexual abuse includes threatened sexual abuse."

Neglect: "Failure by a person responsible for the child's care to supply a child with necessary food, clothing, shelter, or medical care when reasonably able to do so, failure to protect a child from conditions or actions which imminently and seriously endanger the child's physical or mental health when reasonably able to do so, or failure to take steps to ensure that a child is educated in accordance with state law . . ." Medical neglect and prenatal exposure to a controlled substance for a non-medical reason also are considered neglect.

SOURCE: *Minn. Stat.* §626.556, subd. 2 (a), (c), (d), and (k).

Certain professionals are mandated by law to report maltreatment.

enforcement, and social services, and members of the clergy. A mandated reporter who "knows or has reason to believe" that maltreatment is occurring or occurred in the previous three years must report it. A citizen may voluntarily make a report if he or she "knows, has reason to believe, or suspects" that maltreatment is occurring.[13]

According to data collected by the Minnesota Department of Human Services:

- **Mandated reporters have accounted for more investigated maltreatment reports to local social service agencies than voluntary reporters.**

Between 1994 and 1996, 62 percent of investigated reports came from a mandated reporting source, and 39 percent of reports came from a non-mandated source. Table 1.1 shows a summary of investigated reports by source. (The terms "investigation" and "assessment" are often used interchangeably by counties; this report usually uses the term "investigation.")

13 Minn. Stat. §626.556, subds. 3 (a) and (b).

"Mandated" reporters account for most maltreatment allegations that are investigated.

Table 1.1: Source of Investigated Reports, 1994-96

Source of Report	Percent of Reports[1]
Mandated reporters	62%
School personnel	22
Law enforcement	16
Health professionals	14
Social service providers	8
Other mandated reporters	4
Voluntary reporters	39%
Parents and relatives	18
Acquaintances	11
Other voluntary reporters	12

[1]Percentages add to more than 100 percent because social service agencies can indicate more than one source per report.

SOURCE: Program Evaluation Division analysis of child maltreatment data submitted by counties to the Department of Human Services.

Figure 1.2 illustrates the process that occurs following receipt of a report by a child protection agency. When a law enforcement or local child protection agency receives a report of alleged maltreatment, the receiving agency must notify the other agency of the report, orally and in writing, within 24 hours. State law requires child protection agencies to immediately conduct an investigation of any maltreatment report received. The local social services agency must coordinate its investigation with law enforcement if law enforcement is conducting its own investigation.[14]

State rules require the child protection agency to "screen" reports to determine whether a child protection investigation should be done. The agency is required to investigate a report if the alleged incidents in the report constitute maltreatment, the report contains enough identifying information to proceed with an investigation, and the incident in the report has not already been investigated by the agency.[15]

According to state rules, a child protection agency must investigate a report immediately if the report alleges that a child is in "imminent danger" or is the victim of infant medical neglect.[16] Imminent danger exists when a child "is threatened with immediate and present maltreatment that is life threatening or likely to result in abandonment, sexual abuse, or serious physical abuse."[17] Investigations of other reports must begin within one working day, although

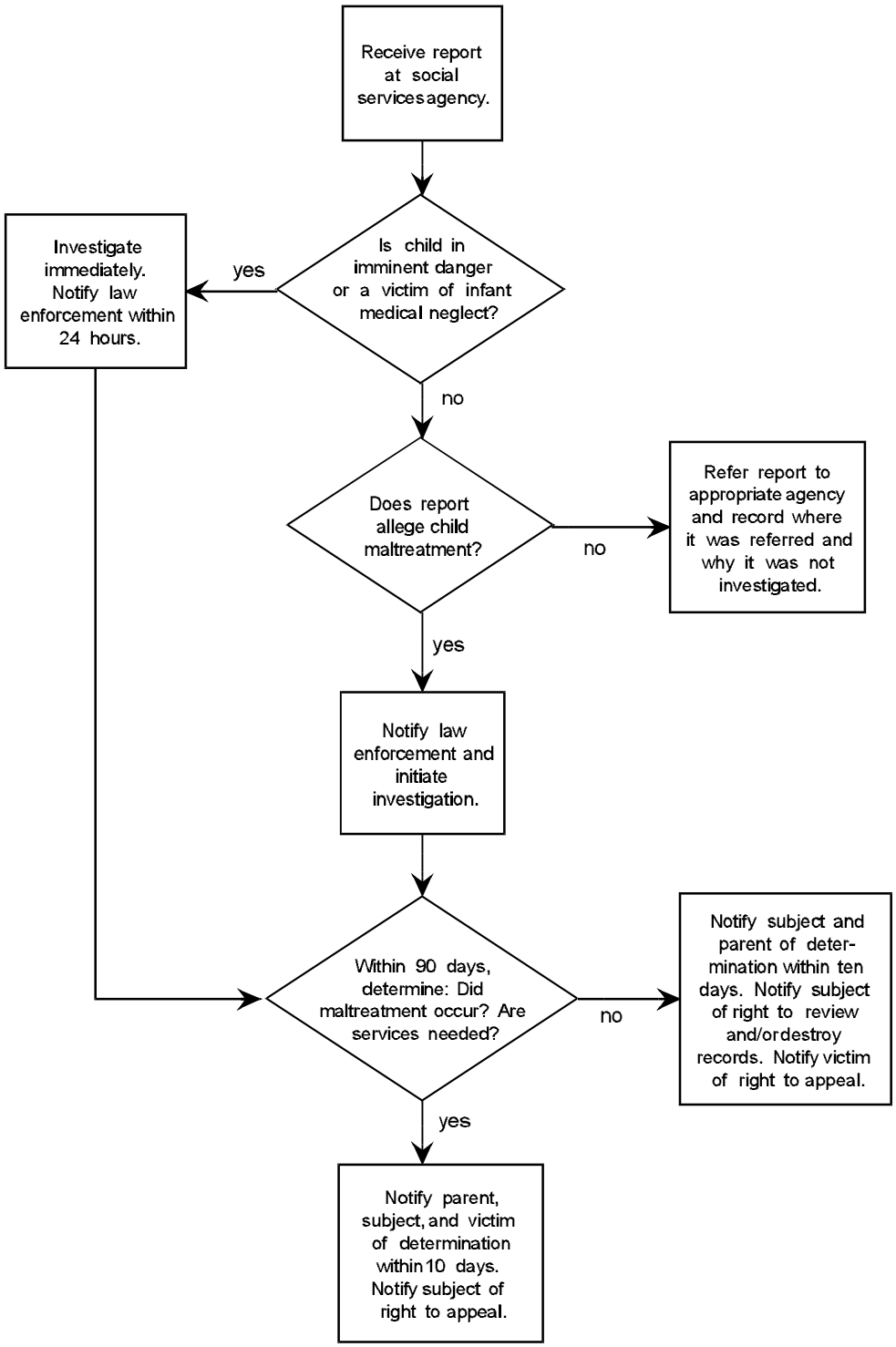
14 Minn. Stat. §626.556, subds. 3 (a) and 10 (a), and *Minn. Rules* 9560.0220, subp 2.

15 Minn. Rules 9560.0216, subp. 3.

16 Minn. Rules 9560.0216, subp. 5.

17 Minn. Rules 9560.0214, subp. 12.

Figure 1.2: Initial Steps in Minnesota's Child Protection Process



the agency can delay initiating an investigation for up to 72 hours if it believes the child is not in imminent danger and more serious reports need to be investigated.[18]

During its investigation, the local child protection agency is authorized to interview the alleged victim and perpetrator, the alleged victim's parents and siblings, and other individuals who may be able to provide relevant information (e.g., teachers and relatives). The agency also may refer to prior reports of maltreatment and medical records of the child. According to the Department of Human Services' most recent social services manual, an investigation should be completed within 90 days of the initial report.[19]

At the conclusion of its investigation, the child protection agency must determine (1) if child maltreatment has occurred, and (2) whether the family needs protective services (see Figure 1.3).[20] We found that:

- **Maltreatment was determined by county child protection agencies in 40 percent of 1994-96 investigations statewide. Agencies determined that protective services were needed in 21 percent of investigated cases.**

Child protection agencies make two determinations at the conclusion of each investigation.

Figure 1.3: Determinations After a Child Maltreatment Investigation

1. **Has maltreatment occurred?**

   A decision that maltreatment has occurred must be based on a "preponderance of evidence that a child is a victim of maltreatment and the maltreatment was caused by the act or failure to act of a person within the family unit who is responsible for the child's care.[1]"

2. **Are child protective services needed?**

   A finding that child protective services are needed means "the local welfare agency has documented conditions during the . . . investigation sufficient to cause a child protection worker . . . to conclude that a child is at significant risk of maltreatment if protective intervention is not provided and that the individuals responsible for the child's care have not taken or are not likely to take actions to protect the child from maltreatment or risk of maltreatment."[2]

[1] *Minn. Rules* 9560.0220, subp. 6.A.

[2] *Minn. Stat*. §626.556, subd. 10e (b).

18 Minn. Rules 9560.0216, subp. 5.C.

19 Minnesota Department of Human Services, *Social Services Manual* (St. Paul, 1989 revision), XVI-4340.

20 Minn. Stat. §626.556, subd. 10e.

In about 23 percent of 1994-96 investigations, agencies determined that maltreatment occurred but no protective services were needed. Below are examples of such cases:

- In October 1995, a child protection agency received a report from a school employee that an 11-year-old boy had a bruise that he attributed to his father slapping him. After speaking to the boy and his mother and observing the bruise, the child protection worker determined that maltreatment had occurred. The mother had a court order for protection against the father, which she had allowed him to violate the night of the incident. Since the order was still in force and the father was out of the home, the agency determined that no services were necessary, but the child protection worker warned the mother that future reports of abuse by the father could result in an allegation that the mother neglected the children.

- A child protection agency received a report that a single mother left her two children, ages 7 and 10, alone for an hour in the evening. The child protection worker determined that maltreatment occurred and told the mother about the county's criteria for supervision. The mother arranged for a baby-sitter for future evenings when she would not be home and the child protection worker called the baby-sitter to confirm the arrangement. Since supervision was expected to be provided in the future, the agency determined there was no need for services.

In about 4 percent of 1994-96 maltreatment investigations, counties determined that protective services were needed but made no determination of maltreatment. Examples of this type of case include the following:

- In December 1995, a child protection case was opened for a newborn child without a finding of maltreatment. The mother had a history of drug use and her parental rights to five older children had been terminated earlier in the year.[21] The child protection agency developed a case plan that required chemical dependency treatment, aftercare, and the mother's demonstration of her ability to provide for the child's needs for three months after reunification.

- A day care provider observed bruises and scratches on a boy when she was changing his diaper. The boy said his mother did it. When the child protection worker interviewed the boy later, he refused to say how he got scratched and two of his siblings gave conflicting accounts of how the boy got the marks. The mother denied hitting her children. The county offered services because of the mother's "questionable parenting skills" even though physical abuse was not determined.

21 According to *Minn. Stat*. §260.015, subd. 2a (13), a child may need protection or services if the child's "custodial parent's parental rights to another child have been involuntarily teminated within the past five years."

According to Minnesota law, the local social services agency has ten working days from the conclusion of its investigation to inform the child's parent or guardian and the alleged perpetrator of the determinations made, including the specific reasons for the determinations.[22] Unless doing so is not in the best interests of the child, the local social services agency is directed by law to inform mandated reporters of the disposition of any case they report, and to provide non-mandated reporters with a "concise summary" of the disposition of a report upon request of the reporter.[23]

County determinations may be appealed.

Under a law passed in 1997, the alleged perpetrator may request in writing that the local social service agency reconsider a determination that maltreatment occurred. If the local agency refuses to reconsider the determination, or does not reconsider it within 15 days, the individual may submit a request for a hearing to the Commissioner of the Department of Human Services. The alleged victim's designee may appeal to the local social service agency its determination of maltreatment, regardless of the determination. There is not a provision for the child's designee to request a hearing.[24]

Services

When a county social service agency determines that child protective services are needed, state rules specify, in order of preference, that the agency (1) provide services to the family while the alleged victim remains in the home, (2) seek the removal of the alleged offender from the home, or (3) seek the removal of the alleged victim from the home.[25]

If a county agency determines that protective services are needed, the agency must develop a plan for services with the family and other appropriate individuals within 60 days of its determination.[26] Some services that may be provided by local agencies directly or by contract are listed in Figure 1.4.

As part of its "case management" responsibilities, the county is required to arrange, monitor, and evaluate the services provided for in the plan. The agency must terminate services to a family when the family (1) has accomplished the goals in its case plan and no longer needs services or

22 Minn. Stat. §626.556, subd. 10f. *Minn. Rules* 9560.0230, subp. 5, does not state that the letter to the alleged offender and the child's parent or guardian should contain the specific reasons the determination was made.

23 Minn. Stat. §626.556, subd. 3 (d). *Minn. Rules* 9560.0226, subp. 2, states that the summary to mandatory reporters should indicate whether maltreatment was determined, the nature of the maltreatment, the name of the person who investigated the report, and a description of the services being provided.

24 Minn. Laws (1997), ch. 203, art. 5, secs. 6 and 29.

25 Minn. Rules 9560.0220, subp. 8.B.

26 Minn. Rules 9560.0228, subp. 2. The plan must indicate the reason services are being provided, the services that will be provided, the tasks and goals expected of the family members, the consequences to the family if the goals are not achieved, the tasks expected of child protection staff, and the date of the quarterly review.

Counties develop case plans for families needing protective services.

Figure 1.4: Examples of Child Protective Services

- Assessment (e.g., chemical dependency, mental health, sex offender)
- Case management
- Day care
- Family counseling
- Individual counseling
- Life management skills education
- Parenting education
- Public health nurse visits
- Treatment

(2) has not achieved its goals but there is not enough evidence to pursue court action ordering involuntary services.[27]

If a county social services agency determines that a family needs services and the family will not voluntarily accept them, the agency must ask the county attorney to file a petition in court to order the family to accept services.[28] Such petitions are called "CHIPS" (children in need of protection or services) petitions. Upon receiving a CHIPS petition, the court schedules a hearing in which the agency, the child's parents, and certain others can participate. The court may:

- place the child under protective supervision of the local social services agency while the child remains in the home and the family receives any needed social services;
- transfer legal custody to the local social services agency, thereby permitting the agency to place the child outside the home;
- order the child's parent or guardian to provide special treatment or care needed by the child;
- order a child 16 years or older to be allowed to live independently;
- dismiss the petition if it is not within the court's jurisdiction or if the allegations in the petition have not been proven; or

27 Minn. Rules 9560.0228, subp. 6.

28 Minn. Rules 9560.0220, subp. 8.C.

- continue the case for up to 90 days if the allegations in the petition have been admitted or proven.[29]

According to law, the court must base its decisions on the best interests of the child, clear and convincing evidence supporting the CHIPS petition, and whether the county social services agency made "reasonable efforts" to keep the child with (or return the child to) his or her family.[30]

Counties may file court petitions when families refuse to comply with recommended services.

If the court grants the petition, the agency, family, and others as appropriate develop a case plan for the family. State law requires the court to review court-ordered out-of-home placements at least every six months. The court must hold a hearing to determine the permanent placement of the child within 12 months of out-of-home placement. The Legislature passed a law in 1997 that requires that the 12-month period begin the first day of court-approved voluntary placement or the first day of court-ordered placement, whichever is first, and count cumulatively all days the child has spent in out-of-home placement in the previous five years.[31] At a permanency hearing the court determines how the best interests of the child would be served. For example, the court may decide that the child should be returned home or that the parents' rights to the child should be terminated so the child may be placed for adoption.

Through the Minnesota Indian Family Preservation Act (MIFPA), Minnesota incorporates and expands on the federal Indian Child Welfare Act's directives for handling child protection cases involving American Indian children.[32] MIFPA requires child protection agencies to notify an Indian child's tribe if the child could be placed and needs the involvement of the child protection agency for more than 30 days. Under a law passed by the Legislature in 1997, official tribal representatives were given a right to participate in court proceedings involving ICWA cases.[33]

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29 Minn. Stat. §260.191, subds. 1 and 4; *Minn. Stat.* §260.181, subd. 1.

30 Minn. Stat. §260.011, subd. 2 (a), *Minn. Stat.* §260.155, subd. 1 (a), and *Minn. Stat.* §260.012 (c) as amended by *Minn. Laws* (1997), ch. 239, art. 6, sec. 13. "Reasonable efforts" are "(1) relevant to the safety and protection of the child; (2) adequate to meet the needs of the child and family; (3) culturally appropriate; (4) available and accessible; (5) consistent and timely; and (6) realistic under the circumstances. In the alternative, the court may determine that provision of services or further services for the purpose of rehabilitation is futile and therefore unreasonable under the circumstances."

31 Minn. Stat. §260.191, subds. 3a (a) and 3b (a) as amended by *Minn. Laws* (1997), ch. 239, art. 6, sec. 26. If a child's cumulative time out-of-home includes time under previous CHIPS petitions, the court may extend the time out of the home under the current petition before a permanency determination up to six months if it is in the best interests of the child. If a child has been in voluntary placement for 90 days, *Minn. Laws* (1997), ch. 239, art. 6, sec. 6, requires social services agencies to return the child to his or her home or petition the court for a 90-day extension of voluntary placement.

32 Minn. Stat. §§257.35-257.3579.

33 Minn. Stat. §257.352, subd. 2 and *Minn. Laws* (1997), ch. 239, art. 6, sec. 18.

Administration and Funding

Child protective services in Minnesota are administered by 84 county social services agencies.[34] We found that:

- **Minnesota is one of only 10 states with a county-administered child protection system.**

Unlike most states, Minnesota's child protective services are administered by county employees and funded mainly with property taxes.

In most states, child protective services are provided by state employees, often working out of field offices throughout the state. The states with county-administered child protective services are Minnesota, California, Colorado, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Virginia, and Wisconsin.

A second difference between Minnesota and other states is that:

- **Minnesota's social services system is funded with local property taxes more than most states' systems.**

Because child protective services in most states are provided by state employees, state appropriations are typically a much larger revenue source than local revenues. According to data gathered in 31 states by the American Public Welfare Association, federal funds accounted for 46 percent of total fiscal year 1990 social services expenditures, state funds accounted for 41 percent, and local funds accounted for 13 percent.[35] In Minnesota, however, county property tax revenues paid for 57 percent of total child welfare costs in 1995, according to the Minnesota Department of Human Services (DHS).[36] A recent survey of 38 states by the Child Welfare League of American indicated that Minnesota was one of only seven states in which local revenues accounted for more than 20 percent of child welfare spending.[37]

Counties spent about $300 million on child welfare services in 1995, according to DHS.[38] About $161 million of this was for out-of-home placements in foster care, mental health, shelter, and other settings. The rest was for community-based services, such as case management, counseling, family preservation services, and others. The state does not separately budget or account for services to families being served by child protection agencies, but Table 1.2 shows total spending in several categories of services that are commonly used by families in the child protection system. For example,

34 Faribault and Martin counties provide services through one agency, as do Lincoln, Lyon, and Murray counties. The other 82 counties provide services through their social services agencies.

35 American Public Welfare Association, *A Statistical Summary of the VCIS Social Services Block Grant (SSBG) Data for Fiscal Year 1990* (Washington, D.C., 1994), 27.

36 Minnesota Department of Human Services, *Funding for Child Welfare Through County Social Service Agencies* (paper presented to the Minnesota Supreme Court Foster Care and Adoption Task Force), June 27, 1996, 2.

37 Michael Petit and Patrick A. Curtis, *Child Abuse and Neglect: A Look At the States: The 1997 CWLA Stat Book* (Washington, D.C.: Child Welfare League, 1997), 159. The survey reported spending (excluding Medicaid) for FY 1996.

38 Minnesota Department of Human Services, *Funding for Child Welfare*, 2.

reported spending (adjusted for inflation) for child protection assessment and investigation grew 18 percent between 1991 and 1996 and foster care spending grew 12 percent.

Aside from county property taxes, the largest revenue sources for Minnesota child welfare services were federal and state block grants, which together totaled about $43 million in 1995. Funds from Minnesota's Community Social Services Act (CSSA) block grant accounted for $25.8 million in 1995, and the federal Title XX block grant accounted for $17.5 million. Counties have considerable discretion about which activities to support with these grants, and child protection programs are one of many services funded partly with block grant funds.

The state Department of Human Services plays a limited role.

Perhaps because Minnesota's child protection system has evolved as a county-based system supported largely by county funds, the Minnesota Department of Human Services has played a limited role. The department administers federal and state child welfare funds, adopts rules, provides statewide child protection staff training, approves counties' biennial social services plans (and prepares a state social services plan), and plays a leadership role in state policy development. Department staff do not investigate maltreatment reports or directly provide services to families, and the department does not regularly examine the practices of county child protection agencies (as we discuss in Chapter 6).

CASELOAD TRENDS AND CHARACTERISTICS

The number of cases of suspected maltreatment has increased greatly in the United States from the time the "battered child syndrome" was publicized in 1962. In 1963, an estimated 150,000 children were reported as victims of abuse.[39] In 1993, almost three million reports were filed.[40] This growth probably reflects several factors. First, there is now greater awareness of abuse as a social problem than there was 30 years ago. Second, there have been expansions of the definition of maltreatment. While early child abuse reporting laws focused on physical abuse, in 1974 Congress defined abuse as "physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child."[41] Third, as the definition of maltreatment expanded, so did the list of professionals mandated to report suspected abuse. In 1975, the Minnesota Legislature increased the professionals required to report maltreatment by adding the psychological, psychiatric, child care, education, and law enforcement professions to the health care professions already required to

39 American Humane Association, as cited in Douglas Besharov, "Child Abuse and Neglect Reporting and Investigation: Policy Guidelines for Decision Making,"*The Problem of False Allegations* (New York: Haworth Press, 1991), 35-50.

40 U.S. Congress, Senate, Labor and Human Resources Committee,*Child Abuse Prevention and Treatment Act Amendments of 1996*, Report 104-117 (July 20, 1995), 2.

41 Child Abuse Prevention and Treatment Act of 1974 (CAPTA), P. L. 93-247, sec. 3.

Table 1.2: County Spending in Selected Social Services Categories, 1991-96

Category	1996 Total Expenditures (Millions)	Change in Real Expenditures, 1991-96[a]
Child protection assessment/investigation	$12.4	+17.7
Child welfare assessment	4.0	-7.4
Counseling (individual, group, family-based)	22.6	+18.4
Family-based crises services	2.7	+182.2
Family-based life management skills services	8.5	+57.0
Child shelter	16.7	+5.5
Foster care	72.8	+12.3
General case management	63.8	+54.2

[a]Data on spending (from all revenue sources) were adjusted using the state and local government deflator for consumption expenditures and gross investment (chain-type price index), Bureau of Economic Analysis, U.S. Department of Commerce.

NOTE: Expenditures in these categories were not limited to families receiving child protective services.

SOURCE: Program Evaluation Division analysis of data from Minnesota Department of Human Services.

report.[43] There are no reliable data to indicate whether the actual incidence of maltreatment has increased or decreased.

In Minnesota, the total number of maltreatment reports investigated rose through the 1980s and early 1990s, with peaks in 1989 and 1993. The greatest percentage increase occurred between 1982 and 1984, when the number of investigations jumped from 9,939 to 13,841 (a 39 percent increase). As Figure 1.5 illustrates,

- **The annual number of investigations increased 93 percent between 1982 and 1993, followed by a 13 percent decrease between 1993 and 1996.**

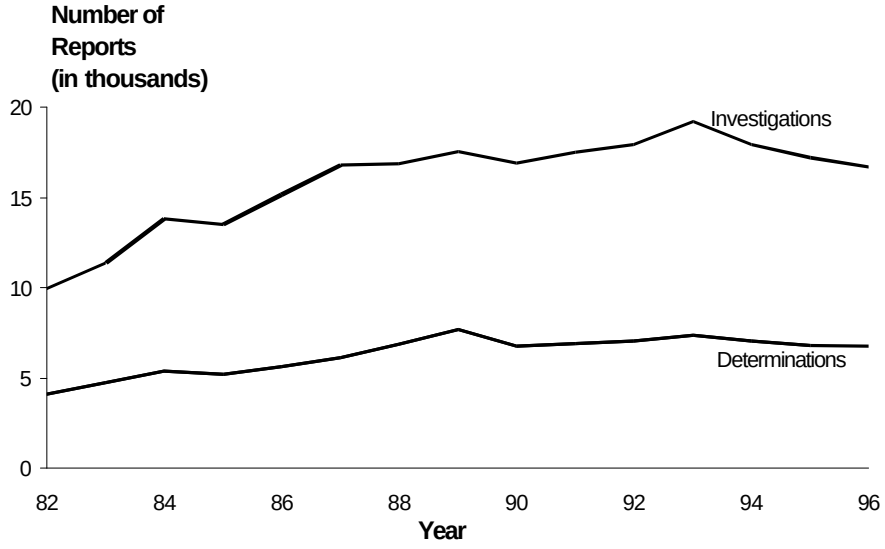
The number of cases in which maltreatment was determined followed a similar pattern, although the pattern was different for some types of maltreatment. For example, as Figure 1.6 shows, the number of determined reports of sexual abuse peaked in the mid-1980s, and then declined by 56 percent through the end of 1996. Since 1992, the most common type of maltreatment has been child neglect, which accounted for 54 percent of all maltreatment determinations in 1996.[44]

43 Minn. Laws (1975), ch. 221, sec. 1.

44 Figure 1.6 does not show mental injury cases, which accounted for 129 determinations in 1996.

The number of investigations and determinations has declined since 1993.

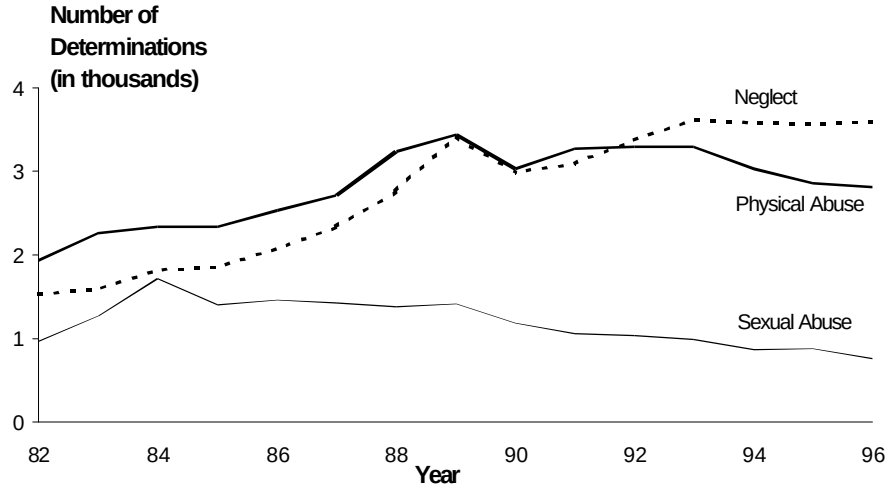
Figure 1.5: Maltreatment Reports Investigated and Determined, 1982-96



SOURCE: Department of Human Services.

Child neglect is the most common type of maltreatment.

Figure 1.6: Cases of Determined Maltreatment, by Type, 1982-96



SOURCE: Department of Human Services.

We were also interested in examining trends in the number of child deaths in Minnesota due to maltreatment. State officials and others often cite child fatality data from the Department of Human Services' maltreatment information system. During the course of our study, we found that:

- **The Department of Human Services does not have accurate data on the number of child deaths that have occurred due to maltreatment.**

When counties report information on maltreatment investigations to DHS, they provide information on the severity of the children's injuries. Options include "death" and "life-threatening injury," for example. The DHS information system identified 49 maltreament-related child deaths between 1994 and 1996. However, when we reviewed some counties' child protection files, the records indicated that deaths had not occurred in all of the cases identified as child fatalities by the state system. Subsequently, we asked counties to confirm whether deaths occurred in each of the 49 cases that theDHS information system identified as involving a child death.[45] We found that 24 deaths occurred in these cases, or about half of the deaths reported in the DHS information system.

Minnesota does not have accurate data on the number of maltreatment-related deaths in the state.

DHS staff told us that nearly all data on this information system are entered by the counties, so the problems with the data apparently reflect county errors, not DHS errors. Just as counties erroneously reported to DHS that some child injuries were child deaths, there might also have been instances in which actual child deaths were erroneously reported to DHS as other types of injuries. If so, there would have been more than 24 maltreatment-related deaths during 1994-96. Unfortunately, documenting whether any child deaths were incorrectly reported to DHS as child injuries would require a more extensive verification of the county-submitted data than we were able to conduct. Consequently, we were unable to determine the exact number of maltreatment-related child deaths that occurred in Minnesota during 1994-96.

In our view, mistakes of this magnitude on matters of such importance should not be tolerated. In Chapter 7, we recommend that DHS implement stronger quality control for the state's maltreatment information system. According to the department, the social services information system that will be implemented in 1999 contains features that will improve the accuracy of county data.[46]

Finally, we examined the characteristics of 1994-96 maltreatment victims and perpetrators in Minnesota. We found that:

- **In 1994-96, 55 percent of perpetrators of child maltreatment were women, and 45 percent were men.**

45 For cases that we did not review during our site visits, we asked staff in the relevant counties to examine case records and determine whether a child death occurred.

46 DHS told us that accuracy will improve because: data elements and definitions will be uniform statewide; data will be edited for accuracy as it is entered; and workers will have greater access to this information for daily uses, so they will be more likely to take steps to ensure its accuracy.

Women were more often the perpetrators of child neglect, and neglect cases accounted for over half of the maltreatment determinations. During 1994-96, 72 percent of the perpetrators of neglect were women. By comparison, women were the perpetrators in 43 percent of physical abuse determinations, 9 percent of sexual abuse determinations, and 43 percent of mental injury determinations.

In addition, we found that:

- **Eighty percent of 1994-96 perpetrator-victim relationships involved a victim's birth parent, and another 12 percent involved a stepparent, adoptive parent, or parent companion.**

- **The median age of victims of maltreatment in Minnesota was 7 years old. About 31 percent of alleged victims were under five years of age.**

- **Victims of maltreatment in 1994-96 were almost evenly split between boys and girls.**

- **About 61 percent of 1994-96 maltreatment victims were white, 23 percent were black, 8 percent were American Indian, 6 percent were of Hispanic heritage, and 2 percent were Asian. By comparison, about 89 percent of Minnesota's general population under age 18 in 1995 was white, 4 percent was black, 2 percent was American Indian, 2 percent was Hispanic, and 4 percent was Asian. Thus, black, American Indian, and Hispanic youth were disproportionately represented among maltreatment victims.**

Variation in County Practices

CHAPTER 2

Because child protective services are administered by county agencies in Minnesota, there actually are 84 child protection systems in the state, not one.[1] State laws and rules provide a foundation for county child protection systems, but ambiguity in state requirements allows much room for local interpretation. This chapter discusses the variety of agencies' child protection practices that we encountered during our study. Specifically, we asked:

- **To what extent do counties differ in the number of maltreatment investigations and determinations? Do these variations reflect differences in county screening practices or definitions of maltreatment?**

- **How do counties assess the risks of repeated maltreatment within families when determining whether to offer protective services?**

- **When counties determine that families need protective services, which types of services are provided most often? To what extent do counties vary in their use of services?**

- **What records do counties keep on allegations of maltreatment, and are there variations in how long they keep information on file?**

To help us answer these questions, we examined data provided by county human services agencies to the Minnesota Department of Human Services (DHS) for all cases of maltreatment investigated during 1994-96. DHS reviews these data and consults with counties regarding certain omissions and inconsistencies, but it does not fully verify the accuracy of the reports. We expressed concerns in Chapter 1 about the accuracy of some of the data collected by DHS, but we think that information on the number of investigations and determinations by counties is probably sufficiently accurate

1 Eighty-two Minnesota counties have their own offices. One office administers child protection for both Faribault and Martin counties, and one office administers child protection for Lincoln, Lyon, and Murray counties.

for general comparisons.[2] We supplemented these data with information we collected from counties in two surveys (in June and September 1997). To help us understand county practices, we reviewed case files in eight counties and interviewed staff in many counties in-person and by phone.

Overall, we found that there are substantial differences in the per capita rates of investigations, maltreatment determinations, and services among counties. These differences may reflect real variation in the incidence of maltreatment in the population, but they also reflect variation in county practices and policies.

SCREENING PRACTICES

County screeners evaluate which reports of maltreatment should be investigated.

According to state rules, a report of maltreatment must allege neglect, physical abuse, or sexual abuse and contain sufficient identifying information for the local social services agency to conduct an investigation.[3] It is not unusual for child protection agencies to "screen out" allegations that appear to be without merit, including many allegations of maltreatment that agencies receive from one parent against the other during custody disputes.

When county screeners receive maltreatment reports, they often collect additional information from the reporters, school staff, health care staff, and others to help them judge whether an allegation should be investigated. For example:

- A woman reported to a screener that the children of a relative looked undernourished. She said that the children seemed hungry when they were offered food, but their mother would not let them eat, claiming that their doctor said they had food allergies. The screener identified the family's medical assistance provider and called the hospital. Hospital personnel informed the screener that the children had not been seen by a doctor since birth. The screener referred the case for investigation because (1) the reporter gave a good description of the children's appearance, including extended stomachs, and (2) there was evidence that the mother lied about the children's medical history. Ultimately, the children were diagnosed by a doctor as "failing to thrive," and the child protection agency determined that neglect had occurred.

Based on information collected in a survey of county human services directors, we estimated that Minnesota child protection agencies received

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2 During our review of case files in selected counties, it appeared to us that the types of determinations listed in the DHS database usually matched the information in county case files. In contrast, the accuracy of some of the more detailed information on the database (such as the severity of maltreatment) appeared to be more questionable. County officials expressed some concerns to us that county staff have not always submitted maltreatment information to DHS in a timely manner and have not always filed maltreatment reports with DHS when new allegations were made concerning families that were already receiving services.

3 *Minn. Rules* 9560.0216, subp. 3. Child protection agencies also screen out allegations that have already been investigated.

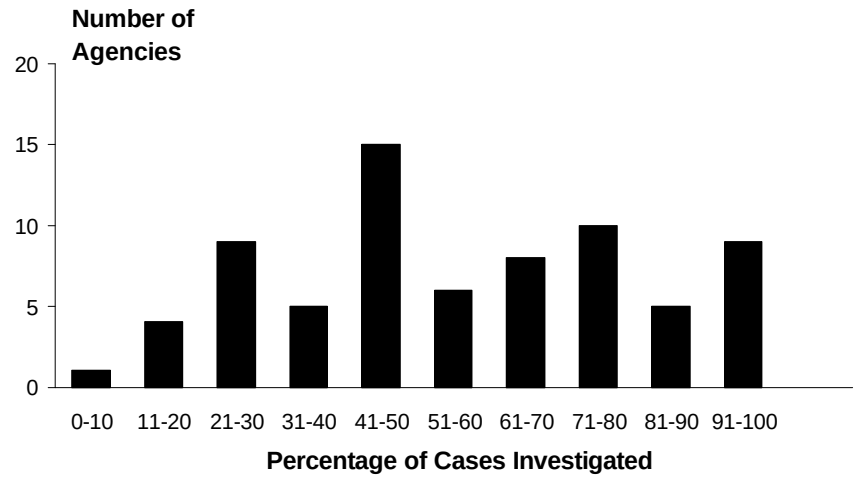
about 50,000 maltreatment allegations during 1996, or 42 allegations per 1,000 Minnesota children.[4] Statewide, 32 percent of these allegations were investigated by the child protection agencies. However,

About one-third of allegations are investigated statewide, but this varies widely among counties.

- **Child protection agencies varied widely in the percentages of allegations they said they investigated.**

For example, Figure 2.1 shows that nine county agencies said they investigated more than 90 percent of maltreatment allegations, while five said that they investigated 20 percent or less of the calls they received in 1996.

Figure 2.1: Percentage of Maltreatment Allegations Investigated by Agencies, 1996



SOURCE: Program Evaluation Division survey of county human services directors, September 1997 (N=82). Ten agency directors did not answer this question.

Based on our discussions with county staff, these variations may partly reflect differences in county screening philosophies. For example, Hubbard County officials told us that they try to investigate a high percentage of maltreatment allegations in order to minimize the risk of overlooking an actual incident of maltreatment. In contrast, Itasca County has implemented a rigorous screening procedure so that families are more likely to be referred for special services (such as parenting education and mental health services) than to be investigated for maltreatment.

In addition, different rates of screening out allegations of maltreatment may reflect agencies' interpretations of what constitutes maltreatment. Some counties have developed written screening criteria that provide more guidance

4 Our estimate was based on directors' estimates of the percentage of maltreatment allegations that were *not* investigated, plus DHS information on the number of investigations conducted. The estimated total number of allegations does not include thousands of other inquiries received by child protection agencies annually that do not involve maltreatment allegations.

about the definition of maltreatment than the broad statements provided in statute and rule. Written criteria can help a county maintain consistency among its child protection workers who screen calls. Screening criteria can also be used to inform the public and mandated reporters about what types of suspected abuse to report and to inform parents about the child protection agency's standards for child supervision and discipline. People calling to report suspected maltreatment may become frustrated if the child protection agency cannot articulate its definition of maltreatment, or if they are given different definitions by different child protection workers.

Most county child protection agencies do not have written screening criteria.

In a June 1997 survey, we asked county human services directors whether their agencies had developed screening guidelines that supplemented maltreatment definitions in law and rule. Their responses and our review of the screening guidelines they sent us indicated that 28 of the 84 county agencies (33 percent) had fairly extensive screening criteria, and another 4 agencies (5 percent) had criteria for screening limited types of calls. In addition:

- **Fifty-two of the 84 county agencies (62 percent) had no written screening criteria, and they accounted for an estimated 17 percent of maltreatment allegations in 1996.**

- **Child protection agencies with screening criteria investigated 28 percent of the allegations they received in 1996, while agencies without screening criteria investigated 51 percent.**

Agencies told us that the screening criteria are used as a guide for decision-making. A report that meets the screening criteria is not guaranteed to be investigated, and a report that does not meet the criteria may be investigated anyway. Screeners consider the circumstances of each report, such as past experience with the family and the age of the child. In the following sections, we discuss the screening criteria used by child protection agencies to help them decide which cases to investigate.

Criteria for Physical Abuse

Minnesota law says that physical abuse is evidenced by an injury that is non-accidental or inconsistent with the child's medical history and that is inflicted by a person responsible for the child's care.[5] Twenty-nine county agencies (35 percent) elaborate on the statutory definition of physical abuse in their screening criteria, and Figure 2.2 shows some of these criteria. For example, 28 county agencies have criteria that include more detailed definitions or examples of what constitutes an injury and what types of acts are considered physically abusive. Twenty-three agencies' criteria indicate that a suspicious explanation for an injury (usually in the judgment of a health professional) may be investigated. Several counties' criteria include the definition of

5 *Minn. Stat.* §626.556, subd. 2 (d).

Figure 2.2: Examples of Criteria for Screening Reports of Physical Abuse

The following examples of screening criteria were selected from criteria submitted by agencies in response to our June 1997 survey. These are not the criteria of one agency; rather, the list is a compilation of criteria used by different child protection agencies in Minnesota.

Reports of alleged physical abuse that may be investigated

Abusive Acts:

- striking a child with a weapon or object
- striking a child on the head
- inflicting on a child an injury incidental to domestic violence
- using discipline prohibited by a child's physical condition
- choking, hitting with fist, smothering, kicking, throwing, shaking, burning, biting, or poisoning a child

Physical Injuries

- bruises, welts, lacerations, abrasions, burns, broken bones
- injuries requiring medical attention
- battered child or shaken baby syndrome
- visible marks or swelling lasting at least 24 hours
- transient marks on a child younger than 18 months old

SOURCE: Program Evaluation Division review of county screening criteria.

"unreasonable restraint" found in Minnesota's criminal code.[6] In addition, some criteria specify that counties will *not* investigate allegations that constitute "reasonable force" under the criminal code.[7]

Criteria for Mental Injury

According to Minnesota's maltreatment law, mental injury is "an injury to the psychological capacity or emotional stability of a child as evidenced by an observable or substantial impairment in the child's ability to function within a normal range of performance and behavior with due regard to the child's culture."[8] The difficulty in identifying cases of mental injury lies in identifying observable and substantial adverse effects that result directly from abusive treatment.

Twenty-two county child protection agencies (26 percent) have supplemented the law by identifying types of allegations that could be investigated for possible mental injury. Most (18) of these agencies' screening criteria identify acts by a parent that would be considered abusive, such as rejecting, ignoring,

6 *Minn. Stat*. §609.255, subd. 3. One agency's criteria identifies specific conditions that constituted unreasonable restraint or confinement.

7 *Minn. Stat*. §609.379.

8 *Minn. Stat.* §626.556, subd. 2 (k).

inadequate nurturing, attempting suicide in the child's presence, or showing little or no attachment to the child. Three agencies' criteria indicate that reports of mental injury should come from professionals who are able to document the mental injury. Many counties include the state juvenile code's definition of "emotional maltreatment" in their criteria.[9] One agency uses examples of reports of alleged mental injury to illustrate the types of allegations that should be investigated.

Criteria for Sexual Abuse

Minnesota law defines sexual abuse more clearly than other types of maltreatment.

Through references to the criminal code and other laws, the sexual abuse definition in Minnesota's maltreatment law is more specific about the acts which constitute maltreatment than the law's definitions of physical abuse and mental injury. Sexual abuse occurs when a person responsible for the child's care (or with a significant relationship to the child) engages in sexual contact, sexual penetration, prostitution, or sexual performances with or in the presence of the child, or encourages such behavior between a child and another person.[10]

Twenty-eight counties have screening criteria that supplement the maltreatment law's definition of sexual abuse. The criteria of 23 counties indicate that reports of pain or injury in the genital area which cannot be explained should be investigated, and 27 counties specify that reports of sexually transmitted diseases in children who are not otherwise sexually active should be investigated. In one agency, a report by the alleged victim that sexual abuse is occurring is sufficient to warrant an investigation. Another county stipulates that a report of highly inappropriate sexual behavior of a child may lead to an investigation.

Criteria for Neglect

Although the maltreatment law defines certain types of actions or omissions which are neglectful, the definition provides little practical guidance about when neglect has occurred. We found that 29 county child protection agencies (35 percent) have screening criteria that supplement at least one of the maltreatment law's following general categories of neglect:

- educational neglect;
- failure to provide adequate food, clothing, and shelter;
- failure to protect from harm;

9 *Minn. Stat*. §260.015, subd. 5a. Emotional maltreatment is defined as "the consistent, deliberate infliction of mental harm on a child by a person responsible for the child's care, that has an observable, sustained, and adverse effect on the child's physical, mental, or emotional development."

10 *Minn. Stat.* §626.556, subd. 2 (a). The definition of sexual abuse specifies the acts constituting sexual abuse by reference to other statutes: §609.342 to §609.345, §609.321 to §609.324, and §617.246.

- medical neglect; and

- prenatal exposure to a controlled substance for other than medical reasons.[11]

In addition, several county agencies have criteria for at least one of the following categories of neglect cited in Minnesota's criminal or juvenile codes: (1) abandonment, desertion, or illegal placement; (2) inadequate supervision; and (3) child endangerment.[12]

Screening criteria for child neglect vary considerably among counties. For example, one county's criteria call for investigating reports of children under age six who are home alone, while another county's criteria suggest that investigations should be conducted if children under age ten are home alone. Likewise, one county's criteria require that housing be condemned by inspectors before allegations of inadequate shelter will be investigated, while several other counties are willing to investigate shelter-related allegations if the reported circumstances suggest unsafe living conditions.

INVESTIGATIONS

After a county screener determines that allegations meet the criteria for investigation, the child protection agency assigns the case to an assessment worker. The purpose of an investigation or assessment is twofold: to determine whether maltreatment occurred and to determine whether the child or family is in need of protective services. During 1994-96, there were 14 reports of maltreatment investigated annually in Minnesota per 1,000 children under age 18. Among individual counties, however, there was considerable variation—both overall and in individual maltreatment categories. As Table 2.1 shows:

- **The number of child protection investigations conducted annually per 1,000 children ranged from 3 in Itasca County to 29 in neighboring Hubbard County.**

Minnesota counties determined that maltreatment occurred in 20,553 cases during 1994-96, or 40 percent of the reports they investigated. Statewide, there were 8.3 maltreatment *victims* per 1,000 children.[13] There was considerable variation among counties in the percentage of investigations that resulted in a determination that maltreatment occurred, as shown in Table 2.2 for selected counties. We found that:

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11 *Minn. Stat.* §626.556, subd. 2 (c).

12 *Minn. Stat.* §260.015, subd. 2a (1) and (7), and *Minn. Stat.* §609.378. Abandonment and illegal adoption are grounds for determining that a child is in need of protection or services.

13 There may be more than one victim per investigated report that results in a maltreatment determination.

The number of investigations per 1,000 children varies widely among counties.

Table 2.1: Annual Investigations Per 1,000 Children in Selected Counties, by Type of Alleged Maltreatment, 1994-96

Type of Alleged Maltreatment	Statewide Rate	Counties With Highest Rates	Counties With Lowest Rates
Physical Abuse	6.3	13.8 (Hubbard) 13.6 (Blue Earth) 13.1 (Mille Lacs)	1.1 (Itasca) 2.2 (Wright) 2.8 (Carlton)
Sexual Abuse	1.6	4.8 (Hubbard) 4.3 (Cottonwood) 3.3 (Watonwan)	0.4 (Itasca) 0.6 (Scott) 0.6 (Wadena)
Mental Injury	0.2	3.0 (Rock) 2.6 (Blue Earth) 2.3 (Polk)	0.0 (Carlton) 0.0 (Sibley) 0.0 (Olmsted)
Neglect	7.0	14.3 (Crow Wing) 13.9 (Hennepin) 13.8 (Polk)	1.0 (Sherburne) 1.4 (Itasca) 1.7 (Carlton)
Any Maltreatment	14.0	29.1 (Hubbard) 26.4 (Mille Lacs) 25.4 (Polk)	2.8 (Itasca) 5.0 (Wright) 5.6 (Sherburne)

NOTE: Twenty counties that investigated fewer than 100 maltreatment reports in the three-year period are excluded. Rates are based on 1995 child population estimates provided by Minnesota Planning.

SOURCE: Program Evaluation Division analysis of child maltreatment data that counties submitted to the Department of Human Services.

- **The percentages of investigations that resulted in determinations of maltreatment ranged from 19 percent (Wabasha County) to 67 percent (Itasca County).**

Screening practices probably account for some of this variation. For example, Itasca County conducted relatively few investigations per 1,000 children but it made maltreatment determinations in two-thirds of them. In contrast, Hubbard County staff prefer to investigate most of the allegations they receive, but only 23 percent resulted in a maltreatment determination.[14]

Other factors may influence the percentage of investigations that result in a finding that maltreatment occurred. For example, it is possible that counties with more persistent, thorough investigators determined maltreatment in a higher percentage of investigations, although we had no way of evaluating

14 In general, counties that conducted more investigations per 1,000 children tended to have lower percentages of investigations that resulted in maltreatment determinations. The correlation was r = -0.41.

Statewide, counties determined that maltreatment occurred in 40 percent of investigated cases.

Table 2.2: Percentage of 1994-96 Investigations Resulting in a Finding that Maltreatment Occurred, Selected Counties

County	Percentage of Investigations with a Finding that Maltreatment Occurred
Itasca	67%
Morrison	64
Carver	56
Beltrami	55
Ramsey	55
Hennepin	36
Rice	23
Hubbard	23
Pope	22
Mower	21
Wabasha	19
STATE TOTAL	40

NOTE: The table includes Hennepin County, the five counties with the highest percentage of investigations resulting in a finding that maltreatment occurred, and the five counties with the lowest percentage. Twenty counties with fewer than 100 maltreatment investigations during 1994-96 are excluded.

SOURCE: Program Evaluation Division analysis of child maltreatment data that counties submitted to the Department of Human Services.

this. It is also possible that counties that made determinations in a higher percentage of investigations have more inclusive definitions of what constitutes maltreatment.

Differences in the types of maltreatment investigated by counties probably did not make much difference in the percentage of investigations that resulted in determinations. Statewide, the percentages of physical abuse, neglect, and sexual abuse investigations resulting in findings of maltreatment were quite similar: 38, 41, and 43 percent, respectively.[15]

We also examined 1994-96 annual rates of determined maltreatment per 1,000 children among the counties. We found that:

- **There are wide differences in the annual rates of determined maltreatment among Minnesota counties. This may partly reflect differences in county maltreatment definitions and investigation practices.**

15 Fifty percent of mental injury investigations resulted in a maltreatment determination, but these cases usually accounted for a small portion of child protection cases.

Table 2.3 shows the counties with the highest and lowest rates of maltreatment determinations, overall and for each type of maltreatment. Generally, the counties with the highest rates had several times more victims per 1,000 children than the counties with the lowest rates.

Undoubtedly, some of the variation among counties reflects real differences in the extent of maltreatment. For example, previous studies have shown that child neglect is especially prevalent in locations with high levels of poverty. But our discussions with child protection staff and our reviews of case files lead us to believe that differences in county policies and practices also play an important role in the differences in maltreatment rates. For example:

- In one county with a high rate of physical abuse determinations, staff told us that any blow to a child's head, including a slap, was inappropriate and could constitute maltreatment. Likewise, staff in that county said that striking a child with an object of any sort was inappropriate and could be considered maltreatment. In contrast, staff

Some counties have maltreatment determination rates that are several times higher than those in other counties.

Table 2.3: Annual Determinations of Child Maltreatment Per 1,000 Children by Type of Maltreatment, 1994-96

Type of Maltreatment	Statewide Rate	Counties With Highest Rates	Counties With Lowest Rates
Physical Abuse	2.7	8.5 (Cottonwood) 8.1 (McLeod) 7.7 (Blue Earth)	0.6 (Itasca) 1.2 (Wright) 1.3 (Washington)
Sexual Abuse	0.8	2.1 (Cottonwood) 2.1 (Hubbard) 1.9 (Faribault)	0.2 (Swift) 0.3 (Scott) 0.3 (Wright)
Mental Injury	0.2	3.3 (Cottonwood) 3.0 (Blue Earth) 2.2 (Polk)	0.0 (Clay) 0.0 (Lyon) 0.0 (Mower) 0.0 (Watonwan)
Neglect	5.3	14.0 (Polk) 12.3 (Swift) 10.0 (Faribault)	1.5 (Sherburne) 2.0 (Itasca) 2.2 (Wright)
Any Maltreatment	8.3	18.6 (Polk) 17.3 (Swift) 15.7 (Cottonwood)	2.7 (Washington) 2.9 (Itasca) 3.6 (Sherburne)

NOTE: Thirty-nine counties with fewer than 100 victims in the three-year period are excluded. Rates are based on 1995 child population estimates provided by Minnesota Planning.

SOURCE: Program Evaluation Division analysis of child maltreatment data that counties submitted to the Department of Human Services.

in many other counties require evidence of an injury—such as a bruise—before making a determination of maltreatment.

- A supervisor in a county with a high rate of child neglect determinations told us that some counties probably tolerate living conditions and levels of child supervision that his investigators do not. He said that other counties may not determine that maltreatment occurred in these types of cases because they have more egregious cases of maltreatment that consume their resources.

County policies and practices account for some of the variation in maltreatment rates.

- Twenty-two Minnesota counties made no determinations of maltreatment based on mental injury in 1994-96, while one county (Blue Earth) made almost as many mental injury determinations during this period (112) as did all of the Twin Cities metropolitan area counties combined (119). Officials from Blue Earth County told us that they regard mental injury as potentially more serious than physical abuse in terms of its long-term impact on children, and this contributes to their willingness to make determinations of maltreatment by mental injury.

As we reviewed case files, it appeared to us that some counties did not make maltreatment determinations in circumstances that would likely have led to determinations of maltreatment in some other counties. For example:

- A child protection agency received a report that a young mother became upset while in a bank. The mother "shook the baby like a rag doll, . . . threw the baby back into the stroller, then she knocked the stroller over and she hit [the baby's] head." The reporter watched the mother leave the bank as she continued to slap the baby. A hospital examination of the baby showed no signs of trauma, so the county did not determine that maltreatment occurred, despite the eyewitness account.

- A child protection investigation found a house in disarray—for instance, without a functioning toilet, with buckets of human feces in the basement, and with dog feces in one of the rooms. The investigator did not find that maltreatment occurred because, "this worker was not able to prove that the home is always in that condition or that it had been that way for a long time."

Conversely, there were some counties that made maltreatment determinations that would not have met some other counties' criteria. For instance, the following three examples are from a county that had relatively high rates of maltreatment determinations per capita:

- Two girls told a school social worker that their father was verbally abusive toward them during his custody visitations. The father denied this, and the case file contained no testimony from psychologists or psychiatrists. Still, the child protection investigator determined that the father maltreated his children by inflicting mental injuries.

- A mother and her 11-year-old son got into a fight. The mother admitted that she grabbed her son in the front of the neck and pushed him down. The child protection investigator determined that maltreatment occurred, even though there was no evidence of a physical injury.

- A therapist reported to a child protection agency that two boys told him that their father slapped their buttocks and faces and hit them with a closed fist "to correct them when they do wrong." The boys denied to the investigator that they had been hit in the face. The mother said the boys were occasionally spanked with a belt, but not in a way that caused injury. The county found that physical abuse occurred.

Overall, counties differed not only in their criteria for what types of behaviors constituted maltreatment, but also in the way they evaluated evidence to make determinations. Some counties seemed disinclined to make determinations without direct evidence of injury, while other counties made findings of maltreatment based on reported actions alone or eyewitness accounts, regardless of whether injuries resulted. In many cases we reviewed, the accounts of the alleged perpetrators and victims differed, and the files did not clearly indicate reasons why certain evidence ultimately proved persuasive to the investigators when making their determinations.

Hennepin County reported to DHS that a majority of its investigations did not begin within three days.

Finally, we examined whether there is variation in the timeliness of county child protection investigations. State law requires county social service agencies to "immediately" conduct an assessment upon receiving a report of maltreatment.[16] State rules specify that counties should begin all investigations within three days of receiving a report of alleged maltreatment, and investigations involving children in imminent danger or victims of infant medical neglect should begin when the report is received.[17] We examined DHS information on 1994-96 child maltreatment investigations and found that:

- **Counties started 77 percent of child maltreatment investigations during 1994-96 within three days of receiving the reports. Hennepin County accounted for most of the cases in which investigations did not start within three days.**

Sixty-one of Minnesota's counties began at least 90 percent of their investigations within three days, including six counties that began all of their investigations within three days.[18] Five counties began less than 70 percent of their investigations within three days, and Hennepin County began only 44 percent within three days.[19] Excluding Hennepin County, 91 percent of the state's maltreatment investigations began within three days.

16 *Minn. Stat.* §626.556, subd. 10 (a).

17 *Minn. Rules* 9560.0216, subp. 5.

18 The six counties were Cook, Grant, Kittson, Pine, Stevens, and Waseca. Waseca was the only one of the six with over 40 maltreatment investigations during 1994-96.

19 The other counties were Wadena (57 percent), Crow Wing (59 percent), Wabasha (60 percent), and Nicollet (66 percent).

Hennepin County officials said that they begin investigations immediately, when the screener forwards a maltreatment report to an intake supervisor. But county staff told us that supervisors often have delayed assigning cases (those not involving imminent danger) as a way of limiting investigators' caseloads to reasonable levels. During 1994-96, there were not enough investigators to keep up with the number of new cases, resulting in a backlog. The county hired additional staff in 1997 to reduce time lags to start investigations.[20]

For the state as a whole, it took an average of 4.7 days for child protection agencies to begin investigations. Three counties averaged over 10 days to begin maltreatment investigations during 1994-96. Nicollet County averaged 15 days, Crow Wing County averaged 12 days, and Hennepin County averaged 11 days. Crow Wing County officials told us that they had recently hired a new intake supervisor who was addressing the problem. Nicollet County attributed its delay in starting investigations to personnel problems.[21]

The following cases are examples of untimely investigations from the files we reviewed:

Some cases we reviewed were not investigated in a timely manner.

- A county received a report on February 22, 1995 that a mother was drinking and using marijuana in front of her three- and five-year-old children and feeding them only once a day. The county began its investigation on March 20 even though it had received two previous neglect reports for this family. The county removed the children from the home and placed them in a shelter on March 27.

- A county received a report on January 23, 1996 that a mother was not adequately supervising her teenage children. The report alleged that the oldest daughter threatened her brother with a butcher knife and also verbally threatened to cut her sister's throat. The county did not begin the assessment until February 7 and did not interview the mother until March 7.

- On March 13, 1995, a landlord reported that his tenant's nine-year-old son was outside unsupervised at 1:00 AM. The landlord also alleged that the boy did not go to school regularly. The mother had been the subject of several maltreatment findings for neglecting her older children in 1991 and 1992. The county did not assign the case to an investigator until March 30. By then the mother had been evicted and it took the county until May 3 to locate her and arrange an interview. The mother denied the allegations and the county determined that

20 Hennepin County provided us with data for the first nine months of 1997. During this period 52 percent of 1997 investigations started within three days, and the average time to start an investigation was about seven days. The county's timeliness improved during 1997; in the third quarter, 67 percent of investigations were started within three days, and the average time to start an investigation was five days.

21 Nicollet County officials provided us with data for 77 cases investigated during the first nine months of 1997. The data showed that 71 percent of the investigations began within three days from the date the case was "screened in" and the average time to start an investigation was three days.

maltreatment did not occur. In July, the county subsequently received a report from the boy's school that he was habitually truant. The report was assigned to an investigator on August 7 who determined that maltreatment occurred and recommended that a CHIPS petition be filed.

Department of Human Services guidelines call for completing investigations within 90 days of receiving a report.[22] For the state as a whole, counties completed 91 percent of their maltreatment investigations within 90 days during 1994-96, and it took counties an average of 37 days to complete an investigation. Reports of sexual abuse (46 days) and mental injury (45 days) took slightly longer to investigate than neglect (38 days) and physical abuse (34 days) reports. Four counties completed less than 75 percent of their investigations within 90 days: Roseau (55 percent), Sherburne (58 percent), Nicollet (70 percent), and Renville (73 percent). Roseau County took an average of 128 days to complete its investigations.[23]

RISK ASSESSMENT

Counties assess families' risk of maltreatment when deciding whether services should be offered.

According to state law, counties may determine that child protective services are needed if "a child is at significant risk of maltreatment if protective intervention is not provided."[24] State rules specify that the determination shall be based on a risk assessment tool approved by the Department of Human Services that includes the factors shown in Figure 2.3.[25] In addition, the rules require that agencies use the risk assessment tool when considering when to terminate protective services for a family.[26]

The risk assessment tool authorized by the department was originally developed in Illinois, and it is used by all but one of Minnesota's counties (Olmsted). This type of instrument is commonly known as a "consensus-based" instrument because its components reflect expert opinion about factors that are predictive of maltreatment. County child protection investigators rate families as "high," "intermediate," "low," or "no" risk in each of the subcategories shown in Figure 2.3, and then they assign an overall risk rating to the family. The overall rating reflects the county investigator's general judgment about the family's risk for maltreatment; it is not computed by numerically aggregating or averaging the ratings of the subcategories. No

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22 Minnesota Department of Human Services, *Social Services Manual* (St. Paul, 1989 revision), XVI-4340.

23 Roseau County officials told us they think that workers usually completed the assessment work in fewer than 90 days but they did not officially close the investigations until all the paperwork was done. Nicollet County sent us 1997 data that indicated that 91 percent of investigations closed during the first nine months of 1997 were completed within 90 days.

24 *Minn. Stat.* §626.556, subd. 10e (b). The agency must also conclude that the individuals responsible for the child's care have not taken or are not likely to take actions to protect the child from maltreatment or risk of maltreatment.

25 *Minn. Rules* 9560.0220, subp. 6.B.

26 *Minn. Rules* 9560.0228, subp. 6.

Figure 2.3: Factors That Must Be Considered in Family Risk Assessments

1) Vulnerability of the child;
2) Location, severity, frequency, and recentness of abuse;
3) Severity, frequency, and recentness of neglect, and condition of home;
4) Physical, intellectual, or emotional capacities and control of the person or persons responsible for the child's care;
5) Degree of cooperation of the person or persons responsible for the child's care;
6) Parenting skills and knowledge of the person or persons responsible for the child's care;
7) Alleged offender's access to the child;
8) Presence of a parent substitute or other adult in the home;
9) Previous history of child maltreatment;
10) Strength of family support systems; and
11) Stressors on the family.

SOURCE: *Minn. Rules* 9560.0220, subp. 6.B.

studies have evaluated whether the families identified as high risk by Minnesota's assessment actually have rates of repeated maltreatment that are significantly above the families identified as low and intermediate risks.

We asked human services directors to identify the purposes for which they use risk assessment. Table 2.4 shows that:

Only about half of the agencies said they use risk assessments to help them decide when to terminate services.

- **Most (87 percent) of the directors said their counties use risk assessment to help them decide whether to open cases for child protective services. Only 54 percent of the directors said their counties use risk assessment to help them decide when to close cases, although state rules require that assessments be used for this purpose.**

In addition, the table indicates that many child protection agencies use risk assessment to help evaluate whether to place children out-of-home or reunite them with their families, but the majority of agencies do not.

Olmsted County is the only Minnesota county that does not use the risk assessment instrument recommended by DHS. Since 1996, Olmsted County has used an "actuarial" or "research-based" risk assessment instrument that was originally developed in Michigan. In contrast to consensus-based instruments, actuarial risk assessments contain variables that research has shown are strongly associated with subsequent maltreatment.

Table 2.4: Uses of Risk Assessments by Minnesota Child Protection Agencies

Have Child Protection Agencies Used Risk Assessment in the Past Two Years to Help Them Decide:	Percent of Child Protection Agencies That Responded "Yes"
Whether to open cases for child protective services?	87%
Whether to substantiate investigated reports of maltreatment?	71
When to terminate child protective services?	54
Whether to recommend out-of-home placement of children?	48
What amount of service "open" cases should receive?	48
Whether to try to reunite children with their families?	37

SOURCE: Program Evaluation Division survey of county human services directors, September 1997 (*N* = 82).

Some research favors "actuarial" risk assessments over the type of assessments currently done in most Minnesota counties.

Actuarial risk assessments have been used (or are being implemented) in the child protection systems of at least ten states, and they have been used widely in criminal justice agencies. Proponents of actuarial assessments cite several advantages. First, there is evidence that actuarial risk assessments are more accurate. As one review of the literature reported: "In virtually every decision-making situation for which the issue has been studied, it has been found that statistically developed prediction devices outperform human judgments."[27] Second, Olmsted County staff think that their actuarial risk assessments are more practical than the tool used by other counties. Specifically, the actuarial instrument uses different variables for abuse and neglect cases, rather than assuming that one set of variables predicts the risks of both types of cases equally well. Also, Olmsted's instrument assesses family strengths (not just risks), and staff consider it useful in developing case plans. A third possible advantage of actuarial risk instruments is greater reliability. A recent study found that staff using Michigan's actuarial instrument made identical decisions about risk far more often than staff using consensus-based instruments.[28]

27 Stephen D. Gottfredson, "Prediction: An Overview of Selected Methodological Issues," in *Prediction and Classification: Criminal Justice Decision Making*, ed. Don M. Gottfredson and Michael Tonry (Chicago: University of Chicago Press, 1987), 36.

28 S. Christopher Baird, "Child Abuse and Neglect: Improving Consistency in Decision-Making," *NCCD Focus* (San Francisco: National Council on Crime and Delinquency, August 1997), 7-13. The study examined the extent of agreement among four persons who rated the risk of selected cases in four states.

We do not know whether a family whose risk is assessed by one Minnesota county would receive the same rating in other counties. But we do know that:

- **Counties vary in the extent to which they provide protective services to families classified as "intermediate" risk.**

Statewide, counties determined that services were needed in 88 percent of the 1994-96 maltreatment investigations where families were classified as high risk, compared with 49 percent of intermediate risk families and 4 percent of low or no risk families. There were 32 counties that determined that services were needed for at least 75 percent of the intermediate risk families. In contrast, Hennepin County determined that services were needed for only 11 percent of intermediate risk families, and five other counties made this determination for fewer than 25 percent of intermediate risk families. Thus, state rules require counties to use risk assessments to help determine whether families need protective services, but counties vary in the extent to which families that are assigned the same risk levels receive services.

SERVICES AND CHILD PLACEMENTS

County child protection agencies offer a variety of services to families. These services range from case management and counseling to more intrusive services such as removing children from their homes and placing them with relatives or foster parents. In some extreme cases, counties seek court action to terminate parental rights and place the children for adoption.

We used data on maltreatment investigations that counties submitted to DHS during 1994-96 to determine the number of families that needed services and the types of services offered. The data reflect conclusions and recommendations of investigators at the time they completed their investigations, but may not represent services actually received. In some cases, service plans may have changed and families may have refused services. However, DHS does not collect data verifying the services that were actually provided to families. We also reviewed data on district court proceedings compiled by the Minnesota Supreme Court for 1994-96 to determine the number of dependency and neglect petitions filed and the number of instances in which counties filed petitions to terminate parental rights.

Counties determined a need for services in 21 percent of investigations in 1994-96.

Determining a Need for Child Protective Services

Statewide, investigators found that child protective services were needed in 21 percent of the maltreatment cases they investigated in 1994-96. Investigators determined that families needed services in 43 percent of the cases where they found that maltreatment occurred and in 7 percent of the cases where they found that maltreatment did not occur. The percentages of physical abuse,

sexual abuse, and neglect investigations resulting in a finding that services were needed were very similar: 20, 21, and 23 percent, respectively.[29]

We found that:

- **Counties differed widely in the extent to which they determined that protective services were needed.**

Table 2.5 shows selected counties' rates of determining that protective services were needed, using three measures. The percentage of cases investigated that were determined to need services ranged from 7 percent (Koochiching County) to 57 percent (Swift and Itasca counties). On a per capita basis, Swift County determined a need for services for a large number of families (11.8 per 1,000 children in the population), while Itasca determined a need for services for relatively few families (1.6 per 1,000 children). By all of the measures, the state's most populous county (Hennepin) determined a need for protective services to a relatively limited number of families.

Table 2.5 does not reflect all families investigated for maltreatment who received services. Sometimes counties refer families (or family members) to service providers *without* determining that protective services are needed. For example, Hennepin County often refers educational neglect cases to county staff who work exclusively with these types of cases but are not in the child protection agency. Child protection investigators in other counties told us that they sometimes provide limited services during the investigation phase without formally determining that services are needed. However, whenever counties make a determination that protective services are needed, they must (1) develop (and revise, as needed) a service plan, and (2) meet with the family at least monthly and consult with other service providers at least quarterly. Thus, opening a child protection case for protective services commits a county to certain levels of case management and oversight that other referrals for services may not.

When child protection agencies open cases for services, their staff often act as brokers who arrange for families to receive services from public or private service providers. For example, a county social worker may arrange for a physical abuse perpetrator to attend an anger management counseling program or a parenting class. Some county child protection staff work directly with families at home, teaching parents how to manage their daily lives and raise their children.

Figure 2.4 shows the types of services that counties offered to families determined to need child protective services during 1994-96. County child

29 Forty percent of mental injury investigations resulted in a finding that child protective services were needed, but these cases usually accounted for a small portion of county investigations. Also, mental injury was often determined in combination with another type of abuse.

Table 2.5: Extent to Which Selected Counties Determined a Need for Protective Services, 1994-96

County	Percent of Investigations Where the Family Was Determined to Need Services	Percent of Investigations Where Maltreatment Was Determined That Were Found to Need Services	Number of Cases Determined to Need Services Per 1,000 Population Under 18
Swift	57%	83%	11.8
Itasca	57	76	1.6
Yellow Medicine	52	81	7.1
Morrison	47	66	3.0
Stearns	45	68	2.7
Ramsey	25	42	3.7
Wabasha	14	49	1.9
Marshall	11	33	1.4
Hennepin	9	26	2.0
Waseca	9	30	0.6
Koochiching	7	25	1.2
STATE TOTAL	21%	43%	2.9

NOTE: The table includes Ramsey County, the five counties with the highest percentage of cases determined to need services, and the five counties with the lowest percentage of cases determined to need services. Twenty counties with fewer than 100 maltreatment investigations during 1994-96 are excluded.

SOURCE: Program Evaluation Division analysis of child maltreatment data that counties submitted to the Department of Human Services.

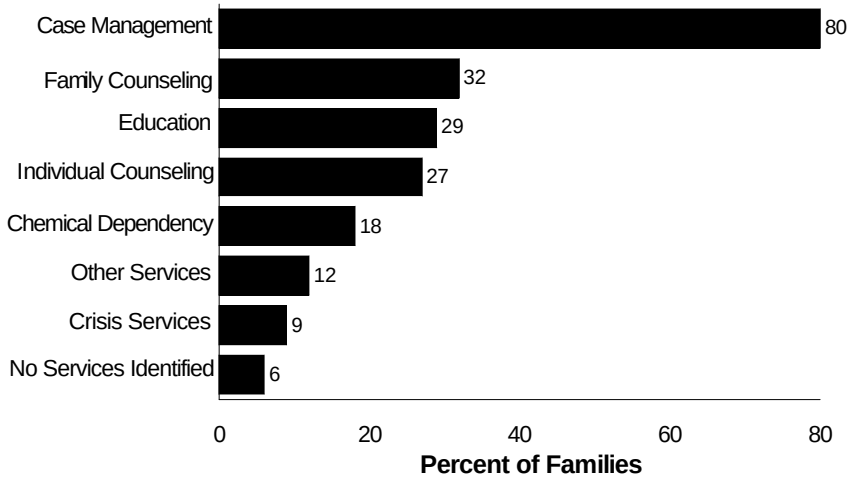
protection agencies found that 10,955 families needed child protective services during this period. The most commonly recommended services were case management (80 percent of families) and family counseling (32 percent).[30]

State law requires counties to establish multi-disciplinary child protection teams to, among other tasks, make recommendations to the county welfare agency about the services that should be provided to individual families and children.[31] The law says that these teams may include (but are not limited to) representatives of the county attorney, county sheriff, mental health agencies, other health agencies, education agencies, and parent groups. Only 10 percent of county human services directors we surveyed said that parents' groups have actively participated on their multi-disciplinary teams in the past two years,

30 Child protection agencies can recommend that families receive more than one type of service.

31 *Minn. Stat.* §626.558. According to our September 1997 survey of county human services directors, 100 percent of county agencies have used these teams for case consultation, 87 percent have used them to help educate professionals about child protection, 62 percent have used them to educate the public about child protection, and 44 percent have used them to help develop resources for maltreatment prevention, intervention, and treatment. In some counties, local child abuse prevention councils authorized by *Minn. Stat.* §119A.14 also assist with these functions.

Figure 2.4: Services Recommended for Families Needing Protective Services, 1994-96



NOTE: Education includes parenting and family-based life management skills programs. Crisis services include crisis intervention, respite care, and day care. Percentages are based on families determined to need services.

SOURCE: Program Evaluation Division analysis of data submitted by counties to the Department of Human Services (*N*=10,955).

Some counties consulted with "multi-disciplinary teams" often, while others did not.

but the majority of counties said that each of the other groups has.[32] We asked county human services directors to identify the number of cases for which these teams provided case recommendations to their agencies in 1996, and we compared this to the total number of cases investigated by each county in 1996. We found that about 16 percent of counties reported that multi-disciplinary teams provided recommendations in less than 10 percent of the investigated cases in 1996, while another 32 percent of counties said their teams provided recommendations in more than 90 percent of investigated cases. Thus, counties varied widely in the extent to which they used multi-disciplinary teams for case consultation.

When a county determines that child protective services are needed, the family does not always receive the recommended services. In our review of case files, we found many cases where the family did not follow through with the services recommended in the case plan, or did so only after considerable effort by the county. The following case is an example:

- In February 1995, authorities found five children, ages 1 through 12, at home alone. The home was dirty and in disarray. The police temporarily placed the children in a shelter but the children returned home when the mother agreed to accept in-home family services. In June, police responded to a call and found the mother drunk, the home

32 Of the 82 responding directors, the percentage who said that the following groups have been active participants were: county attorneys' representatives, 94 percent; education professionals, 84 percent; mental health professionals, 83 percent; other health professionals, 83 percent; county sheriffs' representatives, 76 percent; and city police representatives, 67 percent.

Some families do not comply with treatment plans.

dirty and littered with beer cans, and no food in the house. They again temporarily placed the children in a shelter and the county filed a CHIPS petition with the court. The court granted the petition but allowed the children to return home when the mother agreed again to accept services, including chemical dependency treatment, parenting classes, and home management training. Subsequent contacts by the child protection caseworker revealed that the mother did not use the services, and conditions in the home did not improve. As a result, the court placed the children in foster care until the mother completed chemical dependency treatment. Between September 1995 and March 1996, the mother started and failed to complete three different chemical dependency treatment programs. She finally completed a fourth chemical dependency treatment program in June 1996. The children returned home, and the county closed the case.

In other cases, when the family did not accept the services offered or did not complete the requirements of the case plan, the caseworker simply closed the case. Child protection workers are required to close a case when the family does not cooperate with the plan and there are not sufficient grounds to petition the court to intervene.[33] The following case is an example:

- A mother and her newborn child both tested positive for cocaine in March 1994. Investigators found that the mother's first daughter had also tested positive for cocaine in another county in 1992. The mother admitted using drugs since she was 12. Investigators found that maltreatment occurred and that services were needed. They closed the case in August 1995 even though the mother was still using drugs and not following through on her chemical dependency program. The closing plan noted that the mother was "providing at least the minimum care for her two children."

There were fewer court petitions filed per 1,000 children in the Twin Cities region than elsewhere in Minnesota.

Court Petitions and Out-of-Home Placements

We obtained data on maltreatment-related CHIPS petitions filed by Minnesota counties during 1994-96 from the State Court Administration Division of the Minnesota Supreme Court.[34] These data indicate that:

- **Twin Cities metropolitan area counties filed fewer CHIPS petitions per 1,000 children than non-metropolitan counties. In general, there was considerable variation among counties in their 1994-96 rates of filing petitions per 1,000 children.**

Table 2.6 shows that 3.5 CHIPS petitions were filed in Minnesota per 1,000 children. The four counties with the lowest rates include three Twin Cities

33 *Minn. Rules* 9560.0228, subp. 6.

34 CHIPS petitions are filed when a child is thought to be in need of protection or services and are distinct from juvenile delinquency petitions. We included in our analysis CHIPS petitions categorized by the courts as dependency and neglect (which are usually the result of maltreatment) and we excluded petitions for juvenile status offenses such as truancy and runaway.

Table 2.6: Rates of CHIPS Petitions Filed in Juvenile Courts of Selected Counties, 1994-96

	Annual Number of Maltreatment-Related CHIPS Petitions	
County	Filed Per 1,000 Children	Granted Per 1,000 Children
Watonwan	12.1	6.5
Cottonwood	11.9	8.6
Polk	11.3	6.0
Aitkin	10.9	7.3
Cass	9.0	6.1
Hennepin	4.0	1.4
Ramsey	2.2	1.5
Fillmore	1.8	1.2
Anoka	1.7	1.4
Wright	1.6	1.3
Dakota	1.5	0.9
Washington	1.1	0.7
STATE TOTAL	3.5	1.9

NOTE: The table includes Hennepin and Ramsey Counties, the five counties with the highest rates of CHIPS petitions filed per 1,000 children, and the five counties with the lowest rate of CHIPS petitions filed. Twenty counties with fewer than 100 maltreatment investigations during 1994-96 are excluded. Hennepin County's rates are based on 1995-96 data due to concerns we had about the completeness of its 1994 data. Maltreatment-related CHIPS petitions are petitions for "dependency and neglect" and do not include CHIPS petitions for truancy, runaways, or delinquency under age 10. Rates are based on 1995 child population estimates provided by Minnesota Planning.

SOURCE: Program Evaluation Division analysis of juvenile court data that courts provided to the State Court Administration Division of the Minnesota Supreme Court.

metropolitan area counties and one county bordering the metropolitan area. In the seven-county Twin Cities metropolitan area, there were 2.7 CHIPS petitions filed per 1,000 children versus 4.3 petitions per 1,000 children in the non-metropolitan counties.

For the state as a whole, we estimated that the number of CHIPS petitions filed in 1994-96 was 74 percent of the total number of maltreatment victims in families determined to need services during this period.[35] Juvenile courts granted 62 percent of the CHIPS petitions they ruled on during 1994-96, with similar percentages in the Twin Cities region and in outstate Minnesota. Among individual judicial districts, the percentage of petitions granted ranged from a high of 78 percent in the tenth judicial district (including counties just north and northwest of the Twin Cities) to a low of 47 percent in the sixth judicial district (northeastern Minnesota).

35 We were unable to match CHIPS petitions directly to individual maltreatment victims. Some of the petitions filed early in 1994 may have related to maltreatment that occurred in 1993 and some of the 1996 victims may have been the subject of CHIPS petitions in 1997.

Ten percent of victims were recommended for foster care placements.

Table 2.7: Number and Types of Out-of-Home Placements for Victims of Child Maltreatment, 1994-96

Type of Placement	Number of Victims Placed[a]	Percent of Victims Placed[b]
Shelter Facility	3,927	12%
Foster Placement With Relative	1,355	4
Foster Placement With Non-Relative	2,057	6
Any Placement	6,982	21

[a]Children may have experienced more than one type of placement so the sum of the three placement types exceeds the number who received any type of placement.
[b]Percentages based on 33,923 victims in cases where maltreatment occurred or services were needed.

SOURCE: Program Evaluation Division analysis of child maltreatment data that counties submitted to the Department of Human Services.

We looked at child maltreatment data that counties submitted to DHS to determine how many child maltreatment victims were placed outside the home. Because child protection investigators usually complete maltreatment reporting forms when they finish their investigations, the reports only include out-of-home placements that occurred or were recommended up to that point. As a result, the actual number of out-of-home placements may differ somewhat from the data reported here.[36] Table 2.7 shows that:

- **County child protection agencies recommended that 21 percent of the 1994-96 maltreatment victims be placed outside the home. A majority were temporary placements in shelter facilities.**

Twelve percent of the maltreatment victims were placed (or recommended for placement) in a shelter facility. Shelter facilities serve as temporary placements in emergencies, such as cases involving abandonment or sexual abuse. About three-fourths of the victims placed in shelters were placed there by police on a "72-hour hold."[37] Children usually left the shelter facility after a few days and either returned home or moved to a longer term foster home.

36 In our review of case files, there were some cases where the children were placed after the parents failed to complete recommended treatment or after subsequent incidents of maltreatment. Some of these placements may not have occurred by the time the county submitted reports on the initial incident to DHS. On the other hand, the court does not always follow the recommendations of child protection agencies for out-of-home placements. In general, however, we found that data on Minnesota's total number of recommended placements was similar to summary data we obtained from DHS on the total number of actual child protection-related placements. We primarily used data on recommended placements because this information gave us more detail.

37 Minnesota law authorizes peace officers to remove a child from the home without a court order for up to 72 hours (excluding weekends and holidays) when a child is found in surroundings or conditions that endanger the child's health or welfare. *Minn. Stat.* §260.165, subd. 1 (c) (2) and *Minn. Stat.* §260.171, subd. 2 (d). Longer stays must be authorized by the court.

Table 2.8: Rates of Foster Placements for Selected Counties, 1994-96

County	Annual Number of Victims Placed in Foster Care Per 1,000 Children	Percent of Victims Placed in Foster Care
Cottonwood	5.7	33%
Cass	5.7	40
Polk	3.5	15
Faribault	2.6	16
Aitkin	2.4	18
Hennepin	0.6	5
Benton	0.4	7
Ramsey	0.4	3
Sherburne	0.3	7
Wright	0.3	7
McLeod	0.2	2
STATE TOTAL	0.9	10%

NOTE: Foster care includes placements with relatives or non-relatives, whether voluntary or court ordered. It excludes temporary placements in a shelter facility. The table includes Hennepin County, the five counties with the highest foster care placement rates per 1,000 children, and the five counties with the lowest rates. Thirty-nine counties with fewer than 100 maltreatment victims during 1994-96 are excluded. Rates are based on 1995 child population estimates provided by Minnesota Planning. Percentages are based on the number of victims with maltreatment determined or services needed.

SOURCE: Program Evaluation Division analysis of child maltreatment data that counties submitted to the Department of Human Services.

Use of foster placements by counties varies considerably.

Ten percent of maltreatment victims were placed in a foster home run by either a relative or non-relative. About three-fifths of the foster placements were court-ordered and two-fifths were voluntary placements.[38] We found small differences in the likelihood of an out-of-home placement for different types of maltreatment. Seventeen percent of sexual abuse victims, 19 percent of physical abuse victims, 25 percent of neglect victims, and 36 percent of mental injury victims were placed outside the home.[39]

Table 2.8 shows placement rates for selected counties with over 100 maltreatment victims during 1994-96. We found that:

- **Annual foster home placement rates ranged from a high of 5.7 placements per 1,000 children to a low of 0.2 .**

38 About half of the relative foster placements were court-ordered and half were voluntary placements. About 70 percent of the non-relative foster placements were court ordered and 30 percent were voluntary.

39 Ten percent of physical and sexual abuse victims, 11 percent of neglect victims, and 24 percent of mental injury victims were placed in a foster home. Eight percent of sexual abuse victims, 10 percent of physical abuse victims, 13 percent of mental injury victims, and 15 percent of neglect victims were placed in a shelter facility.

Some children are reunified with their families after the risk of maltreatment has been reduced.

There are several possible reasons for variation in out-of-home placement rates. Unless a placement is voluntary or shorter than 72 hours, counties must file a CHIPS petition to place a child outside the home.[40] Some county officials told us their county attorney will only file a CHIPS petition or recommend removal of a child from the home as a last resort. Other county officials told us that limited budgets or shortages of acceptable foster homes have forced their county to curtail the use of court petitions and out-of-home placements.[41]

In most cases, child protection workers view out-of-home placements as temporary. They direct their efforts towards correcting the conditions that led to maltreatment so the child can safely return home. The following are examples of out-of-home placements and subsequent family reunifications that appear, from case file information, to have protected the children from further harm:

- In August 1995, police found a one-year-old child alone in an alley and four other children, ages two through five, unsupervised in a yard full of scrap metal. The children were hungry, dirty, and poorly clothed. The father was verbally abusive toward the children and the police officers. The county filed a CHIPS petition and placed the children with their grandparents. The court ordered both parents to get psychological evaluations and chemical dependency assessments, and it ordered the father to complete parent education classes and anger management counseling. The parents cooperated with the program and completed its requirements. Two of the children returned to the home in February 1996, and the other three returned in May. The family continued to receive visits from an in-home skills worker. The court dismissed the CHIPS petition in September 1996. The child protection agency continued to monitor the family until March 1997 and there have been no subsequent maltreatment reports.

- A six-month-old with multiple bruises and serious injuries to the head and pelvic region was hospitalized for 17 days in December 1995. The investigation revealed that the boy's father beat him while the mother was drunk. Upon his release from the hospital, the child was voluntarily placed with his maternal grandmother. The mother accepted services including a chemical dependency assessment, counseling, and a parenting class. The father was convicted of first degree assault and sentenced to 42 months in prison. The county filed a CHIPS petition in September 1996 that formalized the child's placement with his grandmother, who had become licensed as a foster parent. After completing chemical dependency treatment and aftercare in December 1996, the mother moved in with her mother and son, and

40 The correlation among county out-of-home placement rates and rates of filing CHIPS petitions was r = 0.63, indicating a strong relationship.

41 The foster home shortage is of particular concern for cases involving American Indian children because tribes sometimes insist that counties place these children in American Indian foster homes.

in February 1997, she moved with her child to her own apartment. The court dismissed the CHIPS case in April 1997.

When parents continue to maltreat their children, when they refuse to cooperate with case plans, or when they simply abandon their children, the county may petition the court to terminate parental rights. Based on data from the State Court Administration Division of the Minnesota Supreme Court, we found that:

Counties may petition the courts to terminate parental rights, although this option is pursued infrequently.

- **County attorneys filed 2,868 petitions to terminate parental rights during 1994-96, or 0.8 petitions annually per 1,000 children.**

Six counties filed no petitions to terminate parental rights and only five counties with at least 100 maltreatment victims during 1994-96 filed over one petition annually to terminate parental rights per 1,000 children during this period.[42] For the state as a whole, county attorneys filed termination of parental rights petitions for about 9 percent of the 1994-96 victims with maltreatment determined or services needed.[43] Courts granted 68 percent of the petitions.[44] County officials we talked to said that county attorneys were sometimes reluctant to file termination petitions and courts were unlikely to grant them if the parents contested the petition and there was any hope of family reunification. The following are examples from our review of case files where counties sought to terminate parental rights:

- A mother brought her six-week-old baby to a hospital emergency room in June 1995 with a broken leg and cracked rib. The county immediately filed a CHIPS petition and placed the child in foster care. After an investigation, the county attorney charged the mother's boyfriend with assault, and the mother agreed to a service plan that included counseling, parent education, and no contact with the boyfriend. The mother was permitted to have supervised visits with the child but visits were suspended because she failed to complete counseling and parenting education and did not sever relations with the boyfriend. On the recommendations of a counselor and the child's guardian *ad litem*, the county filed a petition to terminate parental rights in June 1996. The mother first objected to the petition, but then agreed to it. The court granted the petition in August 1996.

- In November 1995, a doctor reported that an 11-month-old child brought in for an apparent ear infection had bruises on his earlobe and head. The mother claimed that the child fell. About one month later, while the original report was still under investigation, the child was

42 The five counties were Freeborn (1.7 filings per 1,000 children), Hennepin (1.4), Ramsey (1.3), Martin (1.2), and Blue Earth (1.0).

43 We were unable to match termination of parental rights petitions directly to individual maltreatment victims. Some of the petitions filed early in 1994-96 may have related to maltreatment that occurred prior to that period and some of the 1994-96 victims may be the subject of CHIPS petitions after 1996.

44 We excluded Hennepin County's 1994 data from this calculation due to concerns we had about its completeness.

hospitalized with multiple head bruises and a fractured skull. The county filed a CHIPS petition and placed the child with an aunt. In December 1996, after the mother's first unsupervised visit with the child, the aunt reported that the child had bruises on both ears. In January 1997, the county attorney charged the mother with malicious punishment of a child. She pleaded guilty in April 1997 and was sentenced to two years probation. The county filed a petition to terminate the mother's parental rights in June 1997. The county located the child's biological father, who agreed to take custody.

We reviewed many case files where counties did not petition the court to terminate parental rights, sometimes despite many unsuccessful efforts to work with parents and reunite families. We discuss some of these cases in Chapter 3.

RECORD-KEEPING

A final area in which we examined county child protection agency practices was record-keeping. We looked at the types of information that county agencies keep on file, how long they keep it, and how they communicate the results of their investigations.

Many counties do not keep records of all allegations they receive.

First, we examined whether county agencies "maintain a record of every report of maltreatment" they receive, as required by state rules.[45] The rules indicate that a report is any allegation of maltreatment, not just those that are eventually investigated by the child protection agency.[46] Counties' records of maltreatment reports received, or "screening logs," can serve two important purposes. Screening logs can help agencies document previous allegations that have involved particular perpetrators or victims. This can help counties assess the credibility of new allegations. For instance, a child protection agency might be less inclined to investigate an allegation from a person who has repeatedly made accusations against an ex-spouse. Or perhaps an agency that did not investigate an allegation of maltreatment of a child because the report was not detailed enough might be especially inclined to investigate a report alleging similar maltreatment of the child in the future. The other purpose of screening logs is to provide a record of the agencies' decision-making practices. Without a complete screening log, it is difficult to evaluate what portion of maltreatment allegations are "screened out." Also, without a log of allegations that were not investigated, it is impossible to subsequently evaluate whether the agency adequately responded to reports that were made about particular families. We found that:

45 *Minn. Rules* 9560.0230, subp. 1.

46 For example, *Minn. Rules* 9560.0216, subp. 3 says, "The local agency shall screen reports of maltreatment to determine the need for assessment."

- **Fifty of 84 county child protection agencies (60 percent) maintain screening logs, and these counties accounted for 31 percent of Minnesota's child protection investigations in 1996.**

Some child protection agencies told us that they thought that state data practices laws prohibited them from keeping records of allegations that were received but not investigated. However, the Department of Administration's expert in the data practices law told us that he did not agree with this interpretation. Some other child protection agencies told us that they did not keep logs of all allegations received because this would take time away from other duties.

Among the counties that do have screening logs, there is variation in the type of information collected. Table 2.9 shows the types of information that counties with screening logs said they have in their records. State law provides no guidance on what information should be recorded or how long child protection agencies should keep records of maltreatment allegations that were not investigated.[47]

In some counties, certain investigative records tend to be destroyed quickly.

A second record-keeping issue we examined is how long agencies keep records of child protection investigations. If an agency concludes that maltreatment did not occur *and* services are not needed, state law allows the agency to keep the investigation records for up to four years. The agency must inform the alleged perpetrator that he or she has the right to have the record destroyed and, upon request, the agency must do so within 30 days.

We asked county human service directors to estimate how many 1996 records they had destroyed in cases where the investigations yielded determinations of no maltreatment and no protective services needed. Most directors told us that

Table 2.9: Information Maintained by Child Protection Agencies in Screening Logs

Report Information	Number of Agencies Maintaining Information
Date of report	50
Whether an assessment was done	48
Alleged victim's name	44
Whether a referral to another agency was made	39
Report source	37
Reason for not doing an assessment	36
Alleged perpetrator's name	33
All of the above	23

SOURCE: Program Evaluation Division survey of county human services directors, June 1997 (*N* = 84).

47 Minn. Stat. §626.556, subd. 11c (a) and (b) only indicate how long agencies should keep ree ords of cases that were investigated.

the vast majority of records for such 1996 investigations were still in county files in mid-1997.[48] However, we found that:

- **Ten of the 84 county child protection agencies told us that at least 75 percent of their 1996 records had been destroyed by the middle of 1997.**

The ten counties were Anoka, Clay, Freeborn, Hennepin, Kandiyohi, Norman, Pope, Rice, St. Louis, and Washington. Contrary to law, four counties destroyed these records within 30 days after the investigation unless the alleged perpetrator requested that they be retained.[49] Overall, there are significant differences in counties' record retention practices for child protection investigations that do not result in a determination that maltreatment occurred.

A third record-keeping issue we examined was the availability of information to county child protection agencies on families' prior records of maltreatment. Each county agency keeps its own child protection records and DHS requires that counties assign each family an identification number unique to that county. Counties do not have an information system they can query to obtain a *statewide* maltreatment history of a particular family, perpetrator, or victim. Consequently, as shown in Figure 2.5,

- **Most county human services directors told us that it is "sometimes, rarely, or never" easy to determine families' comprehensive maltreatment histories.**

Child protection staff who screen cases or conduct investigations may have difficulty knowing the histories of families who have moved from county to county. The Department of Human Services is designing a statewide social services information system that will assign families a single identification number, regardless of the county in which maltreatment occurs. Department staff expect this system to be implemented in early 1999.[50]

A final record-keeping issue is the clarity of child protection agency determinations. Within ten days of completing an investigation, child protection agencies are required to notify parents, guardians, and alleged maltreatment perpetrators "of the determination and a summary of the specific reasons for the determination."[51] In cases we reviewed, some of the

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48 For example, 60 of 84 human services directors estimated that their agencies had destroyed no more than 20 percent of the 1996 records.

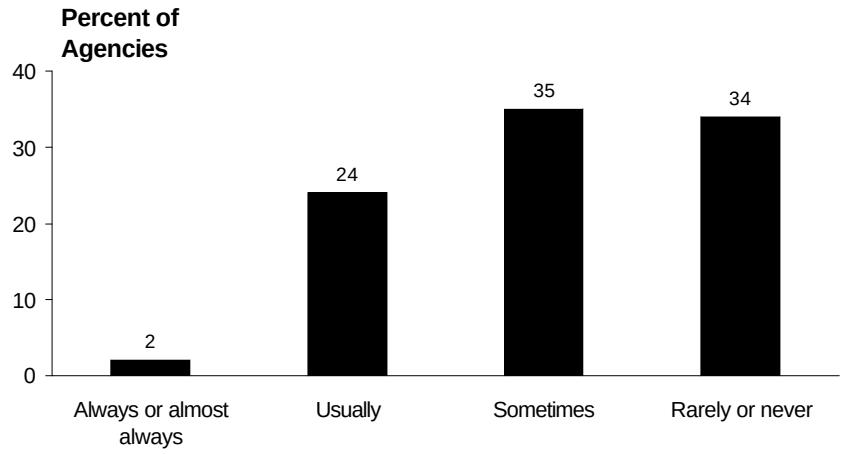
49 The counties were Clay, Kandiyohi, Rice, and Washington. It is possible that these agencies were following the requirements of earlier child protection laws that directed agencies to destroy records of false reports within 30 days *unless* the alleged perpetrator requested that the records be maintained.

50 A 1988 study found that Minnesota was one of only three states without a *statewide* maltreatment registry. See National Center for State Courts, *Central Registries for Child Abuse and Neglect: A National Review of Records Management, Due Process Safeguards, and Data Utilization* (Williamsburg, VA: July 29, 1988).

51 *Minn. Stat.* §626.556, subd. 10f.

Counties often have difficulty documenting family maltreatment histories.

Figure 2.5: Is It Easy For County Agencies to Document a Family's Child Protection History In Other Counties?



SOURCE: Program Evaluation Division survey of county human services directors, September 1997 (N=82).

notifications directly indicated the basis for the county's conclusions, such as the following: "This referral has been substantiated based on the fact that you acknowledged that [the child] was alone for a short amount of time at the apartment." In contrast, other notifications, such as the following, did not provide reasons for the agency's determination: "The reason that this determination was made is due to my assessment." In some cases, we found that it was difficult to identify the exact basis for the determination even after reading all case notes on the investigation.

SUMMARY

County child protection agencies vary widely in their rates of investigation, determination, and services, and they have varying practices for screening cases and retaining maltreatment-related records. Variation might reflect differing community standards, although Chapter 6 indicates that there may be little public discussion of agencies' criteria. Also, given that local property taxes pay for the majority of child welfare services, it may be appropriate for services to reflect the preferences of individual counties. As we suggest in Chapter 7, however, legislators should consider whether the local variations result in too much inconsistency in Minnesota's child protection system. If so, it may be useful to try to develop greater statewide consensus on maltreatment definitions and practices.

Repeated Maltreatment of Children

CHAPTER 3

Child protection agencies intervene in the lives of families that maltreat their children in part to protect the children from immediate danger, but also to reduce the likelihood of future abuse or neglect. There has been little study of rates of repeated maltreatment, both nationally and in Minnesota. We asked:

- **What percentage of Minnesota families who abuse or neglect their children maltreat them again?**
- **Are some types of maltreatment more likely than other types to be followed by subsequent maltreatment?**
- **What could the child protection system do to reduce repeated maltreatment?**

We measured rates of repeated maltreatment over periods of one, two, and three years.

We measured the incidence of repeated maltreatment using the reports of child maltreatment that counties submit to the Department of Human Services (DHS). We measured repeated investigations and repeated determinations of maltreatment over three different time periods. First, we looked at each family that had a maltreatment determination in 1995 and examined whether the same family had a subsequent maltreatment determination within 12 months of the first. We also looked at each family that was the subject of a maltreatment determination in 1994 and examined whether the same family was the subject of a subsequent determination within two years. Finally, we looked at each family that was the subject of a 1993 maltreatment determination and examined whether the same family was the subject of a subsequent determination within three years. Similarly, for families that were subjects of maltreatment investigations (but not necessarily determinations) in 1993, 1994, and 1995, we looked at whether the families were the subject of subsequent investigations over one-, two-, and three-year periods. We excluded Hennepin County from the analysis. Hennepin County does not comply with DHS reporting requirements to use a single case number for each maltreatment investigation involving the same family, making it impractical for us to track repeated incidents of maltreatment. [1]

1 Department of Human Services, *Instructional Bulletin # 93-68C* (July 8, 1993), Attachment B, 4. While Hennepin County workers can link family records through the family's name, the names are not reported to DHS. We also excluded Blue Earth County from the three-year analysis. Blue Earth County changed its family case numbering system between 1993 and 1994, so we were unable to match 1993 reports with subsequent reports.

Overall, we found that at least 29 percent of families investigated for maltreatment were the subject of another investigation during the next three years. Of families determined to have maltreated their children, at least 18 percent were determined to have maltreated their children again within three years. The actual rates of repeated maltreatment are probably higher because these rates only include repeated maltreatment (and repeated investigations) within the same county. The state's maltreatment information system is unable to track cases across counties. Based on our review of cases, we think there are some instances of repeated maltreatment that occur despite appropriate interventions by the child protection system. But we think there are probably instances where children could be protected more effectively through more thorough assessment, better case monitoring, and more involvement of the courts when families do not comply with agency interventions.

INCIDENCE OF REPEATED MALTREATMENT

Table 3.1 shows the percentage of families that were the subject of more than one maltreatment investigation for the state as a whole (excluding Hennepin County) for different types of maltreatment. We found that:

- **Of families that were the subject of a maltreatment investigation, 18 percent were the subject of another investigation in the same county within one year, 25 percent were investigated again within two years, and 29 percent were investigated again within three years.**

Twenty-nine percent of families investigated in 1993 were investigated again in the same county within three years.

Table 3.1: Subsequent Maltreatment Investigations Over One-, Two-, and Three-Year Periods

Type of Maltreatment Originally Investigated	Percent of Investigated Families With Subsequent Investigations in the Same County During the Next:		
	12 Months	24 Months	36 Months
Physical Abuse	17%	24%	27%
Sexual Abuse	14	20	23
Mental Injury	19	23	28
Neglect	19	29	33
Any Maltreatment	18	25	29

NOTE: The 12-month data indicate the percent of families investigated for maltreatment in 1995 that were the subject of at least one additional maltreatment investigation within 12 months of the first investigation. The 24-month data indicate the percent of families investigated for maltreatment in 1994 that were the subject of at least one additional maltreatment investigation within 24 months of the first investigation. The 36-month data indicate the percent of families investigated for maltreatment in 1993 that were the subject of at least one additional maltreatment investigation within 36 months of the first investigation. All results exclude Hennepin County and reports of maltreatment in facilities. The 36-month results also exclude Blue Earth County.

SOURCE: Program Evaluation Division analysis of child maltreatment data that counties submitted to the Department of Human Services.

There were 10,925 families (excluding Hennepin and Blue Earth counties) who were the subject of at least one maltreatment investigation in 1993. We found that 3,134 of those families (29 percent) were the subject of at least one additional maltreatment investigation within three years. Sixty-three percent of the 3,134 families had only one subsequent maltreatment investigation within three years and 37 percent had two or more subsequent investigations. Seven families were the subject of ten or more investigations, and one family was the subject of 14 investigations within a three-year period.

Table 3.1 also shows that families that were investigated for neglecting their children were slightly more likely to be investigated again than were families investigated for other types of maltreatment. For example, 33 percent of families originally investigated for neglect were investigated again at least once within three years (1993-96), compared to 28 percent of families originally investigated for mental injury, 27 percent of families originally investigated for physical abuse, and 23 percent of families originally investigated for sexual abuse.

We believe that the percentages reported in Table 3.1 may understate the true level of ''recidivism'' for several reasons. First, some repeated maltreatment likely went undetected and unreported. Second, the percentages do not include families that moved and were the subject of maltreatment investigations in a different county or state. Each county has its own case numbering system and there is no central state registry of victims or perpetrators that would permit cross-county matching. Third, some county staff told us that they do not always provide DHS with information on newly investigated reports of maltreatment if the family is already under investigation or receiving services. It is also worth noting that some children were placed out-of-home for part or all of the follow-up period, so they were not at risk of maltreatment from their parents for as long as the other children whose records we tracked.

Of families with maltreatment determinations in 1993, 18 percent had another determination in the same county within three years.

As a second measure of maltreatment recidivism, we looked at families where county investigators determined that maltreatment occurred. As shown in Table 3.2,

- **Of families with maltreatment determinations, 11 percent were determined to have maltreated their children again in the same county within one year, 15 percent did so within two years, and 18 percent did so within three years.**

There were 4,552 families (excluding Hennepin and Blue Earth counties) who were found by county investigators to have maltreated their children at least once in 1993. We found that 835 of those families (18 percent) were found to have maltreated their children within the same county at least once more within three years. Three-fourths of those 835 families had one subsequent maltreatment finding and one-fourth were found to have maltreated their children at least two more times within three years. Sixteen families maltreated their children five or more times and one family was found to have maltreated its children eight times within three years.

Table 3.2: Subsequent Maltreatment Determinations Over One-, Two-, and Three-Year Periods

Type of Maltreatment Originally Determined	Percent of Families With Subsequent Determination in the Same County During the Next:		
	12 Months	24 Months	36 Months
Physical Abuse	11%	14%	16%
Sexual Abuse	7	10	15
Mental Injury	13	14	21
Neglect	13	19	22
Any Maltreatment	11	15	18

NOTE: The 12-month data indicate the percent of families with a maltreatment determination in 1995 who were the subject of at least one additional maltreatment determination within 12 months of the first determination. The 24-month data indicate the percent of families with a maltreatment determination in 1994 who were the subject of at least one additional maltreatment determination within 24 months of the first determination. The 36-month data indicate the percent of families with a maltreatment determination in 1993 who were the subject of at least one additional maltreatment determination within 36 months of the first determination. All results exclude Hennepin County and reports of maltreatment in facilities. The 36-month results also exclude Blue Earth County.

SOURCE: Program Evaluation Division analysis of child maltreatment data that counties submitted to the Department of Human Services.

Repeat cases of neglect are more common than repeat cases of abuse.

Table 3.2 also shows that families who were determined to have neglected or caused mental injury to their children were slightly more likely to have maltreated their children again than were families determined to have physically or sexually abused their children. For example, 22 percent of families originally determined to have neglected their children and 21 percent of families originally determined to have caused mental injury were determined to have maltreated their children again within three years (1993-96), compared to 16 percent of families originally determined to have physically abused and 15 percent of families originally determined to have sexually abused their children.

Although we were unable to use the state's maltreatment information system to measure repeated maltreatment in Hennepin County, researchers from Hennepin County recently used the county's maltreatment information system to study the issue.[2] The study examined families that were first investigated for child maltreatment in 1990, 1991, and 1992, and it looked at repeated investigations of maltreatment within one, two, and three years of the close of the original investigation.[3] The results were similar to our findings for other counties in Minnesota. The study found that 17 percent of investigated families were investigated again within one year, while 25 percent had subsequent investigations

2 Hennepin County Office of Budget and Finance,*Analysis of Multiple Protection Investigation Assessments in Child Protection Services* (Minneapolis, April 1995).

3 This is slightly different from our approach, which tracked new investigations within one, two, and three years of the date the initial maltreatment report was received. The Hennepin County study excluded families that had been investigated for child maltreatment in the two years prior to the study year (although they could not do so for unsubstantiated cases if the family had requested that the records be destroyed). New incidents of maltreatment were not counted if they were made while the family was receiving child protective services, so rates of repeated maltreatment may have been underreported.

within two years, and 30 percent had new investigations within three years.[4] The study also found slightly higher rates of repeated investigations for neglect cases. Over the three-year period, 32 percent of the families originally investigated for neglect were the subject of another investigation within three years, compared with 28 percent of the families investigated for physical abuse and 23 percent of the families investigated for sexual abuse.[5]

In some counties, nearly half of investigated families had a subsequent investigation within three years, as shown in Table 3.3. Some of the variation in county rates may be due to differences in county screening practices and maltreatment definitions. For example, if two counties receive the same number of maltreatment allegations but one investigates more cases and determines maltreatment more often, the rates of recidivism would likely be higher in that county. It is also possible that counties with very low rates of repeated maltreatment have not reported all instances of maltreatment to DHS.

In some counties, nearly half of all investigated families were investigated again within three years.

Table 3.3: Subsequent Maltreatment Over Three-Year Period for Selected Counties

County	Percent of Families Investigated For Maltreatment in 1993 That Were Investigated Again in the Same County Within Three Years	Percent of Families With Maltreatment Determined in 1993 That Had Another Determination in the Same County Within Three Years
Faribault	48%	38%
Hubbard	47	29
Pipestone	46	42
Winona	46	20
Clay	42	26
Hennepin	30	19
Ramsey	28	19
Wright	20	9
Renville	19	8
Nobles	17	11
Todd	15	0
Sherburne	10	5
Statewide	29%	18%

NOTE: The table includes Hennepin County, Ramsey County, the five counties with the highest percentage of families with subsequent investigations, and the five counties with the lowest percentage. Thirty-one counties with fewer than 50 families investigated in 1993 are excluded. Hennepin results are for families originally investigated in 1990 and 1991. Statewide results exclude Hennepin and Blue Earth counties.

SOURCE: Program Evaluation Division analysis of child maltreatment data that counties submitted to the Department of Human Services. Hennepin County results are from Hennepin County Office of Budget and Finance, *Analysis of Multiple Protection Investigation Assessments in Child Protection Services* (Minneapolis, April 1995).

4 Hennepin County, *Analysis of Multiple Protection Assessments,* 7.

5 *Ibid.,* 10.

We also looked at the relationship of county risk assessments to the likelihood of repeated maltreatment. We found that:

- **Families originally rated by county investigators as "no" or "low" risk had a lower rate of repeated maltreatment determinations than families rated as "intermediate" or "high" risk, but there was little difference in the rate of repeated maltreatment between intermediate and high risk families.**

Families rated as "high" risks did not have the highest levels of maltreatment "recidivism."

As shown in Table 3.4, 22 percent of the high risk families, 23 percent of intermediate risk families, and 13 percent of no or low risk families originally determined to have maltreated their children in 1993 had another maltreatment determination within three years. For families investigated for maltreatment in 1993, intermediate risk families (38 percent) were also more likely than high risk families (31 percent) to have been investigated for maltreatment again within three years. As noted in Chapter 2, counties use the risk assessment tool to help make decisions about when to open cases for services. Our findings raise questions about the accuracy of county risk assessment tools for predicting future incidents of maltreatment. It is conceivable that effective interventions may have produced recidivism rates for high risk families that were equal to or lower than the rates for intermediate risk families, but it is also possible that the risk assessments were not sufficiently predictive.[6]

Table 3.4: Subsequent Maltreatment Over Three-Year Period by Family Risk Level

Risk Level	Percent of Families Investigated For Maltreatment in 1993 That Were Investigated Again in the Same County Within Three Years	Percent of Families With Maltreatment Determined in 1993 That Had Another Determination in the Same County Within Three Years
No or Low Risk	26%	13%
Intermediate Risk	38	23
High Risk	31	22

SOURCE: Program Evaluation Division analysis of child maltreatment data that counties submitted to the Department of Human Services.

In our view, it is not possible to reliably evaluate how Minnesota's rates of repeated maltreatment compare with those in other states. There have been relatively few studies of repeated maltreatment, and the studies have used varying definitions of recidivism and reported widely varying results. State laws and practices regarding what constitutes maltreatment may also differ. Although no

6 We considered whether the lower recidivism rates of high risk families could reflect their greater likelihood of receiving services. We found that the provision of services did not seem to explain the recidivism pattern, although we did not have good indicators of the intensity or quality of services provided. Among families determined to need services, the rate of repeated investigation for high risk families was 31 percent, compared with 37 percent for intermediate risk families. Among families that were not found to need services, the rates of repeated investigation were about the same for high (41 percent) and intermediate (40 percent) risk families.

consensus has emerged about ''typical'' rates of repeated maltreatment, some recent studies showed that:

- Ten percent of Colorado families that had been the subject of maltreatment determinations during 1986-89 had subsequent maltreatment determinations within two years, and 14 percent had new determinations within four years.[7]

- Seventeen percent of children admitted to a pediatric hospital for abuse victims in Chicago in 1986 and 1987 were the subject of a substantiated maltreatment report within five to six years of their discharge date.[8]

- Forty-eight percent of California families investigated for maltreatment in 1993 had been investigated at some previous time.[9]

CAN REPEATED MALTREATMENT BE PREVENTED?

Minnesota law declares that ''the public policy of this state is to protect children whose health or welfare may be jeopardized through physical abuse, neglect, or sexual abuse.''[10] Of course, child protection agencies typically do not intervene directly in the lives of families until abuse or neglect has been reported. But when families have been the subject of multiple maltreatment investigations or determinations, it is reasonable to ask whether agencies took appropriate steps to protect the children.

We reviewed child protection case files in eight counties.

We reviewed samples of child protection files in eight counties, and this section focuses on cases which had repeated maltreatment (or repeated investigations) within one family. The cases discussed here are not a representative cross-section of all child protection cases in the counties, but we think it is instructive to consider their circumstances and the issues they raise. We recognize that issues may be clearer in hindsight than they were at the time the cases unfolded.

Sometimes it appeared to us that repeated incidents of maltreatment occurred within families *despite* reasonable, active interventions by child protection agencies. Likewise, it is possible that some families had repeated maltreatment determinations partly because their activities were being closely monitored by the agencies. For example:

7 George Fryer and Thomas J. Miyoshi, ''A Survival Analysis of the Revictimization of Children: The Case of Colorado,'' *Child Abuse and Neglect* (1994), 18:1063-1071. Younger children were more likely to be revictimized than older ones, and neglect cases had a higher rate of repeated maltreatment than physical or sexual abuse cases.

8 Howard B. Levy, John Markovic, Urmila Chaudhry, Sharon Ahart, and Heriberto Torres, ''Reabuse Rates in a Sample of Children Followed for Five Years After Discharge From a Child Abuse Inpatient Assessment Program,'' *Child Abuse and Neglect* (1995), 19:1363-1377.

9 Moira Inkelas and Neal Halfon, ''Recidivism in Child Protective Services,'' *Children and Youth Services Review* (1997), 19:139-161.

10 *Minn. Stat.* §626.556, subd. 1.

- A child protection agency determined that neglect occurred when a mother was arrested for drunk driving in May 1995 while her child was in the car. During the investigation, child protection staff located the mother (her whereabouts were previously unknown), arranged for her to get a chemical dependency assessment, and took her to the assessment after she missed previous appointments. The chemical assessment found no evidence of problems, and the agency's records indicated that the son was well cared for and that the family would receive ongoing home visits by a nurse. Within two weeks of the date that the agency closed its investigation, the mother abandoned her child for three days.

- One family was the subject of four investigations within a two-month period in 1995, and each resulted in a maltreatment determination. First, a mother and her 16-year-old daughter argued, and the girl received an abrasion when the mother pulled her to her room. Two weeks later, and during the time when the child protection agency was regularly monitoring the family's case, the mother and daughter fought, and the mother bruised the daughter's head. The agency offered the family intensive, in-home services; the mother refused but signed a voluntary child placement agreement. Three weeks later, the child protection agency was told of an incident (perhaps from several months earlier) in which the mother pointed a gun at the daughter and threatened her; maltreatment was determined for this previous incident. Finally, the parents refused to allow the daughter to return home after her placement, so the county made a fourth determination of maltreatment--for neglect of the child.

Repeated maltreatment within a family sometimes involves different perpetrators, different victims, and different types of maltreatment. In such cases, it may have been especially difficult for the child protection agencies to foresee all of the risks for harm, since some of the problems that eventually became apparent differed considerably from those that were the subject of the original investigations:

Sometimes there are multiple victims, perpetrators, and types of maltreatment within a family.

- A county determined that a mother neglected her children (ages seven and ten) in May 1995 when she sent them home on their bikes alone while she stayed at a bar. In June 1995, one of these children was hit by his father's fiancee, resulting in bruises and a determination of maltreatment.

- Over a five-year period, a county made determinations of child neglect related to four separate reports against a mother of three children. The mother's boyfriend then allegedly physically abused one of the children, so all of the children went to live with their grandparents. Subsequently, the county determined that the grandfather physically abused the children.

- In 1995, a child protection agency determined that a mother neglected her four children, and it placed the children out-of-home. Previously, the county had determined that the mother's boyfriend sexually abused one of the children, and that the maternal grandparents neglected the children.

Some child protection staff think that investigations focus too narrowly on the alleged incidents.

Although patterns of maltreatment within families are sometimes complex, several county child protection staff we interviewed thought that their agencies could do a better job of identifying risks of repeated maltreatment and intervening to prevent it. ''We've become *observers* to the demise of children,'' said one child protection employee. Some staff thought that investigations and assessments were not sufficiently thorough due to staffing limitations, and some expressed concern that investigations can become too narrowly focused. For instance, they said that child protection workers sometimes restrict their investigations to determining whether or not an alleged incident did, in fact, occur, and this can result in too little attention being given to evidence of (1) other family problems that could pose a threat to children's safety, or (2) family strengths that could provide a foundation for addressing family problems. In the following example, a supervisor seems to have instructed staff to limit the scope of investigations:

- On January 4, 1995, a relative reported that a mother was physically abusing her nine-year-old son. The caseworker determined that neglect and threats of physical abuse occurred and closed the investigation January 27. The mother was not interested in protective services, so a case was not opened. Five days later, a school social worker called child protection to convey concerns that the boy had been physically abused. A note from a child protection supervisor expressed frustration about the new investigation: ''It is truly amazing how we as an agency can constantly intrude into the lives of families such as this without any statements or visible injuries. *If the original allegation does not indicate physical abuse issues, we should not be asking now*. If you have already interviewed the children and discussed the concerns of the original report with the parents, offer resources and close'' (emphasis added).

Child protection agencies' efforts to intervene with families are sometimes met with resistance. When this happens, the county is supposed to petition the court to require protective or other services on behalf of the children.[11] But some families move out of the county before investigations are completed, services are provided, or the court is petitioned:

- A Minnesota county received a report of child maltreatment in February 1995 and determined that a mother neglected her two-year-old son. The mother did not want chemical dependency treatment and the county determined that no protective services were needed. The county received another report of neglect in June 1995; the county determined that maltreatment occurred but that no services were needed because the mother had left the state. After the mother returned to Minnesota, the child protection agency determined in March 1996 that she again neglected her child, but this time she agreed to receive services. Following another neglect determination in December 1996, the mother again moved to another state with her child. The Minnesota county subsequently closed its child protection case, noting that the mother's chemical problems had continued and her risk of repeated maltreatment was high.

11 Minn. Rules 9560.0220, subp. 8.B.

- On October 3, 1995, a county placed two children (ages one and two) in an emergency shelter following a drug raid of their house. The county determined that the mother neglected her children, and the police arrested her for child endangerment. The child protection agency was going to monitor the family for two months to help determine a need for further services, but the case was closed October 23 when the mother moved to Illinois. When the mother returned to Minnesota in November, the county reopened the child protection case. The mother then moved to a neighboring Minnesota county in February 1996, which chose not to open a case.

Investigations and services sometimes end when families move to other counties or states.

- In 1994, a county investigated allegations that a mother smoked crack in front of her two-year-old son and left the child for long periods without adequate supervision. The mother and child moved from the state, so the county was unable to develop evidence to determine whether maltreatment had occurred. The mother returned to Minnesota, and her boyfriend was investigated for physical abuse of her six-month-old daughter (reported on April 8, 1995). The children were removed from the home but were returned April 16 after the mother got an order for protection against the boyfriend. The mother abandoned her infant the next morning (April 17). The child's father immediately travelled to Minnesota and offered to help the mother establish a good home for the children in another state. The abandoned child was returned to her parents on April 19. By 1996, the mother had returned to Minnesota and reported to a child protection agency that an ex-boyfriend had inappropriately touched her son. But the mother and family left the state again, preventing the county from interviewing the child and making a maltreatment determination.

When a family that is under investigation or receiving services moves to another county or state, the original child protection agency may refer the case to the child protection agency in the family's new location. But sometimes the family does not inform the original county that it has moved, or where it has moved. Also, there are no requirements that agencies in the new location provide services or continue previously-started investigations. And, as noted in Chapter 2, Minnesota counties do not have access to a statewide registry of maltreatment victims or perpetrators, so they may know little about the maltreatment history of a family that has recently moved into the county.

The safety of maltreated children can be affected by the thoroughness of county investigations, the effectiveness of services provided, and the willingness of counties to petition the courts in cases involving uncooperative families. It is difficult to conclusively evaluate county efforts solely by reviewing case files, which may not fully convey the information that agency staff had at the time they made key decisions. But we saw cases, such as the following, in which it was unclear to us that the counties made sufficient efforts on behalf of maltreated (or allegedly maltreated) children:

- On four separate occasions between 1991 and 1996, a county determined that a mother neglected her children by failing to provide adequate shelter,

In some cases, it was unclear whether adequate efforts were made to protect children following reports of maltreatment.

food, and supervision. The county attorney's office filed criminal neglect charges against the mother in mid-1996 but expressed concern that the child protection agency had never filed a CHIPS petition. In 1997, an assistant county attorney wrote: "The criminal court is clearly of the impression that [a CHIPS petition] ought to have already been filed. It does not make sense to [the criminal court judge] that such outrageous treatment of a child can merit the involvement of the criminal court system and yet not be brought to the attention of the juvenile court."[12]

- In November 1995, a severely disabled girl was admitted to a hospital with a fever and vaginal discharge. The child protection agency determined that the girl had been sexually abused, but it was unable to identify the perpetrator. In April 1996, the girl became ill and was not brought to the hospital by her parents until she was near death; this incident did not result in a child protection investigation. In May 1996, the child protection agency investigated a report of bruises on the girl's leg that were the result of an incident that occurred while she was in her parents' care, but the agency did not determine that maltreatment occurred because of the possibility that the injuries were accidental. In March 1997, the child protection agency found that someone apparently injured the girl by pulling her ribs until they protruded from her body, but it made no determination of maltreatment because the cause of the injury was unclear. Even if the county could not determine the perpetrators of these acts or whether they were accidental, it could be argued that this vulnerable child's caregivers neglected to provide her with a safe environment.

- On February 1, 1995, school staff expressed serious concern about a teenager who stole money to buy food, apparently because he did not get enough to eat at home. According to a school counselor, the boy's home situation was the most emotionally abusive environment she had seen in more than 20 years with the schools. Within days of receiving the report, the child protection agency closed the investigation without determining that maltreatment occurred, but it referred the family to a licensed therapist in order to better assess the emotional abuse. The mother was uncooperative, and the therapist refused to meet with her. Subsequently, the therapist referred the case back to child protection on March 16. This second report resulted in the boy being placed out of the home March 17, and the county agency's subsequent investigation determined that maltreatment occurred. The case file did not indicate that the home situation worsened between February 1 and March 16, so it is unclear why the first investigation ended so quickly, and without a maltreatment determination.

Sometimes it appeared to us that perpetrators were not required by the courts or by counties to demonstrate their competence as caregivers for a sufficiently long period of time before cases were closed or children were returned home. This

12 The assistant county attorney told us that judges may prefer to have cases handled as CHIPS cases because the juvenile courts often play an active role in developing and monitoring family case plans. In contrast, he noted, criminal courts often play a more limited role in determining the conditions of probation for offenders.

seemed particularly true in the case of chemically dependent caregivers. Some had abused drugs or alcohol for many years and had been in many treatment programs. Although chemical dependency treatment research has shown that relapses are common, some case plans only required perpetrators to demonstrate that they had completed treatment programs, not that they were ''clean and sober.'' Other plans required that perpetrators demonstrate sobriety, but often the period of monitoring was relatively short. Children who remained in the home were at risk of maltreatment when their chemically-dependent parents received ''second chances'' before chemical problems were addressed or ongoing drug testing was in place:

Chemically-dependent parents sometimes received "second chances" before their problems were addressed or ongoing monitoring was in place.

- A 24-year-old mother and her newborn child tested positive for cocaine in April 1995. The county determined that maltreatment occurred and provided protective services. The county closed the case in August 1995 although the mother was still using drugs and not following through on her chemical dependency treatment. At the time, county staff noted that the mother provided ''at least the minimum care for her two children.'' When the mother left the children alone and got drunk the next month, she agreed to voluntarily place her children in foster care. The children returned home in August 1996 after the mother completed a treatment program. Two months later, she refused to comply with aftercare and drug tests, and the children were placed in foster care again.

- The court placed four children out-of-home in 1994 following a determination of child neglect. The mother received various services, including treatment for chemical abuse. The children were reunited with the mother in 1995 (one in January, one in July, and two in November). Child protection continued to monitor the family until April 1996, when the case was closed. One of the children was beaten to death in 1997. The medical examiner's report indicated that the child had been subjected to long-term physical abuse, and court records indicated that the mother had apparently relapsed with her chemical problems during early 1996.

- A county determined that a mother neglected her three children in September 1990 after she drank too much and left them unattended. Pursuant to a CHIPS petition, the court placed the children--two with a maternal grandmother and one with a paternal grandmother. The court ordered the mother to obtain a chemical dependency assessment and heed the assessment's treatment recommendations. She did not complete the assessment until nearly a year later, and then she did not attend the alcohol treatment program to which she was referred. In the meantime, she had a fourth child, whom she abandoned several months after the birth. The court placed the child with the maternal grandparents. In October 1992, after the mother completed treatment, the court dismissed the CHIPS petition and returned three children to the mother (paternal grandparents were awarded permanent custody of the second youngest child in October 1993). In October 1994 and January 1995, the mother got drunk and abandoned the children, and both incidents resulted in maltreatment determinations. In June 1995, the court granted a new CHIPS petition and

placed the mother's three children with relatives and ordered chemical dependency and psychological assessments. A June 1996 report to the court indicated that the mother had not yet obtained the assessments and was still drinking. The mother gave birth to another child in October 1996, and she abandoned the child in both April and May 1997. The court placed the infant with a relative and again ordered assessments. At the time we reviewed the file, the mother was in a 90-day residential treatment program and her five children were in temporary or permanent living arrangements with family members.

- In 1989, a mother left her baby with drunk strangers at a party for three hours, resulting in a determination of maltreatment. In 1991, the county determined that the mother was too intoxicated to care for her child, but no services were provided because the family moved from the county. The mother moved back to the county, and in 1993 the county again found that she was too drunk to care for her children. The children were placed with an aunt and returned to the mother in 1994. In 1995, the child protection agency received a report that one of the children had lice and had missed a lot of school; the report also indicated that the mother had continuing chemical problems. The county determined that maltreatment had occurred, and the children were placed in foster care. Although the mother failed to complete a treatment program, the children were reunited with their mother in June 1996. The mother failed to complete a subsequent treatment program in 1996, and the case file noted new reports of lice problems in late 1996 and mid-1997.

In some cases we reviewed, it is possible that investigating agencies did not sufficiently reduce the risk of subsequent maltreatment by conducting proper assessments, communicating information to other agencies, or offering services to families. For example:

In some cases, investigating agencies did not take actions that might have reduced the risks to victims.

- A county was preparing to close a child protection case in 1996 after reuniting several children with their mother, but one of the children reported to her mother that her stepfather had molested her. Child protection staff subsequently ''rediscovered'' information in the family's child protection file that indicated that a local hospital had identified genital warts for one of the children in 1994--but an assessment of sexual abuse had never been conducted by the child protection agency. In 1996, the county made a determination of maltreatment for this 1994 abuse, but the file contained no indication that the county investigated in 1996 whether the sexual abuse victim's siblings were ever abused by this perpetrator. In 1997, one of these siblings told a counselor that she had been sexually abused by the man who abused her sister. The child protection agency did not make a maltreatment determination, noting that information on the incident was vague, and the incident may have occurred several years earlier. Furthermore, a purported eyewitness to the abuse was now refusing to discuss the matter with the child protection agency. In this case, the county's failure to conduct a timely investigation of sexual abuse could have put the victim and her siblings at further risk. In

addition, had a timely investigation uncovered allegations of abuse toward other siblings, it is possible that better evidence could have been developed to document maltreatment and intervene on behalf of the victims.

- In December 1995, a county child protection agency investigated possible neglect of a seven-year-old girl. When the agency did a criminal check on the girl's father, it discovered that he had been charged with child endangerment several months earlier for driving drunk with his two children in the car. Apparently, law enforcement had not reported this case to the county child protection agency, so no assessment of the family had been conducted and no services had been offered to the family.

Some of the families whose cases we reviewed were the subject of repeated investigations, determinations, and services over a period of many years. There is no statewide database that indicates the length of time a given child protection case was open, nor the cumulative time that cases for one family were open over a period of years. But child protection agencies sometimes intervene with individual families over periods of many years, with child victims sometimes growing up to become adult perpetrators:

Child victims sometimes grow up to become adult perpetrators.

- A family with three children was the subject of numerous child protection investigations for neglect, physical abuse, and sexual abuse between 1979 and 1996. The child protection agency offered protective services many times during this period, but the family sometimes refused to participate and the county sometimes closed the case when the family reached a ''minimally acceptable'' level of functioning and further services were considered futile. At several times when cases were closed, staff notes commented that the family was likely to be reported for problems again soon--and it was. In 1995, the county investigated allegations that the oldest daughter--a victim in previous reports--was neglecting her one-month-old child. She voluntarily transferred legal custody of the child to her aunt in 1996, by which time she was pregnant again.

Laws enacted by the U.S. Congress and Minnesota Legislature in 1997 were intended to shorten the amount of time that the courts have for making permanent placement determinations for children placed out-of-home.[13] It will take time to determine whether the laws have the intended impact. In cases where children have *not* been placed outside their homes by the courts, families could still be the subject of repeated child protection investigations, determinations, and services, perhaps over many years. But it is likely that the new laws would have expedited the child placement process in some of the cases discussed above, perhaps resulting in faster permanent removal of children from high-risk homes.

In the files we reviewed, we saw cases where the eventual consequences of repeated maltreatment determinations for some parents were very serious, including criminal prosecutions, placement of children away from home, and termination of parental rights. Overall, however, it seemed to us that:

13 P.L. 105-89, signed by President Clinton in November 1997, and *Minn. Laws* (1997), ch. 239, art. 6.

- **Children in some families could probably be more effectively protected from repeated maltreatment:**

  1) **if counties had better methods of identifying the types of cases in which repeated maltreatment is most likely to occur, as dis - cussed in Chapter 2 and earlier in Chapter 3;**

  2) **if child protection agencies and courts monitored the behavior of high-risk families for longer periods, with caseplans that in - cluded behavior-related goals (e.g., sobriety) rather than only process-related goals (e.g., completion of programs);**

  3) **if family assessments focused broadly on the problems and strengths of families, not solely on investigating the incidents that led to the initial allegations; and**

  4) **if counties petitioned the courts more quickly in some cases in - volving non-compliant families.**

Improved assessment, intervention, and monitoring might protect children more effectively.

We recognize that current county and court practices may reflect constraints on their staff and budgets. For instance, counties probably conduct narrow investigations of particular incidents partly because these require less staff time than broad-based family assessments. Likewise, increasing the number of cases with CHIPS petitions would increase the workloads of the county attorneys who file these cases and the child protection staff who monitor them. In Chapter 5, we discuss staffing issues in child protection agencies more fully.

SUMMARY

Minnesota does not have child protection information systems that make it possible to readily determine whether a family has been the subject of maltreatment determinations or investigations in more than one county. This limited our ability to comprehensively evaluate rates of repeated maltreatment statewide. But we did find that 18 percent of families who were the subject of maltreatment determinations had another determination in the same county within three years, and 29 percent of families who were the subject of maltreatment investigations were again investigated in that county within three years. We think it is possible that some instances of repeated maltreatment could be prevented through more aggressive or long-term interventions by child protection agencies or the courts.

Perceptions About The Child Protection System

CHAPTER 4

There is no statewide consensus on how to measure the effectiveness of Minnesota's child protection system, and there are limited existing data that could be used for this purpose. In Chapter 3, we examined the incidence of repeated maltreatment as one way of measuring whether the child protection system is effectively meeting the goal of protecting children.

In the absence of additional measures of the system's performance, it is valuable to consider whether the people who work closely with the child protection system believe that it is operating effectively. We surveyed several groups of professionals required by law to report instances of suspected maltreatment—pediatricians, school social workers, and heads of local law enforcement agencies. We also surveyed district court judges, who hear court cases involving some of the families for whom maltreatment has been determined, and county human service directors, who administer child protective services. We asked:

- **Do mandated reporters feel well-informed about the outcomes of the cases they have reported and the criteria used by counties to screen cases?**

- **Do those who work closely with child protection agencies believe that interventions have been effective and that decisions have been consistent?**

- **How do child protection agencies balance the goals of child safety and family preservation?**

- **Do child protection and law enforcement agencies have good working relationships, and are their investigations considered to be thorough?**

- **What do child protection agencies identify as the most important unmet service needs? Do budget considerations affect the decisions made by their staff?**

We surveyed several types of professionals who work closely with child protection agencies.

The response rates of all of the surveyed groups were relatively high—68 percent for pediatricians, 85 percent for school social workers, 89 percent for judges, 99 percent for law enforcement officials in counties and cities with more than 10,000 population, and 100 and 98 percent for the two surveys of county human services directors.[1] In our view, these rates are high enough to indicate that survey respondents are generally representative of their colleagues statewide. Still, it is important to consider that some of these groups are more heavily concentrated in the seven-county Twin Cities area than others. In particular, about 71 percent of the surveyed pediatricians worked primarily in a metropolitan area county, compared with about 56 percent of the school social workers, 39 percent of the law enforcement officials, and 8 percent of the county human services directors. About 7 percent of the surveyed judges were from the second and fourth judicial districts, representing Ramsey and Hennepin counties; judges serving the other five counties in the Twin Cities region are part of judicial districts that include non-metropolitan counties, too.

We found that some of the people who work most closely with the child protection system lack confidence in its ability to intervene effectively on behalf of children. In addition, many of the "mandated reporters" believe that child protection agencies do not have clearly articulated standards, are inconsistent in decisions, and do not provide feedback about the victims and their families to the reporters. Child protection and law enforcement agencies generally believe they have forged cooperative relationships with each other, and other observers agree. Most judges said that child protection agencies sometimes give parents too many "second chances," and many think that budget considerations are sometimes a factor in agency decisions. Finally, we found no clear consensus among various groups when we asked them whether child protection agencies' practices seem to give priority to the safety of children or to the preservation of families.

In the following sections, we have only reported survey results for those respondents who have had recent involvement with the child protection system. For example, about one-third of the pediatricians who responded to our survey said they had not made a maltreatment report during the previous two years, and about 9 percent of school social workers said they had not

1 We sent surveys to all of Minnesota's pediatricians, sheriffs in counties with over 10,000 population, and police chiefs of cities over 10,000. For school social workers, we mailed surveys to a systematic sample (two-thirds of state's total school social workers), and the responding sample was large enough to keep sampling error to +/- 3 percentage points in 95 of 100 cases. We sent our survey to all district court judges in counties other than Ramsey and Hennepin, but we limited our analysis to those who said they had heard at least five maltreatment-related cases in the prior two years. In Ramsey and Hennepin counties (districts 2 and 4, respectively) we sent our survey to judges that court staff identified for us as having heard child protection cases during the previous two years.

made a report during this time. We generally did not consider their responses when calculating survey results.[2] Likewise, the responses of pediatricians and school social workers who had not recently reported any cases of suspected sexual abuse, for example, were not considered in questions related to the county's handling of sexual abuse cases. All respondents were asked to answer survey questions based on their experiences during the previous two years.

Although we think our survey findings generally reflect statewide opinion for these groups of professionals, the findings for subgroups should be considered with more caution. For this reason, and to protect the identity of survey respondents, the only individual counties for which we have separately reported results are the state's two most populous counties (Hennepin and Ramsey).

Our surveys often asked respondents to indicate the relative frequency of events. For instance, we asked various professionals to indicate whether county child protection agencies "always or almost always," "usually," "sometimes," or "rarely or never" conducted thorough investigations of maltreatment cases. Because child protective services affect the health and welfare of children, it is worth noting that there may be times when "usually" conducting thorough assessments may not be sufficient. Our analysis of the surveys conveys general, statewide perceptions about how the child protection system is performing, but it is possible that even infrequent or isolated problems could lead to serious consequences for individual children.

COMMUNICATION BETWEEN CHILD PROTECTION AGENCIES AND MALTREATMENT REPORTERS

Many professionals said they are not adequately informed about county screening criteria.

Anyone can report suspected child maltreatment to a child protection or law enforcement agency, but the child protection system relies considerably on people mandated by state law to report abuse and neglect. For example, pediatricians see children daily and are trained to recognize signs of physical or emotional problems. School social workers often work with teachers and other school staff to identify and respond to the needs of students who have problems at home. Although counties have trained many mandated reporters to help them understand their responsibilities, our surveys indicated that:

- **Large percentages of pediatricians and school social workers said they are not adequately informed about child protection agencies' criteria for screening allegations of maltreatment.**

2 The percentages shown in this report usually indicate the percentages of all respondents who said they had reported maltreatment in the previous two years, including any who responded "don't know" to a question or left it unanswered. We *did* examine the responses of pediatricians and social workers who had not reported any cases of maltreatment for one question that asked whether the respondents had ever considered not reporting instances of suspected maltreatment.

For example, Table 4.1 shows that 21 percent of school social workers and 38 percent of pediatricians statewide said that they have "rarely or never" been adequately informed about county screening criteria for physical abuse. Conversely, only 23 percent of school social workers and 13 percent of pediatricians said they have "always or almost always" been adequately informed about these criteria.

Table 4.1 shows that respondents who primarily report cases to Ramsey County were much more likely to report that they were adequately informed

Table 4.1: Pediatricians' and School Social Workers' Knowledge of County Child Protection Screening Criteria

Percent responding to survey question: "In your judgment, have county child protection employees adequately informed you about the criteria they use to decide which reports they will (or will not) investigate/assess?"

Respondents and Categories of Maltreatment	Always or Almost Always	Usually	Sometimes	Rarely or Never	Don't Know
Pediatricians: All Counties					
Physical abuse (*N*=184)	13%	20%	25%	38%	4%
Sexual abuse (*N*=141)	15	31	23	26	4
Neglect (*N*=132)	11	24	24	38	2
Pediatricians: Hennepin County					
Physical abuse (*N*=68)	3	27	27	38	6
Sexual abuse (*N*=50)	10	30	28	26	6
Neglect (*N*=50)	8	22	30	34	4
Pediatricians: Ramsey County					
Physical abuse (*N*=23)	35	13	17	30	4
Sexual abuse (*N*=20)	30	30	10	20	10
Neglect (*N*=18)	22	28	17	28	6
School Social Workers: All Counties					
Physical abuse (*N*=373)	23	34	21	21	0
Sexual abuse (*N*=267)	25	31	20	21	2
Neglect (*N*=324)	21	30	22	25	1
School Social Workers: Hennepin County					
Physical abuse (*N*=120)	23	37	26	13	1
Sexual abuse (*N*=84)	24	37	24	12	2
Neglect (*N*=90)	18	34	28	18	0
School Social Workers: Ramsey County					
Physical abuse (*N*=49)	43	37	16	4	0
Sexual abuse (*N*=35)	37	34	20	6	3
Neglect (*N*=42)	29	36	19	17	0

NOTE: The number of respondents shown for Hennepin and Ramsey counties is the number of respondents who listed these counties as the ones they most often made reports to in the previous two years.

SOURCE: Program Evaluation Division surveys, August-September 1997.

about screening criteria than respondents reporting to Hennepin County and the state as a whole. For example, 43 percent of Ramsey County school social workers said they were "always or almost always" informed about screening criteria for physical abuse, compared with 23 percent statewide and in Hennepin County. Relatively few Hennepin County pediatricians said they had sufficient information on county screening criteria. For instance, only 3 percent of the Hennepin County pediatricians reported that they have "always or almost always" felt adequately informed about the county's screening criteria for physical abuse.

If the professionals who work regularly with the child protection system have limited knowledge about the maltreatment criteria used by counties, we think it is safe to assume that the general public knows even less. As we discuss in Chapter 7, there seems to be a need for child protection agencies to communicate information about screening criteria more effectively to community professionals and the general public.

Understandably, people who report instances of suspected maltreatment like to find out whether their concerns were validated by investigators and how the safety of the child was addressed. According to state law, "any person mandated to report shall receive a summary of the disposition of any report made by that reporter, unless release would be detrimental to the best interests of the child."[3] But, we found that:

- **Most pediatricians and school social workers said they have usually not been informed about the disposition of maltreatment reports.**

As shown in Figure 4.1, about 70 percent of pediatricians and 54 percent of school social workers said they were "sometimes, rarely, or never" informed about report dispositions. Conversely, only 18 percent of school social workers and 13 percent of pediatricians said that they were "always or almost always" informed about case dispositions. Respondents who reported cases primarily to Hennepin County were less likely to say they received case disposition information than respondents who reported to Ramsey County. For example, 63 percent of pediatricians primarily serving Hennepin County said that they were "rarely or never" informed about the disposition of reports, compared with 24 percent of pediatricians reporting cases to Ramsey County.

Our surveys offered respondents an opportunity to suggest ways to improve child protective services, and improvement in communication to mandated reporters was the change most frequently requested in the surveys of school social workers and pediatricians.[4] Their comments included the following:

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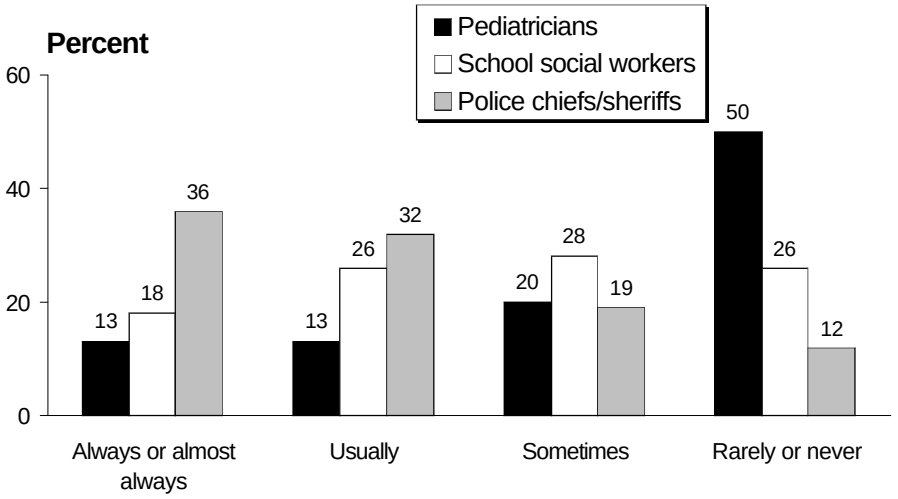
3 *Minn. Stat.* §626.556, subd. 3 (d).

4 About 17 percent of school social workers and 15 percent of pediatricians offered comments about communication issues.

Many mandated reporters said they are not routinely told about the disposition of cases they report.

Figure 4.1: Percentage of Professionals Informed About Disposition of Reports



SOURCE: Program Evaluation Division surveys, August-September 1997 (N=225 pediatricians, 385 school social workers, and 147 police chiefs/sheriffs).

"Too often school staff report abuse but the county is unable to give feedback because of policies on confidentiality. It would work well to include school staff [in] the investigation process as a consultant." (School social worker in the Twin Cities area)

"The first year I worked in this position I did not meet with child protection workers on a regular basis. This made my job harder (and perhaps their's) because we did not know where we stood when it came to policies, procedures, etc. The second year we met monthly to discuss reports, community agencies, etc. and this was a vital meeting to open communication lines between the social workers in the county and the schools. This is one thing I would like to see continue in all communities." (School social worker in east-central Minnesota)

"It would be nice to know what is going on. When I see a child for a medical consultation, I send a report to the referring physician. I receive no follow-up on patients I report [to child protection] with possible neglect/abuse." (Pediatrician in the Twin Cities area)

"[I would like] for the county to return courtesy calls, saying that the case is being looked into or they have enough evidence. Sometimes more school information can be given. We need to realize that school and county are working with the same kids—so work together!" (School social worker in west-central Minnesota)

"[There needs to be] better communication between reporting physician and [child protection] agency. Follow-up reports of investigation and on-going involvement of physician in management are important to the health care of the child." (Pediatrician in the Twin Cities area)

School social workers and pediatricians often told us they would like better communication with child protection agencies.

"[Child protection workers] often forget that we have the same skills [and] background [that they do] and want what's best for the child. They need to let us know immediately what the plan is for the safety of the child since we work with them daily." (School social worker in the Twin Cities area)

"Improve communication among child protection, law enforcement, and medical providers. There exists a climate of suspicion and mistrust, not in the best interests of the children." (Pediatrician in central Minnesota)

"[Make it possible] for [child protection] workers to be able to communicate more broadly to school social workers to better ensure the safety of students. Confidentiality should be granted/included for school social workers (when appropriate) regarding case determination, [which would enable the school social worker] to better respond and serve the student in question." (School social worker in the Twin Cities area)

In Chapter 7, we offer recommendations for changes in law to improve communication between child protection agencies and mandated reporters. In addition, it is possible that state rules contribute to the lack of communication about disposition of reports. Contrary to the law requiring that mandated reporters be informed about case dispositions, state rules indicate that mandated reporters shall receive case disposition summaries "upon request."[5] The Department of Human Services is in the process of amending state rules to address this discrepancy, and it expects the amended rules to be adopted in early 1998.

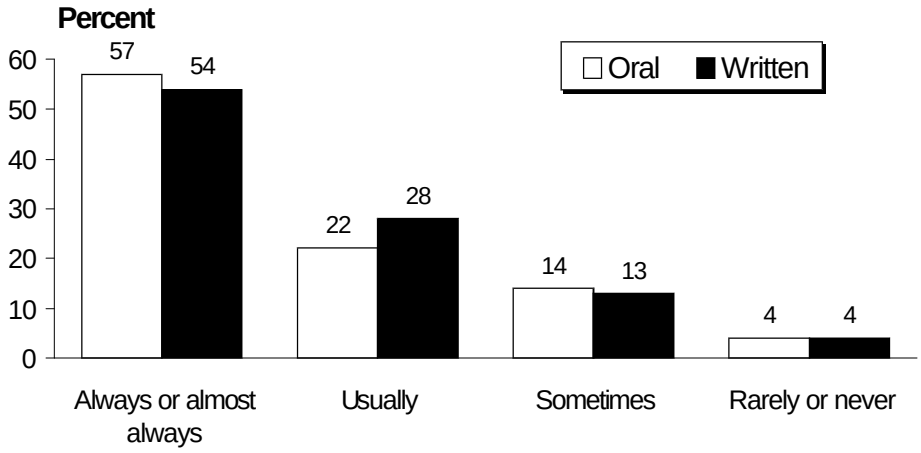
A final communication issue that our survey examined was the speed with which child protection and law enforcement agencies notify each other about reports of maltreatment. State rules require child protection agencies to notify law enforcement agencies orally *and* in writing within 24 hours of receiving a report of maltreatment.[6] As shown in Figure 4.2, the heads of local law enforcement agencies told us that this typically happens, but there is room for improvement. We received similar responses from county human services directors when we asked them whether law enforcement agencies "promptly" notified their agencies about maltreatment allegations. Fifty percent said "always or almost always," 37 percent said "usually," and 12 percent said "sometimes."

5 *Minn. Rules* 9560.0226, subp. 2. The rules require that reporters be informed about the nature of the determined maltreatment and services provided, where applicable.

6 *Minn. Rules* 9560.0216, subp. 4.

Sheriffs and police chiefs said child protection agencies typically notify them about maltreatment allegations within 24 hours.

Figure 4.2: Percentage of Law Enforcement Agencies Receiving Prompt Notification



SOURCE: Program Evaluation Division survey of law enforcement officials, August-September 1997 (N=147).

EFFECTIVENESS OF CHILD PROTECTION INTERVENTIONS

Our surveys asked a variety of questions that helped us evaluate whether the respondents perceived the child protection system to be effective. This section begins by examining a general measure of mandated reporters' confidence in the child protection agencies to which they are required to report suspected maltreatment. In addition, we examined the perceptions of various professionals about the adequacy of investigations, the appropriateness of interventions, and the consistency of actions by child protection agencies.

Mandated Reporters' Confidence in Child Protection Agencies

Some mandated reporters have considered not reporting instances of suspected maltreatment.

To have an effective child protection system, county child protection agencies need the confidence of the professionals who submit reports of possible maltreatment. Persons who report instances of suspected maltreatment want county agencies to take their reports seriously. When appropriate, they want these cases to be investigated thoroughly and they want actions taken to ensure the safety of the children. Our surveys indicated that:

- **About 45 percent of school social workers and 18 percent of pediatricians statewide said they have considered not reporting an**

instance of suspected maltreatment during the past two years because they thought the child protection agency would not respond appropriately.

- **Thirty-six percent of pediatricians who have primarily reported cases to Hennepin County child protection said they considered not reporting at least one case of suspected maltreatment; 33 percent of pediatricians who have mainly reported cases to Ramsey County said the same.**

School social workers and pediatricians are mandated by law to report maltreatment. Failure to report suspected maltreatment is a misdemeanor in Minnesota law, so the fact that many reporters said they have considered not reporting indicates a serious lack of confidence in child protection agencies.[7]

Perceptions About Investigations

We asked pediatricians, school social workers, law enforcement officials, and judges to evaluate the thoroughness of child protection agency investigations. Many respondents to our surveys acknowledged the difficult jobs that child protection staff perform. As one pediatrician noted, "Often the [accounts of alleged maltreatment given by] two parents are widely divergent and a multitude of issues intertwine. I appreciate the work [child protection staff] do." But, as shown in Table 4.2, the surveys indicated that:

- **Pediatricians and school social workers expressed concern about the way child protection agencies screened and investigated cases, particularly cases involving suspected child neglect.**

Many mandated reporters expressed concern about the responsiveness of child protection agencies.

For example, a majority of school social workers (54 percent) and a large percentage of pediatricians (38 percent) said that child protection agencies "sometimes, rarely, or never" conducted thorough investigations of child neglect. In our view, the perceptions of pediatricians and school social workers merit particular consideration because they work directly with the alleged victims and many have been specially trained to recognize maltreatment. Some of the concerns raised by pediatricians and school social workers included the following:

> "[There is a need to] address the issue of child neglect and make it more reasonable for county social services to become involved; it seems to be a third priority, compared to physical and sexual abuse." (School social worker in southeastern Minnesota)

> "I don't report neglect unless I believe there is a true problem. I've come to believe someone has to die before [child protection staff] pay attention. We [refer cases to] public health more and more because child protective services never feels reports [can be] substantiated." (Pediatrician in western Minnesota)

7 *Minn. Stat.* §626.556, subd. 6.

Law enforcement staff and judges had more favorable perceptions of county investigations than did pediatricians and school social workers.

Table 4.2: Perceptions About County Screening Decisions and the Thoroughness of Child Protection Investigations

Have Child Protection Agencies:	Pediatricians (*N* = 225) Always or Usually	Pediatricians (*N* = 225) Sometimes, Rarely, or Never	School Social Workers (*N* =385) Always or Usually	School Social Workers (*N* =385) Sometimes, Rarely, or Never
Made reasonable decisions about which cases to investigate?				
Physical abuse	56%	30%	58%	39%
Sexual abuse	65	21	65	27
Neglect	49	38	42	51
Conducted thorough investigations/assessments?				
Physical abuse	48	29	45	44
Sexual abuse	62	20	55	31
Neglect	45	38	33	54

	Police Chiefs and Sheriffs (*N* = 147) Always or Usually	Police Chiefs and Sheriffs (*N* = 147) Sometimes, Rarely, or Never	Judges (*N* = 140) Always or Usually	Judges (*N* = 140) Sometimes, Rarely, or Never
Conducted thorough assessments?	91%	6%	77%	15%

NOTE: Pediatricians and school social workers were asked to evaluate screening decisions and investigations for all three categories of maltreatment. Law enforcement officials and judges were only asked a general question about the thoroughness of investigations.

SOURCE: Program Evaluation Division surveys, August-September 1997.

"We have students who miss one-third to one-half of the school year and are excused by the parent for various reasons. Even when school personnel try multiple interventions with the family and get no response, county social services will not intervene." (School social worker in northwestern Minnesota)

"I think every case reported by a physician should have more thorough investigation—more than one visit—and check again in six months or so. Too many cases about which I was very concerned have been completely dropped after one home visit." (Pediatrician in the Twin Cities area)

"[The county is] less inclined to investigate when the children are older, i.e. [ages] 14-15. There have been times when scared children of this age have reported, but because there were no obvious physical injuries, a social worker did not even come out to talk with them. I wish that when these children take the risk of reporting, they would at least get to talk to a county social worker." (School social worker in the Twin Cities area)

"[School officials] have a big picture on the situation and would not report if we did not believe it to be VERY serious. The simple criteria of only accepting a report based on actual physical signs of abuse misses a

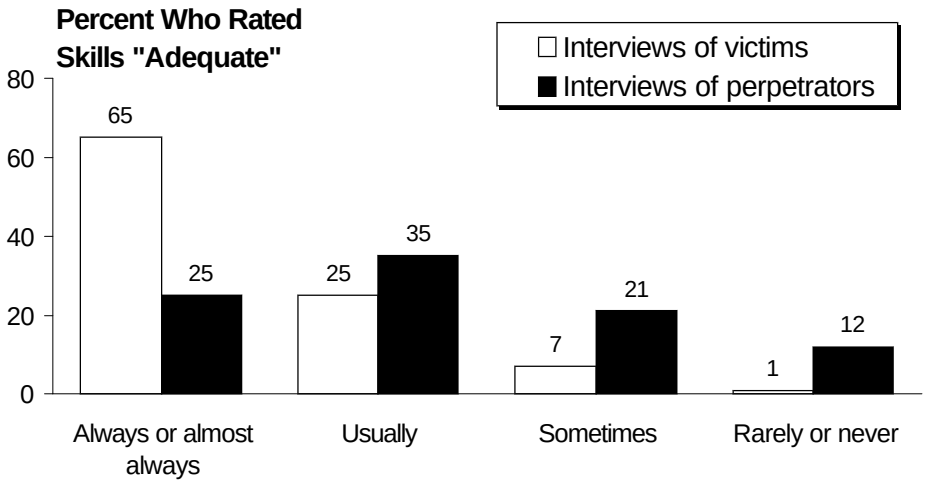
> whole spectrum of children and families in need." (School social worker in the Twin Cities area)

Table 4.2 also indicates that most law enforcement agencies (91 percent) and judges (77 percent) said that child protection agencies "usually" or "always" investigated cases thoroughly. These favorable ratings are encouraging. On the other hand, however, law enforcement agencies tend to work with child protection agencies on certain types of cases—primarily those where there is a possibility of criminal behavior—and they may have little knowledge about child protection agency practices in cases that are "screened out" (that is, not investigated). Judges are most familiar with maltreatment cases that come to the court through a CHIPS petition, but they would usually not be aware of cases that did not result in a determination or a CHIPS petition.

Although law enforcement officials expressed general satisfaction with the investigations done by child protection agencies, three topics were cited by at least 10 police chiefs or sheriffs in our survey as areas needing improvement. First, police chiefs and sheriffs said that child protection staff would benefit from additional training. For instance, they said that child protection staff were more skilled in interviewing alleged maltreatment *victims* than in interviewing alleged *perpetrators*, as shown in Figure 4.3. Second, some chiefs and sheriffs said there is a need for additional child protection staff. They expressed special concern that many child protection staff are not available during weekends and evenings when law enforcement staff need

Law enforcement officials said child protection staff were better interviewers of alleged victims than of alleged perpetrators.

Figure 4.3: Law Enforcement Satisfaction with Child Protection Agency Interview Skills



SOURCE: Program Evaluation Division survey of law enforcement officials, August-September 1997 (*N*=147).

their advice or assistance.[8] Third, some chiefs and sheriffs expressed a desire for better communication by child protection agencies about maltreatment allegations, family maltreatment histories, and case dispositions.

Table 4.3: County Human Service Directors' Perceptions About the Adequacy of Law Enforcement Investigations

Human services directors said that law enforcement agencies often give insufficient attention to cases of child neglect.

	Percentage of Directors Who Said That Law Enforcement Has Given Sufficient Attention to Investigations of These Cases			
Type of Maltreatment	Always or Almost Always	Usually	Sometimes	Rarely or Never
Physical abuse	56%	27%	17%	0%
Sexual abuse	73	23	4	0
Child neglect	31	29	31	10

SOURCE: Program Evaluation Division surveys, September 1997 (*N* = 82).

We asked county human services directors to evaluate whether law enforcement agencies have given sufficient attention to various types of maltreatment cases. As shown in Table 4.3, the directors gave generally high ratings to law enforcement agencies' investigations of sexual abuse cases, with lower ratings for physical abuse cases and still lower ratings for neglect cases. Less than one-third of the directors said that law enforcement agencies "always or almost always" give sufficient attention to investigations of child neglect.

Finally, we asked human services directors to evaluate their own child protection agencies' investigations/assessments. Directors from all counties said that they "always" or "usually" adequately document evidence related to maltreatment allegations, but they said they have been somewhat less likely to document families' *strengths* as part of the assessment process.[9] A recent child protection casework handbook by the American Humane Association strongly urged staff to "complete the assessment of clients' strengths as rigorously as you do risks and problems," so this, too, may be an area where Minnesota counties have room for improvement.[10]

8 Eleven percent of chiefs and sheriffs said that child protection staff were "sometimes, rarely, or never" available *during regular business hours* "at the times we needed them;" 39 percent said they were "sometimes, rarely, or never" available *after regular hours*.

9 Among the directors, 31 percent said their agencies "always or almost always" adequately document family strengths, 42 percent said they "usually" do, 27 percent said they "sometimes" do, and 1 percent said they "rarely or never" do. By comparison, 66 percent said that their agencies "always or almost always" adequately document evidence related to maltreatment allegations, and 34 percent said they "usually" do.

10 American Humane Association, *Helping in Child Protective Services: A Competency-Based Casework Handbook* (Englewood, CO, 1992), 198.

Perceptions About Interventions

Effective child protection agencies take actions that are *appropriate* to the circumstances of the families with which they work. Early in our study, some legislators expressed concerns to us about the considerable discretion of child protection staff to intervene in the lives of troubled families. Some thought that child protection staff seek placements too quickly or before alternative approaches have been explored. In contrast, others thought that parents received too many "second chances" or that children were reunified with parents too quickly following out-of-home placements.

We asked pediatricians, school social workers, and law enforcement officials whether child protection agencies had taken appropriate steps to protect maltreatment victims from further harm.[11] Table 4.4 shows that:

- **Pediatricians and school social workers expressed concern about the adequacy of child protection interventions, especially for victims of child neglect. In general, law enforcement officials said that child protection agencies have usually taken appropriate steps.**

Some of the written comments made by pediatricians and school social workers in our surveys suggested that employees of child protection agencies should not shoulder all the blame for inappropriate interventions. For example, many survey respondents cited a need for smaller child protection caseloads and more services (discussed in Chapter 5), and some said that the actions of courts or county attorneys allowed children to remain in high-risk families. The comments included the following:

Table 4.4: Perceptions of Pediatricians, School Social Workers, and Law Enforcement Heads About Child Protection Interventions

	Percentage Who Said That Child Protection Agencies Have Taken Appropriate Steps To Protect Victims From Further Harm:					
	Pediatricians		School Social Workers		Law Enforcement	
	Always or Usually	Sometimes, Rarely, or Never	Always or Usually	Sometimes, Rarely, or Never	Always or Usually	Sometimes, Rarely, or Never
Physical abuse	51%	30%	48%	42%	91%	8%
Sexual abuse	59	23	53	33	93	6
Neglect	39	45	33	55	85	9

SOURCE: Program Evaluation Division surveys, August-September 1997 (*N* = 225 pediatricians, 385 school social workers, and 147 law enforcement officials).

11 We also asked law enforcement officials whether child protection agencies have taken appropriate steps within their control to protect the well-being of siblings of maltreatment victims. Fifty-two percent said "always or almost always," 26 percent said "usually," 8 percent said "sometimes," and 1 percent said "rarely or never."

Many survey respondents said that interventions into troubled families could be more effective.

"There are wonderful child protection workers. However, if a case is already open, and I make a maltreatment report, I feel it just gets handed to the existing caseworker as information for that worker. Often that worker is more family- or parent-focused (due to parents volunteering for services) and the needs of the child go unmet!" (School social worker in the Twin Cities area)

"Child protection workers are extremely limited in their ability to "service" families. I often find that the length of their involvement with families is so short-term that it is often limited to meeting the family, discussing the suspected maltreatment, and providing very limited follow-up—sometimes one to two visits." (School social worker in the Twin Cities area)

"The county attorney doesn't seem to be accountable to anyone. He/she makes what seems like a subjective decision and that is the end of it. Especially in small, rural counties it seems like the child protection social workers' hands are tied. They can only do so much with their resources. Nothing ever seems to get better, even after multiple reports. How bad do things need to be for children before their parents are forced to shape up?" (School social worker in western Minnesota)

"I work with children who have chronic and complicated problems. If parents are neglectful, it is hard for child protection to commit the needed time to follow up with families and ensure proper care for the child." (Pediatrician in the Twin Cities area)

"The [child protection] worker makes [service] recommendations but cannot follow up to see if the family followed through or not. The workers need to be on certain cases longer." (School social worker in southern Minnesota)

"My understanding is that unless a situation is severe enough to warrant court action, [child protection workers] have no leverage and therefore can do very little. I don't know if this is what prevents them from acting. Also, there are so many cases that they seem overwhelmed." (School social worker in the Twin Cities area)

"My understanding from the police department is that 100 percent of the children [that] we place through the emergency department, despite our findings, have been returned to the families. There must be a more effective way of protecting children who are obviously abused and/or neglected." (Pediatrician in the Twin Cities area)

We also asked district court judges a variety of questions about child protection interventions. Judges hear petitions related to out-of-home placements and terminations of parental rights, for example, so they should have a useful perspective on whether counties seem to be seeking these actions in appropriate circumstances. Table 4.5 displays selected results. We found that:

- **Minnesota judges generally do not believe that child protection staff have been too intrusive in the lives of families, and they generally believe that child protection staff have appropriately**

Table 4.5: Judges' Perceptions About Child Protection Agencies' Interventions

Survey Question	Percentage of Judges Who Responded: Always or Almost Always	Usually	Sometimes	Rarely or Never	Don't Know
Have child protection staff been too intrusive in the lives of families in:					
Cases involving physical abuse?	1%	0%	19%	69%	10%
Cases involving sexual abuse?	0	1	11	79	9
Cases involving child neglect?	0	1	25	64	9
Have child protection staff pursued termination of parental rights before making reasonable efforts to preserve families?	1	1	9	86	3
Have child protection staff pursued substitute care before making reasonable efforts to prevent out-of-home placement?	2	13	23	54	9
Have child protection staff given parents too many "second chances" before deciding to seek termination of parental rights?	6	15	54	19	5
Have child protection staff given parents too many "second chances" before deciding to seek substitute care?	1	9	54	27	7

SOURCE: Program Evaluation Division survey, August-September 1997 (*N* = 140).

pursued other options before recommending child placements or terminations of parental rights.

- **The majority of judges think that child protection staff "sometimes" (or more frequently) have given parents too many "second chances."**

Many judges think parents sometimes get too many "second chances."

To state these findings in a different way, judges were more likely to think that child protection agencies have been too timid in their actions than to think they have been too aggressive. For example, 54 percent of judges said that child protection staff "sometimes" give parents too many second chances before seeking termination of parental rights, and another 21 percent said that parents "usually" or "always" get too many second chances.

Our surveys asked several additional questions about out-of-home placements. For example, law enforcement agencies have authority to take a child into

immediate custody when the child's health or welfare is endangered.[12] We asked human services directors whether law enforcement agencies have made appropriate decisions in these cases, and 88 percent said that they "always" or "usually" have.[13]

Child protection agencies may petition the courts to remove children from their homes. The agencies may present "emergency petitions" if there is "immediate and present danger" of child abuse, or they may petition the courts for longer-term placements. More than 90 percent of judges told us that child protection agencies have "always" or "usually" provided the court with sufficient supporting evidence to justify the placements.[14]

Finally, we asked law enforcement officials whether child protection agencies have adequately monitored the safety and well-being of children placed in substitute care. Seventy-two percent said that child protection agencies "always" or "usually" provide adequate monitoring, and most of the other law enforcement heads did not know whether monitoring was adequate.[15]

Perceptions About Consistency

In Chapter 2, we noted that statutory definitions of maltreatment are quite vague, and many counties do not have policies that supplement the statutes to help them make important child protection decisions. We observed that this has contributed to variations in practices among counties. Our surveys asked various professionals to evaluate the consistency of child protection decisions and practices. As shown in Table 4.6,

- **Pediatricians and school social workers think that child protection workers often use inconsistent criteria to make decisions.**

- **Law enforcement officials believe that child protection staff typically use consistent approaches to investigate cases.**

- **Judges think that child protection staff generally have consistent ways of evaluating which children should be recommended to the court for placement in substitute care.**

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12 Minn. Stat. §260.165, subd. 1 (c).

13 Thirty-nine percent said "always or almost always," 49 percent said "usually," 11 percent said "sometimes," and 1 percent said "rarely or never."

14 For emergency removals, 61 percent of judges said "always or almost always," 31 percent said "usually," 3 percent said "sometimes," and 1 percent said "rarely or never." For non-emergency removals, 46 percent of judges said "always or almost always," 44 percent said "usually," 5 percent said "sometimes," and 2 percent said "rarely or never."

15 Forty-nine percent said "always or almost always," 23 percent said "usually," 4 percent said "sometimes," and 1 percent said "rarely or never."

Table 4.6: Perceptions About the Consistency of Child Protection Practices

Child Protection Staff	Percentage of Respondents Who Said Always or Usually	Sometimes, Rarely, or Never	Don't Know	Survey Respondents
Use consistent criteria to make decisions.	38%	50%	12%	School social workers
	26	42	29	Pediatricians
Are consistent in the way they investigate cases.	87	10	2	Law enforcement officials
Have consistent ways to evaluate which children need substitute care.	62	15	23	Judges

SOURCE: Program Evaluation Division surveys, August-September 1997 (*N* = 385 school social workers, 225 pediatricians, 147 law enforcement officials, and 140 judges).

The differing responses probably partly reflected the fact that we asked the various groups of respondents to evaluate different aspects of child protection work. For example, we asked judges to evaluate consistency for the small subset of child protection cases where substitute care is considered, but we asked pediatricians and school social workers a more broadly-stated question about the various types of decisions that child protection staff make. Also, we asked law enforcement officials about the consistency of investigative methods used, not the consistency of the eventual decisions.

GOALS OF CHILD PROTECTION AGENCIES

Nationally and in Minnesota, there has been considerable debate about what the goals of the child protection system should be. On the one hand, Minnesota rules state that the purpose of child protective services is to "protect children from maltreatment," and state law says that the "paramount consideration in all [court] proceedings concerning a child alleged or found to be in need of protection or services is the best interests of the child."[16]

But there has been significant emphasis on "family preservation" since passage of the federal Adoption Assistance and Child Welfare Act of 1980,

16 Minn. Rules 9560.0210 and *Minn. Stat.* §260.011, subd. 2.

which required child welfare agencies to make "reasonable efforts" to prevent out-of-home placement of children.[17] Advocates of family preservation believe that it is usually in the interests of children to maintain family bonds:

The child protection system has tried to balance the goals of family preservation and keeping children safe.

> Children crave continuity in their relationships with their parents. Family ties survive even through periods of tremendous crisis and trouble. . . . Increasingly, it is evident that there are ways to help families change and become safe and strong without removing children from home.[18]

Others believe that family preservation efforts have allowed too many children to remain in dangerous households:

> The essential first step in creating a safe world for children is to abandon the fantasy that child welfare agencies can balance the goals of protecting children and preserving families, [returning instead] to the policy of the early 1960s that established child safety as the overriding goal of the child welfare system. . . . The reality of current child welfare policy is that the rights of parents are almost always given greater weight than the rights of children.[19]

Minnesota law requires courts to ensure "reasonable efforts. . . to eliminate the need for removal [from the home] and to reunite the child with the child's family at the earliest possible time, *consistent with the best interests, safety, and protection of the child*" (emphasis added).[20] As such, it requires efforts to keep families together while acknowledging the continuing need to protect children.

Our surveys asked four categories of professionals to characterize the goals of county child protection staff in practice. As shown in Figure 4.4, their opinions differed considerably:

- **School social workers and pediatricians were more likely than judges or law enforcement officials to cite family preservation, rather than protection of children, as the goal that is more important to child protection staff.**

- **Judges were more likely than others to cite protection of children, rather than family preservation, as the goal that is more important to child protection staff.**

- **A majority of law enforcement officials said that the goals of family preservation and protection of children are equally important to child protection staff.**

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17 P.L. 96-272.

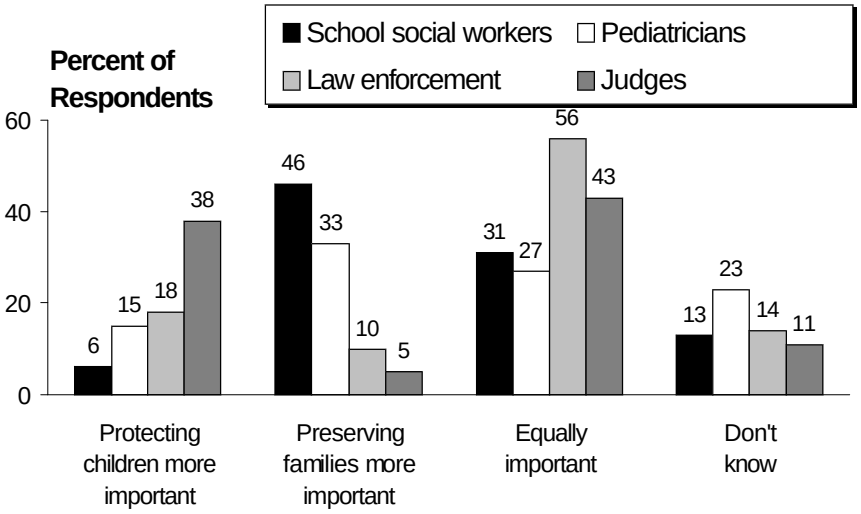
18 Abigail Norman, *Keeping Families Together: The Case for Family Preservation* (New York: Edna McConnell Clark Foundation, 1985), 1-2.

19 Richard J. Gelles, *The Book of David* (New York: BasicBooks, 1996), 148, 150.

20 *Minn. Stat.* §260.012 (a).

There is little consensus about which goal has been more important to child protection agencies.

Figure 4.4: Perceptions About Child Protection Agencies' Goals



SOURCE: Program Evaluation Division surveys, August-September 1997 (N=385 school social workers, 225 pediatricians, 147 police chiefs/sheriffs, and 140 judges).

It is difficult to reconcile these results. Perhaps the results reflect real differences in the types of child protection cases these groups commonly see, or perhaps the respondents' differences in backgrounds and training partly explain their differing perceptions about the priorities of child protection agencies. Whatever the explanation, it appears to us that there is little consensus about the predominant goal of Minnesota's child protection agencies.

RELATIONSHIP BETWEEN CHILD PROTECTION AND LAW ENFORCEMENT AGENCIES

Child protection agencies and law enforcement agencies both play important roles in local governments' responses to allegations of child maltreatment. If a report of maltreatment alleges that a criminal law was broken, a local police or sheriff's department conducts an "investigation" and a county child protection agency conducts an "assessment." (In practice, many child protection staff refer to "assessments" as "investigations" and we usually use the term "investigation" in this report to describe the fact-finding process of child protection agencies.) Although the agencies prepare separate reports summarizing the results of their investigations, state law requires local law enforcement and county child protection agencies to "coordinate the planning

and execution of their respective investigation and assessment efforts to avoid a duplication of fact-finding efforts and multiple interviews."[21]

Through our surveys we found that:

Law enforcement and child protection agencies have usually developed good relationships with each other.

- **Law enforcement agencies and county child protection agencies generally believe they have established cooperative working relationships with each other. Most other professionals we surveyed said this has usually been the case.**

Table 4.7 shows how various categories of professionals evaluated the law enforcement-child protection relationship. For all groups, the percentage who said that the relationship was "usually" or "always" cooperative far outnumbered the percentage who said the relationship was "sometimes, rarely, or never" cooperative. In addition, our surveys indicated that more than 80 percent of law enforcement officials think that their agencies and child protection agencies "usually" or "always" have clear divisions of investigative responsibilities for physical abuse, sexual abuse, and neglect cases.[22]

Interestingly, these apparently good working relationships and clear divisions of responsibility occurred despite the absence of formal inter-agency

Table 4.7: Perceptions About the Working Relationship Between Child Protection and Law Enforcement Agencies

	Percentage of Respondents Who Said That Child Protection Staff Work Cooperatively With Law Enforcement Staff:				
Survey Respondents	Always or Almost Always	Usually	Sometimes	Rarely or Never	Don't Know
City police chiefs (*N* = 77)	69%	27%	3%	0%	1%
County sheriffs (*N* = 70)	79	17	3	1	0
County human service directors (*N* = 82)	68	29	2	0	0
Judges (*N* = 140)	34	46	5	1	14
School social workers (*N* = 385)	27	31	17	3	21
Pediatricians (*N* = 225)	20	36	9	1	32

SOURCE: Program Evaluation Division surveys, August-September 1997.

21 Minn. Stat. §626.556, subd. 10 (a).

22 The percentage of law enforcement heads who said that there is "always or almost always" a clear division of investigative responsibilities was 42 percent for physical abuse, 54 percent for sexual abuse, and 40 percent for neglect cases. Adding respondents who said "usually," the percentages rose to 84, 88, and 82, respectively.

agreements in most counties. The Child Welfare League of America's standards for child maltreatment services indicate that child protection agencies should establish formal, written interagency agreements with law enforcement agencies that address topics such as roles and responsibilities, circumstances that require joint investigations, and training.[23] Similarly, guidelines developed by the National Association of Public Child Welfare Administrators also suggest the need for formal agreements.[24] Our survey of county human services directors indicated that only 18 percent of county child protection agencies had formal, written agreements with at least one law enforcement agency.[25]

Police chiefs and sheriffs offered a variety of comments and suggestions regarding the child protective services system. The following is a small sample of their comments:

Police chiefs and sheriffs offered a variety of suggestions for improving child protective services.

"[Child protection] workers often substantiate maltreatment but close the case due to the overload on the system. Also, they rarely bring a case to CHIPS court even when evidence exists to do so and when that leverage is needed." (Police chief in the Twin Cities area)

"[Modify] data privacy laws to allow for easier access to social service records by law enforcement for investigative and intervention purposes." (Police chief in southern Minnesota)

"[Child protection needs] more staff! The lack of personnel within the agency makes it impossible for all cases to get appropriate attention. Those cases that appear to be less important aren't getting investigated as thoroughly as they should." (Police chief in the Twin Cities area)

"Eliminate [the child protection agency's] utilization of the Tennessen warning when a criminal investigation is [being done]."[26] (Sheriff in central Minnesota)

"I would like the supervisors in human services to worry a little less about budget and a little more about people." (Police chief in the Twin Cities area)

"Have [a child protection] worker working out of our city instead of traveling 20 miles from the intake unit." (Police chief in northern Minnesota)

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23 Child Welfare League of America, *Standards for Service for Abused or Neglected Children and Their Families* (Washington, D.C., 1988), 27.

24 National Association of Public Child Welfare Administrators, *Guidelines for a Model System of Protective Services for Abused and Neglected Children and Their Families* (Washington, D.C., 1988), 37.

25 We reviewed a sample of these interagency agreements. Parts of the agreements merely repeated relevant laws and rules, while other parts delineated county-specific investigation and child placement procedures that, in our view, might prove helpful.

26 *Minn. Stat.* §13.04, subd. 2 requires individuals asked to provide private or confidential data to be informed of the purpose and intended use of the data, whether the individual may refuse to supply the data, any consequences from refusing to supply the data, and the identity of persons or entities authorized to receive the data. This is often called the "Tennessen warning," after the provision's author (Sen. Robert Tennessen).

"Sometimes child protection workers lose focus on their goal to protect the child and focus too strongly on issues that law enforcement has expertise in. . . . When social workers act like cops, the trust of social services is compromised and the victim feels helpless." (Sheriff in southern Minnesota)

"Have child protection workers respond to the scene of a child that needs placement. Presently law enforcement has to "babysit," sometimes for several hours." (Police chief in the Twin Cities area)

"[The] large majority of child protection workers are excellent. Some should be monitored more closely by their supervisors." (Police chief in Twin Cities area)

"In general, the system in Minnesota should react much sooner and should not return these abused children back into the family. This must change or nothing will." (Sheriff in western Minnesota)

SERVICE NEEDS

About 21 percent of Minnesota's cases investigated for possible maltreatment are determined to need child protective services, meaning that county child protection workers are required to maintain ongoing contact with the family until the case is closed. In additional cases (the number is not known), the child protection agency refers families to public or private services without a determination that protective services are needed.

We asked county human services directors to identify types of services that are not available in the quantity or quality necessary to meet the needs of their families. Table 4.8 shows those services that at least 15 percent of the human service directors identified as one of their county's "top three" unmet needs. We found that:

- **The most often-cited "unmet need" was truancy and educational support services; 60 percent of responding directors said they did not have services to meet this need, and one-third of the directors identified it as one of their top three needs.**

As shown, other services that were frequently cited as one of the counties' top three unmet needs included (in order): intensive case management and crisis intervention services, parenting education, transportation services, housing assistance, and sex offender treatment. When asked to identify the single most important unmet need, the following services were cited by at least five county human services directors: truancy/educational support (nine directors), parenting education and intensive crisis intervention (eight directors), victim therapy/counseling and housing assistance (six directors), and perpetrator therapy/counseling, sex offender treatment, and "family-systems" services (five directors). Services which were *not* among county human services directors' most frequently cited top three needs included adult and children's

Truancy and educational support programs were the top "unmet need" noted by county human services directors.

Table 4.8: Top Unmet Service Needs Identified by County Human Services Directors

Service	Percentage of Directors Who Said Their County Has an Unmet Need For This Service	Percentage of Directors Who Identified This Service as One of Their Top Three Unmet Needs
Truancy programs or other educational support programs	60%	33%
Intensive crisis intervention and case management services	49	26
Parenting education	40	22
Transportation services	51	22
Housing assistance	51	21
Sex offender treatment	45	18
Child care	37	15
Perpetrator therapy/counseling	55	15
Foster care	42	15

NOTE: This list includes all services ranked by at least 15 percent of directors as one of the "top three" unmet needs. Fifty-six percent of directors said that they had unmet needs for respite care, but only 11 percent said it was one of their top three needs.

SOURCE: Program Evaluation Division survey, September 1997 (*N* = 82).

mental health services, child protection case worker meetings with families (pre-arranged or unannounced), family therapy, infant/child health services, chemical dependency treatment, kinship care, emergency shelter care, and employment assistance.

In addition, we asked each human services director to identify the category of maltreatment cases for which existing interventions or services were least adequate to meet needs. As shown in Table 4.9,

- **Human services directors most often cited child neglect (of varying types) as the category of maltreatment for which services were least adequate, followed by sexual abuse cases and mental injury cases.**

Fourteen percent of directors said that services were least adequate for educational neglect, and another 26 percent said that services were least adequate for other types of neglect—a total of 40 percent. In addition, 26 percent cited sexual abuse and 26 percent cited mental injury as the categories of maltreatment with the weakest services. None of the 82 human services directors who responded to our survey cited physical abuse as the category of maltreatment with the least adequate services.

Table 4.9: County Human Services Directors' Perceptions About Types of Maltreatment For Which Services Are Least Adequate

Type of Maltreatment	Percentage of Directors Who Said That Services Were Least Adequate For This Type of Maltreatment
Physical abuse	0%
Sexual abuse	26
Neglect	
• Educational neglect	14
• Other neglect	26
Mental injury	26

SOURCE: Program Evaluation Division survey, September 1997 (*N* = 82).

Forty percent of directors said that neglect cases receive the least adequate services.

During our study, many people told us that the services provided to families are affected by county budget constraints, and some said that budget considerations played a larger role in county decision making than the interests of children or families. It is difficult to know for certain whether cost concerns have actually caused counties to make choices that were contrary to the best interests of children or families. According to our survey of county human services directors,

- **Relatively few county human services directors said that budget considerations have caused their agencies to limit the number of cases investigated or opened for services (5 and 12 percent, respectively), but 42 percent of directors said that budget considerations have caused them to limit the number of cases recommended for out-of-home placement.**

It is possible that budget considerations played a role in the decisions of more counties but human services directors were reluctant to say this. As one district court judge commented in his survey response, "Child protection staff (while they won't so admit) are pressured because of budget constraints. Twenty-five years ago when I started this job they had enough money to be more aggressive in investigation and out-of-home placement."

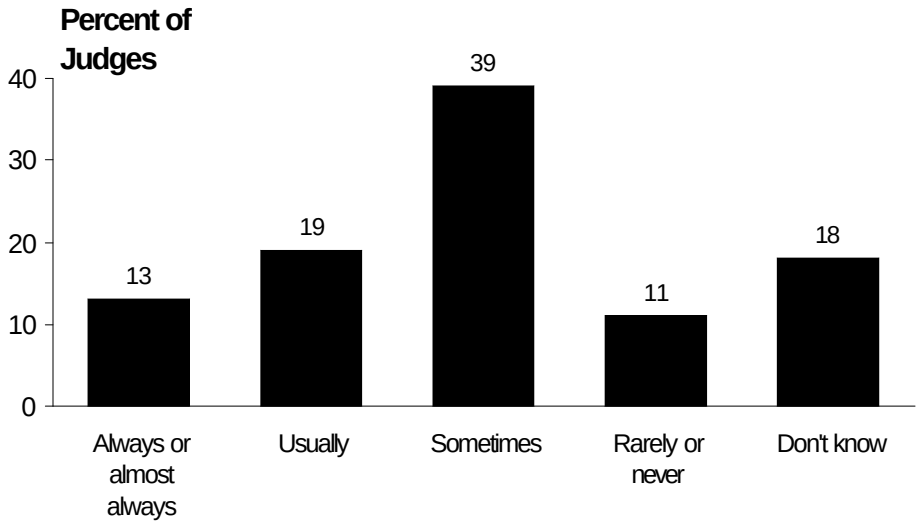
We asked judges to assess the impact of budget constraints in the cases they have heard in the past two years, and Figure 4.5 shows that:

- **More than 70 percent of judges said that budget considerations have at least "sometimes" affected county recommendations and actions regarding children in need of protection or services.**

In addition, 59 percent of judges said that lack of appropriate support services has at least "sometimes" been a barrier to preserving or reunifying families, and 63 percent of judges said that lack of appropriate substitute care has at least "sometimes" been a barrier to making out-of-home placements. Comments we received from judges included the following:

Most judges said that budget considerations sometimes influence county actions.

Figure 4.5: Judges' Perceptions About How Often Budgets Influence Agency Actions



SOURCE: Program Evaluation Division survey of judges, August-September 1997 (*N*=140).

> "Because of budget constraints, when the court requests obvious CHIPS cases to be initiated by the county, the county refuses to assist because they have not risen to [a] level of emergency. . . . Where a custody evaluator in a private case has recommended neither parent to receive custody, the county ignores our pleas to initiate a CHIPS proceeding because of lack of manpower!"

> "The quality and level of legal services delivered by many county attorneys' offices is a disgrace. County boards don't generally like to spend money on lawyers. If the state is going to mandate services, they must fund them. The budget constraints drive the system. Child protection workers. . . are the shock troops of the system and are poorly supported."

> "Often early intervention could be a great help, but staff and budget restrictions (and at times indifference) get in the way and the problems just get more complex and unsolvable."

SUMMARY

Our surveys indicated that many school social workers and pediatricians believe that the child protection system is not sufficiently responsive to their concerns. They also think the system does not give them enough information about county screening criteria and what happens to the cases of suspected maltreatment they report. Law enforcement officials tended to evaluate the performance of child protection agencies more favorably, and most people who work with child protection cases think that law enforcement and child protection agencies have established good working relationships with each other. Many county human services directors perceive a need for better services for educationally neglected and truant children, and many mandated reporters of maltreatment believe that child protection agencies are understaffed. Judges told us that child protection agencies sometimes give troubled families too many "second chances," and many said that budget considerations affect county service recommendations for families.

Staffing and Training

CHAPTER 5

During the course of our study, many people told us that the job of a child protection employee is a difficult one. These employees make judgments that can affect the lives of families profoundly. Employees are expected to understand numerous federal, state, and local laws and policies, and they are expected to work closely with the courts, county attorneys, law enforcement agencies, health professionals, school professionals, and others. Consequently, it is important for child protection agencies to attract and retain good staff, and it is important for staff to have reasonable workloads. We asked:

- **How many cases does a typical child protection worker handle?**
- **What types of educational backgrounds do child protection staff have? Do employees have adequate opportunities for continuing education?**
- **How much turnover is there among child protection staff, and where in Minnesota is turnover the highest?**

Overall, we found that some counties in Minnesota have child protection caseloads that are higher than those recommended by national experts, and many people we surveyed believe there is a need for additional child protection staff. Staff turnover has been higher in outstate counties than in the Twin Cities metropolitan area, and a much higher percentage of staff in the Twin Cities area have master's degrees than do staff in outstate Minnesota. Most county human services officials said they have usually been satisfied with opportunities for their staff's continuing education.

CHILD PROTECTION CASELOADS

Child protection staff are county employees, and the Minnesota Department of Human Services has not routinely collected information on the number or types of staff in counties. Thus, in September 1997, we asked county human services directors throughout Minnesota to provide us with information on each of their child protection employees. This information enabled us to compute the number of "full-time-equivalent" (FTE) employees who

performed various child protection functions in each county.[1] Statewide, all counties combined reported that they had 61 full-time-equivalent screening staff, 184 assessment/investigation staff, and 400 caseworkers for families needing protective services.

We collected information on counties' child protection staff and caseloads.

The Department of Human Services annually collects information from counties on all maltreatment cases that were investigated and recommended for protective services during the year, but it does not have information on the number of open cases on a given date. Consequently, we asked county human services directors to provide us with information to help us examine the caseloads of staff who (1) *investigate* allegations of child maltreatment, and (2) *monitor* families that have been determined to need protective services. Table 5.1 shows child protection caseloads in the ten counties with the state's largest populations under age 18. The data reflect caseloads as of the time of our survey (September 1997). We found that:

- **Statewide, there were 16 cases under investigation per full-time-equivalent child protection investigator. Half of Minnesota counties had 10 or more cases under investigation per full-time-equivalent investigator.**

- **Statewide, there were 15 cases open for protective services per full-time-equivalent child protection caseworker. Half of Minnesota counties had caseloads of 18 or more.**

The information reported in the survey indicated that there may be wide variation in the caseloads of individual counties. For example, 13 counties had fewer than 10 cases open for ongoing protective services per FTE caseworker, while 7 said they had 40 or more cases per FTE caseworker.

There are several reasons to consider these data with caution. First, the number of cases handled by counties can fluctuate during the year. For instance, some counties told us that they receive fewer reports of maltreatment when school is not in session, so their child protection caseloads might sometimes be higher than they were at the time of our September survey. Stearns County had only seven cases under investigation at the time of our survey, but county officials told us that this was unusually few. Second, caseloads of workers *within* a county may vary. For example, certain caseworkers may be assigned relatively few families but are expected to work very intensively with each. Third, some of counties' "open" investigations are cases where the investigative fieldwork has been completed but the paperwork has not. For example, Hennepin County staff estimated that about 20 percent of its open investigations are of this type.

1 A county with two full-time staff who each devote half of their time to investigations would have 1.0 full-time-equivalent investigator.

Table 5.1: Child Protection Caseloads in Selected Counties, September 1997

	Protective Services Cases		Assessments	
Counties	Open Cases	Cases/FTE	Open Cases	Cases/FTE
Hennepin	800	8.4	711	22.5
Ramsey	614	16.8	424	20.2
Dakota	279	8.7	246	23.4
Anoka	293	20.1	93	13.5
Washington	230	20.9	215	30.7
St. Louis	303	14.8	63	6.1
Stearns	157	19.6	7	1.5[a]
Olmsted	131	16.4	60	15.0
Wright	60	20.0	44	16.6
Scott	49	14.0	33	17.4
Twin Cities Metropolitan Counties	2,317	11.5	1,730	21.6
Outstate Counties	3,528	17.7	1,177	11.4
Statewide	5,845	14.6	2,907	15.8

[a]Stearns County told us that an average caseload of about five was more typical of the county's recent experience.

NOTE: The counties shown here are the 10 counties with the largest 1995 population ages 0-17. Protective services caseloads were computed based on the number of full-time-equivalent (FTE) employees who manage cases open for protective services, and assessment caseloads were based on the number of assessment/investigation FTEs.

SOURCE: Program Evaluation Division survey of county human services directors, September 1997 (*N* = 82).

Staff in some counties have high caseloads.

Without knowing more about the nature of the services provided to families in each county, it is difficult to conclusively evaluate whether Minnesota's child protection caseloads are appropriate. The Child Welfare League of America has recommended that child protection caseworkers not have more than 17 open cases, and that investigators not have more than 12 active cases per month.[2] But this organization and others have stated a preference for "workload" rather than "caseload" standards. Rather than simply considering the number of cases per worker, estimates of workload could consider the intensity of services, the risk levels of the families served, travel time, and other factors that may affect the time needed to provide effective services. Staff in several counties told us that they are handling more difficult

2 Child Welfare League of America, *Standards for Service for Abused or Neglected Children and Their Families* (Washington, D.C., 1988), 52. Staff with this organization told us that investigations should generally not take longer than two to four weeks and that the organization is considering reducing its investigative caseload standard from 12 to 10.

cases than they used to, including more families that have multiple problems and service needs. Presently, however, there is no way to reliably compare among counties the risks of families or the quantities of services provided. Also, no statewide studies have examined whether child protection employees are complying with state requirements for monitoring open cases.

Data on the size of existing caseloads may not reflect the full demand for child protective services. For example, counties may limit the number of cases investigated or opened in order to avoid placing undue burdens on their staff. If so, counties may not be serving families for whom interventions would be appropriate. Thus, although the average caseloads of many counties are at or below the Child Welfare League's maximum caseload standard, it is still possible that staffing levels in those counties are inadequate to meet the needs of troubled families.

There are indications that some important child protection tasks have not been done in some counties, perhaps reflecting staffing shortages. As we discussed in Chapter 4, child protection staff appear to provide little feedback to reporters of maltreatment in many parts of the state. In addition, we observed during our visits to counties that some staff have been unable to keep case records up-to-date. In one county we visited (Polk), each of the child protection workers had 15 to 20 cases open for protective services, plus 35 to 50 cases for which assessments (or the paperwork for assessments) were being completed. We were unable to use case records to determine how this county handled some cases because the records were incomplete. And, in some other counties, staff told us they have not always had time to monitor families or update case plans as often as required by state rules due to other demands on their time.

Many people we surveyed said that child protection agencies need more staff.

Our surveys of mandated maltreatment reporters (see Chapter 4) did not explicitly ask respondents to evaluate child protection agency staffing levels or caseloads, but we did offer respondents an opportunity to suggest improvements in child protective services. The most common suggestion was for child protection agencies to provide better feedback on cases to the mandated reporters, but the second most frequent suggestion was for additional staff in child protection agencies.[3] Some of the comments we received include the following:

> "Greatly understaffed at child protective services—need more caseworkers for quicker response and follow through. These people must be totally overwhelmed. Could not possibly do the kind of job they need or want to. I have reported to local police for quicker responses." (School social worker in the Twin Cities area)

3 About 20 percent of school social workers, 12 percent of pediatricians, and 12 percent oflaw enforcement officials made comments on their surveys about the need for additional staff.

> "Teachers would not even be asked to work with over 30 students in a classroom. Social workers don't have any "protection" like this. They need a caseload limit so they can work effectively with families." (School social worker in northeastern Minnesota)

> "Give them enough money to be adequately staffed with adequately trained personnel to respond to the incredible need for their service." (Pediatrician in the Twin Cities area)

> "We need more child protection workers—they are totally overbooked. They need caseload relief in order to do better referral and follow-up work." (School social worker in southeastern Minnesota)

> "The child abuse reporting law and the amount of staff that are allocated to uphold that law are very incongruent. . . . It seems virtually futile to waste my time and theirs to call on issues that I know [child protection staff] don't have time [to investigate]. They are so busy/overwhelmed that unless I can tell them that I have observed a bruise, they cannot open [an investigation]." (School social worker in the Twin Cities area)

It may be possible to shift some resources from investigation to direct services.

Overall, many people we heard from have the perception that child protective services are inadequately staffed to meet the needs of troubled families. If staffing *is* inadequate, it remains unclear whether the appropriate legislative response would be to help counties fund additional child protection staff, to redefine existing staff responsibilities, or both. According to some child protection officials we spoke with, fewer staff resources should be directed toward investigating whether maltreatment occurred and more should be spent directly brokering services to families that need help. The 1997 Legislature authorized a series of pilot projects that will examine alternative approaches to family assessment and investigation. If these projects (or similar efforts in other states) show promising results, we suggest in Chapter 7 that the Legislature consider clarifying which maltreatment allegations require investigation and maltreatment determinations and which do not. Chapter 7 also suggests that legislators consider the possible need for additional state funding for child welfare services.

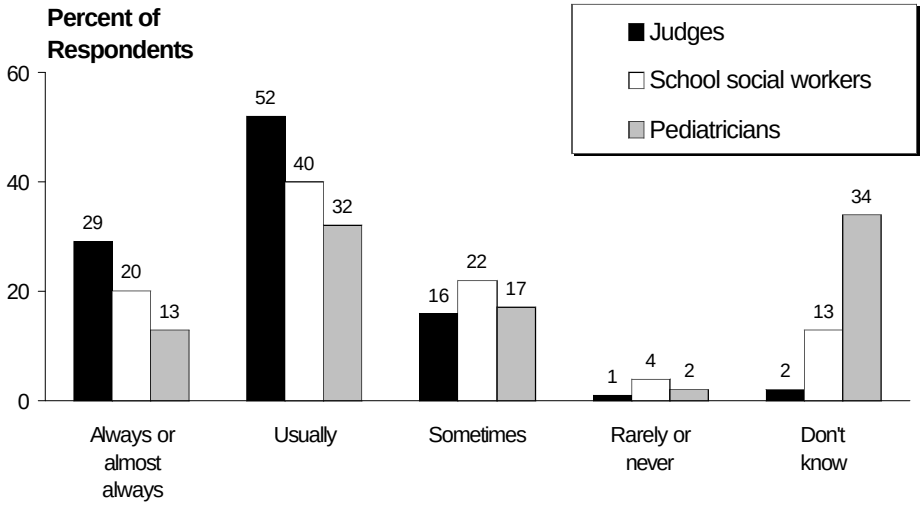
STAFF TRAINING

Our surveys of judges, school social workers, and pediatricians asked respondents to evaluate the overall skill levels of child protection employees. As shown in Figure 5.1,

- **Survey respondents tended to say that child protection staff "usually" or "always" have the skills needed to do their jobs, although judges had a more favorable impression of the skills of child protection employees than did pediatricians and school social workers.**

Many professionals think that child protection staff usually or always have the skills they need.

Figure 5.1: Perceptions About Whether Child Protection Staff Have the Skills Needed



SOURCE: Program Evaluation Division surveys, August-September 1997 (*N*=140 judges, 385 school social workers, and 225 pediatricians).

Eighty-one percent of judges said that child protection staff "usually" or "always" have the necessary skills, compared with 45 percent of pediatricians and 60 percent of school social workers. The percentage who said that child protection workers "sometimes" or "rarely or never" have the necessary skills ranged from 17 percent (judges) to 26 percent (school social workers).

Standards developed by the Child Welfare League of America indicate that child protection employees "should have training in social work," but they do not prescribe particular degrees.[4] The League's standards suggest that child protection supervisors and administrators should have master's degrees in social work. Guidelines developed by the National Association of Public Child Welfare Administrators state that child protection staff should have a bachelor's degree in social work, sociology, guidance and counseling, or psychology, "and ideally a master's degree in social work or a closely related field."[5] We collected information from counties about the educational backgrounds of each of their child protection staff. Among staff who spend at least half of their time screening, assessing, or managing child protection cases, we found that:

4 Child Welfare League of America, *Standards for Service, 50.*

5 National Association of Public Child Welfare Administrators, *Guidelines for a Model System of Protective Services* (Washington, D.C., 1988), 35.

- **About 32 percent of Minnesota's child protection staff have master's degrees, typically in social work. Another 67 percent of the staff have bachelor's degrees, of which a majority had social work majors.**

- **More than half (55 percent) of the county child protection workers in the seven-county Twin Cities region have master's degrees, compared with only 12 percent elsewhere.**

Table 5.2 shows the educational achievement of line staff in county child protection agencies. Only about 30 percent of the county human services directors in Minnesota reported to us that they have at least one child protection employee with a master's degree in social work, either in a supervisory or line staff position.

Child protection staff in the Twin Cities area are more likely to have master's degrees than staff elsewhere.

Table 5.2: Percentage of Child Protection Staff with Various Educational Backgrounds

	Statewide	Twin Cities Metro Counties	Outstate Counties
Master's degree in social work	25%	45%	8%
Other master's degree	7	10	4
Bachelor's degree, social work major	40	21	56
Bachelor's degree, other major	27	22	32
High school graduate	1	2	0

SOURCE: Program Evaluation Division survey of 82 county human services directors, September 1997 (*N* = 634 staff).

At the beginning of our study, legislators asked us to consider the adequacy of continuing education for child protection staff, in addition to their formal educational training. State law requires that child protection staff annually receive 15 hours of continuing education "relevant to providing child protective services."[6] In our survey of county human services directors, 71 percent said that they have "always" or "usually" had adequate training opportunities for their new staff, and 83 percent said they have "usually" or "always" had adequate training opportunities for other staff.[7]

The 1993 Legislature required the Department of Human Services (DHS) to develop "foundation training" for child protection employees to take during their first six months of employment. In addition, DHS has provided training in specialized topics, such as individual service planning, Indian child welfare,

6 *Minn. Stat.* §626.559, subd. 1.

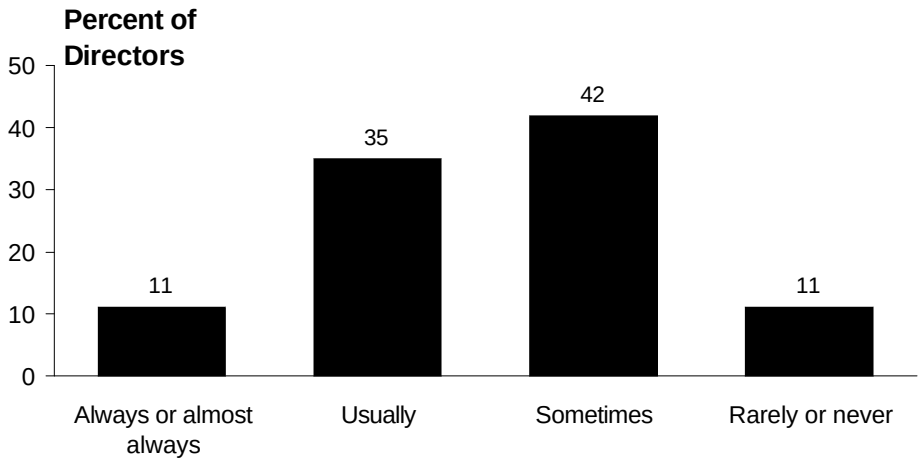
7 For new staff, 28 percent of directors said that training opportunities were "always or almost always" adequate, 43 percent said "usually," 23 percent said "sometimes," and 5 percent said "rarely or never." For other employees, 35 percent of directors said training was "always or almost always" adequate, 48 percent said "usually," 15 percent said "sometimes," and 1 percent said "rarely or never."

DHS has expanded training opportunities for child protection staff in recent years.

CHIPS and child abuse prosecution, forensic interviewing, foster care, adoption, crisis nurseries, services for adolescents, and multi-disciplinary investigation and intervention approaches. DHS records indicate that more than 800 county and tribal child welfare staff have been trained in the department's programs since Fall 1994, including both new and experienced employees. As shown in Figure 5.2, a majority of county human services directors (53 percent) said that their staff were "sometimes" or "rarely or never" satisfied with DHS' training during the past year, so there may be ways that DHS can better address county training needs.[8] On the other hand, we reviewed evaluation forms submitted to DHS by trainees for some of the 1997 courses, and most of the ratings and comments were very positive. In addition, the Minnesota Association of County Social Services Administrators supported DHS' efforts in 1997 to obtain funding for regional training centers that can offer expanded training opportunities for new and experienced staff.

Finally, during our site visits, we examined the 1996 training records of child protection employees to determine whether they complied with state training requirements of 15 hours per employee per year. We counted any courses that appeared to pertain to social services topics, but we did not count topics of more general interest, such as training in computer software, voice mail, sexual harrassment policies, and defensive driving. Using this fairly broad

Figure 5.2: County Staff Satisfaction with DHS Child Protection Training



SOURCE: Program Evaluation Division survey of county human services directors, September 1997 (*N*=82).

8 The directors provided their responses to the following survey statement: "During the past year, our staff have been satisfied with training provided by the Department of Human Services." The directors were not asked to specify the types of training they would like to see improved, and it is possible that some directors were dissatisfied with the amount of DHS training available rather than the quality of the courses their staff took. DHS staff told us that they have tried to improve training for experienced staff, some of whom previously enrolled in courses for new employees.

definition, we estimated that more than one-third of child protection employees in the eight counties we visited did not have at least 15 hours of relevant continuing education in the previous year.[9]

STAFF TURNOVER

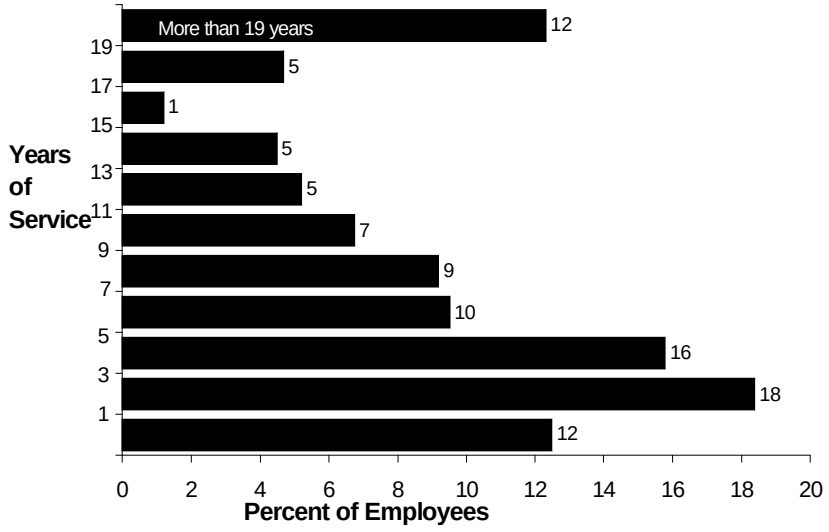
Early in our study, some legislators expressed concern about the ability of child protection agencies to retain qualified staff. In our September 1997 survey of county human services directors, we collected information on the amount of time that child protection screeners, investigators, and caseworkers had worked for their current child protection agencies. We found that:

There is more staff turnover in outstate Minnesota than in the Twin Cities area.

- **Statewide, the average child protection worker has worked for his or her current agency for 8.2 years.**

- **The average tenure of child protection workers in the Twin Cities seven-county metropolitan area (10.6 years) is greater than the average tenure of child protection employees from elsewhere in the state (6.5 years).**

Figure 5.3: Child Protection Staff's Years of Service with Current Employer



SOURCE: Program Evaluation Division survey of county human services directors, September 1997 (N=577 county employees who work at least half-time in line child protection positions).

9 It is possible that some of the employees whose records we reviewed did not work as child protection staff for all of 1996.

Figure 5.3 shows that about 30 percent of the state's child protection staff have worked for their current agencies for three years or less, and 46 percent have worked for their agencies for five years or less. Among individual counties, the longest staff tenure is in Ramsey County, where the average child protection worker has been employed for about 17 years.[10]

SUMMARY

Although average caseload size varies considerably among counties, many child protection employees probably have caseloads that are too large. In addition, this report has discussed the possibility that some services—such as intervention in cases of chronic neglect, or preventive services to families that are not yet the subject of maltreatment determinations—are not provided often enough. Thus, there may be a need for additional child protection (or "child welfare") staff, although the Legislature could also consider giving counties flexibility to shift some staff resources from investigative duties to direct services. The child protection system not only needs adequate staffing, but it also needs staff who are well-trained. This may be a particular challenge in outstate Minnesota, which has had more difficulty than the Twin Cities area attracting staff with master's degrees and retaining staff over time.

10 We limited our analysis to employees who had a total of at least 0.5 FTE devoted to the functions of screening, assessment/investigation, and casework.

Accountability Options

CHAPTER 6

Policy makers have an interest in knowing whether the child protection system is working effectively.

In Chapter 1, we noted that Minnesota state government has a smaller role in the direct provision of child protective services than most state governments. In Minnesota, child protective services are provided by county agencies, and more than half of the funding for services comes from local property taxes. Still, state law establishes the policy framework for Minnesota's child protection system, and state policy makers have an interest in knowing whether the system they have established is working effectively.

Partly because counties' maltreatment-related records are not public data, it has been difficult for the public, policy makers, and professionals who work with families to know whether child protection agencies have acted appropriately.[1] In addition, the restrictions on child protection data limit the ability of agency officials to explain their actions when questions about cases arise. We asked:

- **What mechanisms might provide the public and policy makers with greater assurance that child protection agencies have acted responsibly and observed good social work practice?**

- **How can the performance of child protection agencies be monitored?**

In this chapter, we discuss various accountability options for the Legislature or Department of Human Services (DHS) to consider. For example, the Legislature could consider requiring county child protection agencies to periodically undergo external reviews by staff from DHS or similar counties, or such reviews could be conducted by boards of knowledgable citizens. In addition, DHS has not actively monitored local agency compliance with laws and rules in recent years, and there may be a need for at least selective compliance monitoring. Other options for improving accountability include ongoing performance measurement, opening certain case proceedings or records to the public, improving oversight of child protection decisions by

1 County child protection records are private data, according to *Minn. Stat.* §626.556, subd. 11. The subjects of the data can review county records upon request, and the agencies are also authorized by law to share certain information with local law enforcement agencies, prosecutors, medical examiners, coroners, maltreatment reporters, child mortality review panels, and selected others.

agency supervisors and county boards, and ensuring that key child protection records are retained for a reasonable period of time.

EXTERNAL REVIEWS

The Department of Human Services has not closely scrutinized county practices.

One way to increase the accountability of child protection agencies would be to periodically have someone outside of the agencies review their performance. State law requires the Commissioner of Human Services to "design and implement a method of monitoring and evaluating social services, including site visits that utilize quality control audits to assure county compliance with applicable standards, guidelines, and the county and state social services plans."[2] If counties are not in compliance, the department is authorized to withhold portions of the counties' federal or state funding.[3] Between 1988 and 1991, the department twice reviewed county child protection agencies' compliance with state regulations. But we found that:

- **The department has not systematically monitored county compliance with state child protection regulations since 1991.**

DHS officials told us that compliance monitoring consumed a lot of their staff's time, and responses to the monitoring took a lot of county staff time. While they believe that compliance monitoring prompted counties to make some worthwhile changes, state officials decided that department staff could provide more useful assistance to counties by providing training and other forms of technical assistance.

If DHS decided to resume compliance monitoring, there are some state requirements for which compliance could be routinely monitored by analyzing the state's computerized database of county maltreatment reports. For example, DHS could use this data to evaluate how long counties took after receiving a report to begin an investigation. But there are numerous requirements in law and rule that could only be reviewed by examining case files in county agencies and talking with staff. This could be very time-consuming, especially if DHS annually examined each county's compliance with existing requirements. Unless there is evidence of widespread compliance problems, DHS could limit the scope of compliance reviews by (1) establishing a cycle of county reviews, such as reviewing all counties every three to five years, and (2) focusing the reviews on selected issues of interest, rather than trying to examine compliance with all requirements.

An additional type of external review would focus on the *appropriateness* of child protection decisions, not compliance with regulations. After all, county child protection agencies could comply with state regulations yet still provide inadequate services. Reviews of agency practices and decisions could be

2 *Minn. Stat.* §256E.05, subd. 3 (e).

3 *Minn. Stat.* §256E.05, subd. 3 (f) and subd. 4.

conducted by DHS staff, staff from other counties, or citizen review boards. The 1989 Legislature required the Commissioner of Human Services to establish a pilot program for review of two counties' child protection assessments and services by staff from similar (or "peer") counties.[4] The law required a peer review panel to review the counties' compliance with rules, appropriateness of actions, and case determinations in a random sample of cases. But in 1991 DHS decided not to establish the pilot projects due to county concerns about the time required.[5]

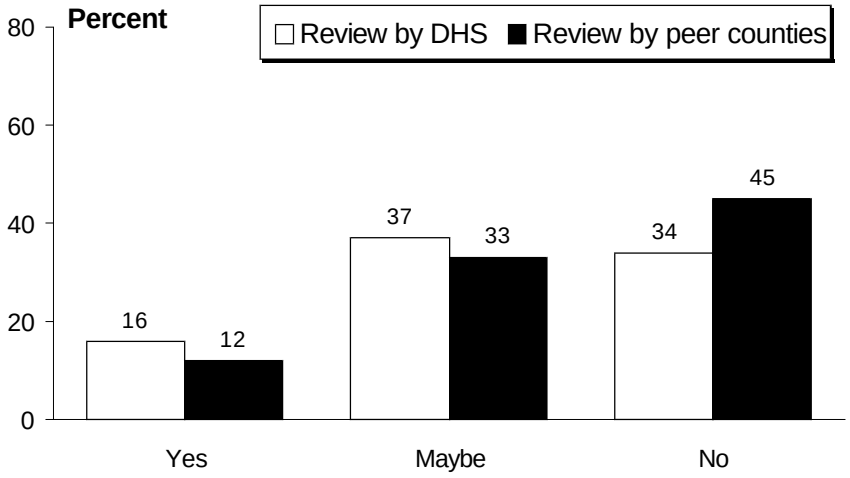
In a September 1997 survey, we asked county human services directors for their opinions about periodic external reviews of their agencies—either by DHS or by staff from similar county child protection agencies. As shown in Figure 6.1,

- **A small percentage of directors said they favored external reviews by DHS or peer counties, and many others said that they might support this idea.**

To date, the main external reviews of Minnesota child protection agencies have been those conducted in cases involving child deaths. State law requires

County directors expressed limited support for external reviews of their agencies.

Figure 6.1: Percentage of Directors Who Favor External Review of Their Agencies



SOURCE: Program Evaluation Division survey of county human services directors, September 1997 (*N*=82).

4 *Minn. Laws* (1989), ch. 282, art. 2, sec. 203.

5 Natalie Haas Steffen, Commissioner of Human Services, letter to Rep. Kathleen Vellenga, Chair, Minnesota House of Representatives Judiciary Committee, March 11, 1992. The letter noted that the department instead focused its efforts on statewide implementation of multi-disciplinary child protection teams, child mortality review panels, compliance monitoring, and training.

the Commissioner of Human Services to establish a statewide child mortality review panel, and the commissioner may also require county agencies to establish their own child mortality review panels. The purpose of these panels is "to make recommendations to the state and to county agencies for improving the child protection system, including modifications in statute, rule, policy, and procedure."[6] However, cases involving a child death are a small fraction of all child protection cases, and the state's child mortality review board has only issued two reports (in 1991 and 1994) since its creation in 1989. In fact, DHS disbanded the panel in 1995, subsequently reinstating it in November 1997.[7]

Minnesota's child mortality review panel was recently reinstated after not meeting for two years.

The 1996 amendments to the federal Child Abuse Prevention and Treatment Act required states receiving federal grants to establish at least three "citizen review panels."[8] The stated purpose of the panels is to evaluate the extent to which agencies are effectively discharging their responsibilities. To do this, the panels may examine state and local policies and procedures, and, where appropriate, individual child protection cases. DHS officials told us they intend to submit proposals to the 1998 Legislature for three such panels, serving individual or multiple counties. If such reviews are done, we think they should be conducted by reviewers with a sufficient understanding of relevant laws, rules, and social work practices.

It is important to consider that case files can take a considerable amount of time to review. Many families' case files are thick with documents and caseworker notes, sometimes spanning years of events. Even if external reviewers can reach reasonable conclusions about whether the child protection agency made appropriate decisions, it is likely that they would have to limit the number of cases reviewed per county to a relatively small number. Still, reviews of even a few cases might help to reassure the public that there is some scrutiny of child protection decisions, and they might result in useful suggestions to the agencies for improvement.

Some states have created special agencies or units to oversee the activities of child protection field offices, respond to complaints, or monitor cases. For example, Illinois has an Office of the Inspector General for its Department of Children and Family Services. This office responds to and investigates complaints filed by the courts, foster parents, biologicial parents, attorneys, and others. It also investigates child deaths and studies systemwide issues that have been a source of complaints. Following investigations, the office makes recommendations to the department and monitors their implementation.

Minnesota has a state ombudsperson for families who, among other duties, "shall monitor agency compliance with all laws governing child protection and placement, as they impact on children of color."[9] Staff from the

6 *Minn. Stat.* §256.01, subd. 12 (a).

7 DHS staff told us they were unsure exactly why department officials decided to discontinue the child mortality review panel in 1995.

8 *Child Abuse Prevention and Treatment Act Amendments of 1996*, P.L. 104-235, sec. 107 (c).

9 *Minn. Stat.* §257.0762, subd. 1.

ombudsperson's office told us they try to respond to any concerns brought to their attention, not just concerns regarding families of racial and ethnic minority groups. The office issues reports and makes recommendations to agencies, but it does not have authority to require agencies to act.[10]

PERFORMANCE MEASURES

Another option for improving accountability is agency self-monitoring and reporting. State law has required each county since 1981 to prepare annual reports on "the effectiveness of the community social service programs in the county."[11] The reports are to include descriptive information on program recipients and "an evaluation on the basis of measurable program objectives and performance criteria for each county social service program." But,

- **While counties have prepared information on the number and type of their social service recipients, most have not regularly evaluated the effectiveness of their programs.**

Counties have had difficulty measuring the performance of child welfare programs.

Since 1994, state law has required counties to include measures of program "outcomes" in their biennial social services plans, but many counties have had difficulty doing so. We examined the child welfare portions of half of the community social services plans submitted by counties for the 1998-99 biennium. Some of the plans proposed potentially useful performance measures. For example, almost one-third of the plans proposed to evaluate services by examining the incidence of repeated maltreatment, although they varied in the ways they defined their measures. In addition, some counties proposed to measure school attendance of children deemed educationally neglected, family satisfaction with services, and the percentage of children who are placed in permanent homes within 6 or 12 months of being placed out-of-home. Many agencies proposed measuring activities rather than program outcomes—such as the number of days children are in out-of-home placements, the number of cases with maltreatment determinations, and the number of families served by in-home services. Long-term trends of activity measures can provide useful information, although these measures generally will not inform counties or others about the effectiveness of agency interventions.

Overall, the social service plans tended to have limited measures of program performance and little historical data. The Department of Human Services has worked with counties in recent years to help them improve their performance measures, but it appeared to us that many counties still have a good deal of

10 Court monitors are another form of external review mechanism. For example, the Minneapolis American Indian Center has a court monitor who reviews Hennepin and Ramsey County cases for compliance with the federal Indian Child Welfare Act. The monitor attends court hearings and produces reports that highlight compliance issues. Similarly, a non-profit organization called Watch monitors Hennepin County court cases involving crimes against women and children.

11 Minn. Stat. §256E.10.

work ahead. We recognize that it may be difficult to find ideal measures of program performance for child protective services, and it may not be feasible to isolate the impact of public agencies from other factors.[12] Still, we think there is considerable room for DHS and counties to improve performance measurement and the accuracy of child protection data already collected, as we recommend in Chapter 7. The need for improved performance measurement was underscored by recent congressional legislation that required the federal Department of Health and Human Services to (1) adopt a system for rating each state's performance in operating child protection and child welfare programs, and (2) develop a method of linking state funding to performance on these measures.[13]

Federal funding may be linked to state performance in the future.

OTHER ACCOUNTABILITY ISSUES

Appeals and Complaints

Until 1997, alleged perpetrators and child victims had very limited means to appeal county maltreatment determinations. They could contest "the accuracy or completeness of public or private data" under the Minnesota data practices laws, but it was unclear that such appeals could challenge whether the maltreatment determination was justified.[14]

The 1997 Legislature authorized a procedure that individuals or facilities can use to appeal child protection agencies' maltreatment determinations.[15] The law allows individuals or facilities to request that agencies reconsider maltreatment determinations, and they are entitled to a fair hearing before a state human services referee if their requests are denied or not acted upon. As of November 1997, only one hearing request had been filed with the state under the new law.

Aside from information on these newly-authorized hearings, Minnesota does not have centralized information on the number or nature of complaints about county child protective services. For example, we noted in Chapter 4 that many mandated reporters have been frustrated by the absence of county feedback on the cases they have reported. People can convey complaints to county agencies, DHS, the state ombudsperson for families, or others, but there is no uniform method of recording or responding to complaints.

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12 It is difficult to find ideal measures of agency performance in providing child protective services. For example, incidents of repeated maltreatment within families could indicate failures of county interventions, but it is also possible that more incidents are identified when a county increases scrutiny of problem families. Also, county staff often evaluate the progress made by individual families toward goals in case plans, but it is difficult to translate information on families with varying needs into general measures of performance.

13 P.L. 105-89, sec. 203, signed by President Clinton in November 1997.

14 *Minn. Stat.* §13.04, subd. 4.

15 *Minn. Laws* (1997), ch. 203, art. 5, sec. 29.

Data Access

Some people believe that child protective services would be more accountable if the public had access to more information on cases. Child protection records are classified by Minnesota law as private data on individuals.[16] In addition, the public usually cannot attend court hearings involving children in need of protection or services; only persons with "a direct interest in the case or in the work of the court" may attend.[17] Likewise, records of juvenile court proceedings are not public, although they may be disclosed by order of the court.

The public has very limited access to information on child protection cases.

In 1997, the Supreme Court Foster Care and Adoption Task Force explored the idea of allowing the public to observe hearings involving children in need of protection or services (CHIPS) and termination of parental rights. Through statewide surveys, the task force found that 58 percent of judges, 79 percent of county attorneys, 86 percent of public defenders, and 89 percent of social service agencies said that these hearings should never be open to the public.[18] Still, the majority of the task force members favored open hearings. They said that opening hearings would expose inadequacies in children's services and encourage citizens to engage in discussions about community standards. Other task force members contended that the publicity associated with open hearings would harm maltreatment victims and make children less willing to report abuse in the future. The 1997 Legislature considered but did not pass legislation to open CHIPS hearings.

Because the task force examined the issue of open CHIPS hearings in some depth, our study did not address this topic. But we did ask human services directors in our September 1997 survey whether they thought there were instances in which child protection agencies' case records should be opened to the public. As shown in Figure 6.2,

- **A majority (57 percent) of directors said that they favor or might favor making agency child protection records public in cases involving child deaths. A smaller percentage of directors (39 percent) said they favor or might favor opening records of cases involving serious injuries, and a still smaller percentage (21 percent) said they favor or might favor opening records of all cases where maltreatment has been determined.**

Federal law restricts the ability of states to make child protection records public. The law requires states receiving federal grants to have "methods to preserve the confidentiality of all records in order to protect the rights of the child and of the child's parents or guardians."[19] Records may only be made

16 Minn. Stat. §626.556, subd. 11.

17 Minn. Stat. §260.155, subd. 1 (c).

18 Final Report: Minnesota Supreme Court Foster Care and Adoption Task Force (St. Paul, January 1997), 120.

19 P.L. 104-235, sec 107 (b) (2) (A) (v).

Figure 6.2: Types of Case Records That Agency Directors Favor Making Public

SOURCE: Program Evaluation Division surveys of county human services directors, September 1997 (*N*=82).

Federal law restricts public disclosure of child protection records but requires disclosure for certain types of cases.

available to: (1) individual subjects of maltreatment reports, (2) public agencies (or their agents) who need the information to protect children, (3) child abuse citizen review panels, (4) child fatality review panels, (5) grand juries or courts, and (6) "other entities or classes of individuals statutorily authorized by the State to receive such information pursuant to a legitimate State purpose."[20] However, the law also requires states to allow "public disclosure of the findings or information about the case of child abuse or neglect which has resulted in a child fatality or near fatality."[21]

Employee Supervision

All public agencies need supervisors who can effectively guide and scrutinize the efforts of staff. In our view, this type of internal accountability and coaching is especially important in child protective services, given that maltreatment definitions are open to interpretation, cases often have contradictory evidence, and decisions can significantly affect the lives of families.

We did not evaluate employee supervision in-depth, although we spoke with county staff about this issue during our site visits. Several line staff told us that maltreatment determinations are often their decisions to make individually, with little supervisory input or review. Some line staff expressed

20 Ibid.

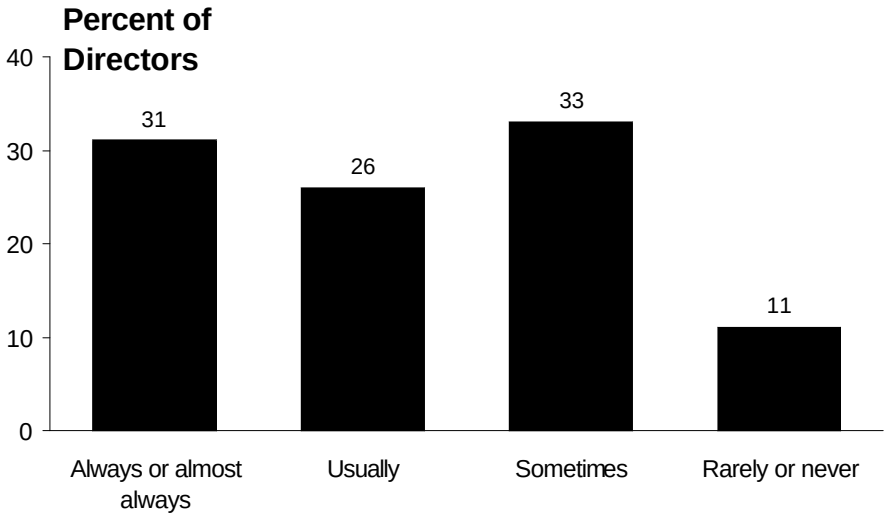
21 Ibid., (vi).

concern to us about this, given the gravity of the cases and the relative inexperience of some staff. In September 1997, we asked county human services directors statewide about supervisory practices. As shown in Figure 6.3, we learned that:

- **In less than one-third of child protection agencies does a supervisor or administrator "always or almost always" review case evidence before maltreatment determinations are made.**

Supervisors do not always review case evidence before their staff make maltreatment determinations.

Figure 6.3: Frequency of Supervisory Review of Agency Maltreatment Determinations



SOURCE: Program Evaluation Division survey of county human services directors, September 1997 (*N*=82).

Some investigative staff told us that they regularly discuss the status of individual investigations with supervisors and sometimes involve peers and others in decisions about maltreatment. In other cases, staff told us that supervisors lack the time or expertise to provide effective oversight.

Elected Officials' Approval of Local Policies

In Chapter 2, we observed that federal and state laws set general policies for local child protection agencies, but many of the federal and state definitions are vague. For example, there is room for interpretation about what constitutes "maltreatment" or "imminent danger" to a child. Consequently, county child protection agencies often develop policies and procedures to supplement federal and state regulations.

We asked staff in the eight counties we visited whether their county boards had ever reviewed the criteria that are used by child protection staff to screen

cases. With one exception (Dakota), the county boards had not formally approved the criteria. Traditionally, the state has granted counties considerable flexibility about how to provide social services, thus enabling them to respond to community needs and standards. But given the variation among counties in the incidence of maltreatment investigations and determinations discussed in Chapter 2, it is important to consider *whose* standards are being reflected in agency decisions. While some counties may have developed standards with considerable public input, the standards of some other counties might largely reflect the preferences of staff. As we discuss in Chapter 7, an option for fostering public discussion and debate about child protection agencies' "standards" is to require public approval of the decision-making criteria used.

Records Retention Practices

In Chapter 2, we noted that counties have differing policies on the length of time they keep child protection records. In cases where counties have investigated maltreatment but made no determinations of maltreatment or a need for services, some counties destroy most records quickly, while others keep most records for four years, as allowed by law. Once records of child protection allegations or investigations have been destroyed, it may be difficult for external reviewers (or the agency itself) to comprehensively evaluate the decision-making process, to evaluate whether appropriate decisions were made in individual cases, or to reconsider cases in light of new information. Thus, a strategy to improve accountability should consider how long counties should keep child protection records.

SUMMARY

In our view, the child protection system can operate most effectively when it has the confidence of the public it serves. But Minnesota's system has operated with little scrutiny, even by some of those who work within the system. There are a variety of options that the Legislature, DHS, and local agencies could consider to improve accountability, ranging from external review to improved employee supervision. We offer our recommendations in the next chapter.

Discussion and Recommendations

CHAPTER 7

Minnesota's child protection system makes important decisions about whether (and how) government should intervene in families' lives to protect maltreated children. Many of the families that child protection staff work with have multiple problems, often including poverty and substance abuse. Several long-time child protection employees told us that the cases they work on have grown more complex and difficult in recent years.

We cannot readily compare the effectiveness of Minnesota's child protection system with that of other states' systems; there simply are not sufficient data to make comparisons. But, based on our research, we do think that Minnesota's child protection system can be improved. In this chapter, we offer recommendations and options for reform to the Legislature and the Minnesota Department of Human Services.

MALTREATMENT DEFINITIONS

In Chapter 2, we discussed the wide variation in county child protection practices. We think the Legislature should consider whether it is acceptable to have varying interpretations about what cases should be investigated, determined to constitute maltreatment, or opened for services. It may be argued that county variation appropriately reflects differences in community norms and perhaps willingness or ability to pay for investigations or services. But variation sometimes reflects inconsistent interpretations of Minnesota's broadly-stated laws and rules. In our view, these laws and rules provide insufficient direction to counties, and the definitions of maltreatment should be a topic of greater public discussion. We recommend:

State rules should provide counties with clearer definitions of maltreatment.

- **The Legislature should require DHS to adopt rules that define various types of maltreatment in more detail than current law. The Legislature should authorize individual counties to implement more detailed definitions or criteria that indicate which allegations to investigate, provided these policies are consistent with state rules and approved by the county board.**

A majority of counties said they favored more state guidance about what constitutes maltreatment.

Alternatively, the Legislature could require each county board to adopt its own maltreatment definitions to reflect local standards, without requiring definitions in state rules. But we surveyed county human services directors and found that 61 percent favored additional guidance in state rules about circumstances or evidence that justify a determination of maltreatment. Another 22 percent of directors said they might favor such guidance, and only 15 percent said they opposed it. In addition, 52 percent of directors said they favored uniform statewide criteria for determining which cases should be investigated, and another 21 percent said they might favor such criteria.[1] Adopting maltreatment definitions in state rules would address the need for more specific, explicit standards about the types of behaviors or circumstances that constitute maltreatment. DHS should also consider developing training materials (and perhaps rules) that help child protection investigators evaluate the credibility of evidence and make decisions when evidence is conflicting.

Also, by adopting the recommendation above, the Legislature would explicitly authorize counties to "screen out" cases of alleged maltreatment (and, thus, not formally determine whether maltreatment occurred). Presently, the law says that agencies "shall immediately conduct an assessment" when allegations against family members or guardians are received.[2] Although all counties "screen out" some of the allegations they receive, the law does not indicate that there are circumstances where assessments and determinations are unnecessary.[3]

COMMUNICATION

Counties should strive to communicate more effectively with mandated reporters.

In general, we think that county child protection agencies should place a higher priority on communicating effectively with mandated reporters about the maltreatment cases they report. To improve mandated reporters' understanding of state and county criteria for determining maltreatment and screening cases, we recommend:

- **The Legislature should require each county child protection agency to periodically inform mandated reporters who work in the county about state maltreatment definitions, plus any supplemental definitions or screening policies adopted by the county board.**

We also think the public—not just mandated reporters—should be better informed about the criteria used by child protection agencies. However, we are not convinced that the Legislature should mandate specific actions by

1 Twenty-four percent of directors said they opposed statewide screening criteria.

2 *Minn. Stat.* §626.556, subd. 10 (a). Subdivision 10 (h) says that the agency "may make a determination of no maltreatment early in an assessment, and close the case. . . if the collected information shows no basis for a full assessment or investigation."

3 State rules say that agencies "shall screen reports of maltreatment to determine the need for assessment," but agencies are required to conduct an assessment if maltreatment is alleged, a family member can be located, and the report contains information not previously assessed by the county (*Minn. Rules* 9560.0216, subp. 3).

counties to accomplish this. County board discussions of maltreatment definitions or child protection screening guidelines might help to publicize the criteria used to make decisions, and we hope that counties can find other creative ways to do this, such as by posting criteria on their Internet "home pages."

In addition, we think there may be times when mandated reporters can better serve children and families if they receive information on child protection investigations, assessments, and ongoing services *besides* the case disposition information that counties must, by law, give to the reporters. For instance, it might be useful for a school social worker to know whether the family of a student has been complying with the requirements of its child protection case plan, or whether a county agency is investigating the family of a student. Due to data practices restrictions in state law, it is likely that most counties would not provide this information to mandated reporters who request it. We recommend:

- **The Legislature should authorize child protection agencies to provide certain mandated reporters with selected case information (other than case dispositions) that is private data.**

In general, we think that mandated reporters with *ongoing* responsibility for children's health, education, and welfare should have access to selected case information. If the Legislature has concerns about how this type of data sharing would work in practice, it could consider starting with pilot projects in selected counties.

ASSESSMENT AND INVESTIGATION

DHS should consider alternative types of risk assessment.

To reduce the incidence of repeated maltreatment in Minnesota, it may be necessary to improve the way that child protection agencies assess families that are referred to them. Research has raised questions about whether the "consensus-based" risk assessment instruments used by Minnesota countie are the most valid, reliable risk assessment instruments available. Furthermore, it is possible that alternative methods of risk assessment might provide counties with better information for case planning. We recommend that:

- **The Department of Human Services should establish a task force of county and state officials to consider during 1998 whether to revise Minnesota's approach to child protection risk assessment.**

In Chapter 4, we showed that many people who work closely with Minnesota's child protection system have concerns about its effectiveness and thoroughness, especially in cases involving child neglect. Some of these concerns are similar to those raised in other states, as summarized in a recent review:

> Most of the [child protection] system's resources are being expended on the mechanics of screening, investigating, documenting and substantiating the large number of abuse reports received each year. As a result, [child protective services are] not responding to the needs of families in crisis, nor [are they] addressing the conditions associated with child maltreatment, including poverty, single parenthood, substance abuse and social isolation. For this reason, some observers argue that the large number of poverty-related neglect cases should be handled outside the [child protective services] system altogether.[4]

County agencies need to find better ways to respond to reports of child neglect.

Several states are experimenting with alternative ways to respond to maltreatment reports. Of particular note are states with "dual track" intake systems—based on the philosophy that some types of allegations require "investigations" that focus on whether maltreatment occurred and whether criminal prosecutions should be pursued, while others (such as certain types of neglect cases) require non-adversarial "assessments" of families' needs and perhaps an offer of services.[5] For example, Virginia's state social services department has stated that assessments (rather than investigations) should be conducted in cases involving the following:

- Minor physical injuries resulting from excessive discipline;
- Injuries indicating inattention to the child's safety;
- Lack of supervision where the child is not in danger at the time of the report;
- Inconsistent satisfaction of the child's needs for food, clothing, shelter, or hygiene;
- Untreated physical injuries, illnesses or impairments where the child is not in danger at the time of the report;
- Unexplained absences from school suggesting parental responsibility for non-attendance; and
- Sporadic fulfillment of the child's emotional needs, with some evidence of negative impact on the child's behavior.[6]

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4 Stephen M. Christian, *New Directions for Child Protective Services: Supporting Children, Families and Communities Through Legislative Reform* (Denver, CO: National Conference of State Legislatures, July 1997), 6.

5 Child protection agencies in Virginia and Missouri conduct either investigations or assessments, depending on the type of maltreatment reported. Florida's regional child protection agencies also have dual track intake systems, and the agencies can transfer responsibility for investigating certain cases to law enforcement agencies. Iowa child protection agencies are still required to conduct investigations in all cases, but now these are part of broader assessments that are intended to identify the families' service needs. See a summary of several states' recent changes in Christian, *New Directions for Child Protective Services.*

6 Virginia Department of Social Services, "Child Protective Services Multiple Response System Policy," (Richmond, VA, December 1997), 4-5.

Our survey of county human services directors indicated that 45 percent of directors favor implementing a "dual track" child protection intake system, and another 40 percent said they might favor it.[7] Some Minnesota counties told us they already have a sort of dual track system, in which cases that are not investigated by child protection staff are referred to other child welfare workers for possible assessment. In addition, the 1997 Minnesota Legislature authorized the Commissioner of Human Services to approve pilot projects "to use alternative methods of investigating and assessing reports of child maltreatment."[8] DHS approved nine projects, totalling $1.6 million in state funds.[9]

Overall, we think there is a need for county human services agencies to respond more effectively to cases involving child neglect. It may make sense to implement a "dual track" intake system statewide, although DHS and the Legislature should closely monitor the results of the local pilot projects authorized in 1997. If the Legislature adopts a dual track approach, there should be a clear designation in state law or rule about which types of cases require investigation and maltreatment determinations and which do not.

SERVICES AND FUNDING

Many of the child protection system's resources are devoted to a small percentage of families who are repeatedly the subjects of child protection investigations. Naturally, it is hard to know for certain whether county agencies or courts could have prevented repeated maltreatment through different types of interventions. But, based on our review of cases and discussions with staff, we think there may be steps that agencies and courts can take to more effectively protect children. In Chapter 3, we said that there appear to be cases where:

- **Child protection agencies should broadly assess the problems and strengths of families, rather than focusing solely on the incidents alleged in a given report of maltreatment.**

- **Child protection agencies and courts should monitor the behavior of high-risk families for longer periods, with case plans that include behavior-related goals (e.g., sobriety) rather than just process-related goals (e.g., completion of programs).**

- **Child protection agencies should petition the courts more quickly in cases involving non-compliant families.**

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7 Eleven percent of directors said they opposed the dual track approach.

8 *Minn. Laws* (1997), ch. 203, art. 5, sec. 5.

9 Four of the nine projects received waivers of administrative requirements from DHS.

In our view, these actions do not necessarily require legislative mandates. Child protection agencies have authority to assess families and, when necessary, to petition the courts to authorize protective supervision. The courts have authority to place children under protective supervision at home following (or instead of) an out-of-home placement, and they also approve case plans which set conditions for family reunification or preservation.[10] Thus, we think the suggestions above could be done within existing law, but they would require continuing commitment and diligence by the county agencies, courts, and others responsible for acting in the best interests of children.

Some families may need to be monitored by counties for longer periods.

Because the courts and counties sometimes terminate their involvement with families once the goals of case plans have been met, it might be helpful for state rules and laws to clarify the authority of counties to provide continued monitoring of certain families. For example, it may be reasonable to monitor for extended periods the behavior of caregivers with histories of repeated chemical abuse or maltreatment—as a way of better ensuring the children's safety. We recommend:

- **The Legislature should require the protective services case plans authorized by *Minn. Stat.* §260.191, subd. 1e (in CHIPS cases) and *Minn. Rules* 9560.0228 (in cases where counties have determined a need for protective services) to address the need for continued monitoring of families by child protection agencies once the families have completed the services required in their case plans.**

Another option would be to create a new type of CHIPS disposition category in *Minn. Stat.* §260.191, specifically for continued protective supervision of CHIPS families following child placements or other services. We think the law allows this type of supervision, but some people told us that it is rarely used by the courts and that a separate category of disposition might increase the use of this practice.

It is possible that these actions (and other service improvements) would require additional resources in child protection and other agencies. Presently, child protection caseloads in many counties are higher than standards recommended by experts. In addition, many people we surveyed told us that child protection agencies need additional staff—to meet the needs of troubled families already on their caseloads, as well as those who are not.

Compared with most states, Minnesota's child welfare system relies to a unusually large extent on property tax revenues. Variation in counties' willingness and ability to raise revenues through property taxes may explain some of the variation we observed in child protection practices. If the Legislature perceives a need for expanded child welfare services or smaller child protection caseloads, it should consider providing state funding to help

10 The 1997 Legislature amended state law so that courts may order that "reasonable efforts" to prevent placement and reunify families be ceased if further services are "futile and therefore unreasonable under the circumstances." See *Minn. Laws* (1997), ch. 239, art. 6, sec. 13.

Minnesota counties may need additional staff, and they are already paying for a large share of the child welfare system's costs.

accomplish this. For example, in recent years the Legislature has earmarked state funds for caseload reduction in Minnesota probation services, another state-mandated service for which counties are a primary service provider.

Finally, we think the Legislature should consider ways to encourage families to accept protective services offered by counties. For example, the Legislature could amend *Minn. Stat.* §260.015, subd. 2a, further defining a "child in need of protection or services" as one from a family that (1) has been the subject of a county determination that protective services were needed, and (2) has a caregiver who fails to help develop or comply with a protective services case plan. This might make it easier for county attorneys to assemble "clear and convincing" evidence about non-compliant families for the purpose of filing CHIPS petitions.

ACCOUNTABILITY

Child protection agencies make decisions that can profoundly affect families, yet most of the case details and decisions are not subject to public scrutiny. In our view, this has weakened the credibility of child protection agencies. We recognize that, to some extent, the "closed" nature of the system reflects data privacy requirements in federal law. But we think there are approaches that the Legislature could consider to improve the system's accountability.

The Minnesota Department of Human Services provides training and technical assistance to local child protection agencies, but it has not closely reviewed agency practices or compliance with laws and rules. In our view, the department's oversight of county child protection agencies has not met the requirements of state law that DHS "design and implement a method of monitoring and evaluating social services, including site visits that utilize quality control audits to assure county compliance with applicable standards, guidelines, and the county and state social services plans."[11] We recommend:

- **The Department of Human Services should present to the Legislature by January 1999 a plan for periodic, external reviews of (1) county compliance with state requirements, and (2) the appropriateness of decisions made by county child protection agencies in selected individual cases.**

In our view, any reviews that focus on *compliance* with state laws should be conducted by DHS or some other statutorily-authorized monitor—such as an ombudsman, court monitor, or inspector general. But reviews that examine the *appropriateness* of a county's actions could be conducted by DHS staff, staff from a child protection agency in a similar county, or citizen review panels. External reviews could help identify problems and possible solutions, although it is unlikely that reviewers could look at a sample of cases large enough to be statistically representative of all cases. In general, we think that

11 Minn. Stat. §256E.05, subd. 3 (e).

external reviews should be conducted by people with a sufficient understanding of relevant laws, rules, and social work practices.

External reviews and performance measures might help strengthen accountability.

In addition, we recommend:

- **The Legislature should direct DHS to establish a "performance measurement task force" of state and county officials to identify by January 1999 (1) statewide measures of the performance of child welfare services, and steps needed to collect reliable information on these measures, and (2) potentially useful practices that individual counties could use to monitor and evaluate child welfare services.**

DHS has helped counties improve their child welfare performance measures and intends to continue to do so, but we think that a directive in law for a coordinated state-county effort might further advance this cause. We recognize that it is difficult to develop performance measures for child welfare services, and it may not be possible to develop measures that isolate the impact of public agencies on families and children. But we think the task force could help develop a consensus about what can and should be measured. For instance, the task force could aim to develop a small number of key indicators that could be regularly reported in DHS' biennial budget, agency performance report, or elsewhere. The task force could also consider how to respond to recent federal requirements for Minnesota to adopt child welfare performance indicators.[12] As the task force considers how to define key performance measures, it could consider how to collect and analyze information in a uniform manner. The task force's efforts would not be intended to discourage counties from developing additional performance measures for their own purposes. In fact, the task force could help spread information about good practices in performance measurement that have been used by Minnesota counties or other states.

In Chapter 6, we noted that some child protection determinations are made by county investigators with little or no supervisory review. We recognize that the Legislature cannot "mandate" adequate employee supervision, but we think that county maltreatment determinations are important decisions in the lives of families and merit special scrutiny. We recommend:

- **The Legislature should amend state law to require that the determinations made in all investigated cases be reviewed and approved by a county child protection supervisor.**

In addition, we think the Legislature should more clearly define the role of state and local child mortality review panels—to respond to recent changes in federal law, and to provide additional accountability in cases of severe maltreatment. For example, state law says that the purpose of the state panel is to recommend improvements to the child protection system, but it does not

12 P.L. 105-89, sec. 203, signed by President Clinton in November 1997, and P.L. 104-235, sec. 107.

indicate whether the state or local panels should draw conclusions about the individual cases they review and how the cases were handled. We recommend that:

Cases involving child deaths (or near deaths) should be scrutinized, and more records from these cases should be made public.

- **The Legislature should require state and local child mortality review panels to review cases resulting in "near fatalities" in addition to child deaths, consistent with federal requirements. In addition, the Legislature should amend the statutory purpose of the panels to include examining, to the extent possible, whether public agencies took appropriate actions in individual cases. The Legislature should adopt policies (perhaps with input from the state child mortality review panel) for making public the county child protection records in cases involving fatalities and near fatalities, including policies that indicate types of information that should *not* be made public.**

This recommendation would require counties to make public some information that is now classified as private data. However, state policy should identify particular types of records of child protection agencies that should not be made public—such as records that could be harmful to surviving victims or the victims' siblings.

MALTREATMENT RECORDS

State law requires county child protection agencies to destroy records of investigations where they did not find that maltreatment occurred or services were needed, if the alleged perpetrator so requests. In many such cases, it is possible that maltreatment occurred but the available evidence was insufficient to prove it.[13] We do not think there are benefits to destroying private maltreatment records in cases where the evidence does not point to a clear conclusion. New evidence sometimes emerges over time, and having a more complete record of prior investigations may help counties identify patterns of behavior within a family. We recommend that:

Records of investigations should be kept by counties for longer periods.

- **The Legislature should require counties to keep for four years the records of investigations that did not result in determinations of maltreatment or services needed. It should authorize counties to share these records with other counties conducting investigations of the same family members, upon request.**

Alternatively, the Legislature could require (as the law formerly did) that counties make one of three determinations at the conclusion of each investigation: (1) that maltreatment occurred, (2) that maltreatment did not occur, or (3) that the county was unable to determine whether maltreatment occurred. The Legislature could then require counties to keep records from

13 The law usually refers to cases with "no determination" of maltreatment, but at least onepart of the law (*Minn. Stat.* §626.556, subd. 10 (h)) refers to a "determination of no maltreatment."

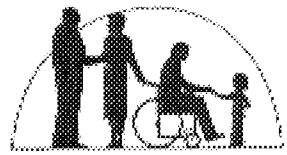
the third category for four years, and it could continue to allow subjects of investigations in the second category to request destruction of their records. State officials told us that this three-category approach was changed partly because so many investigations ended without clear findings (the third category).

We noted that one county (Hennepin) assigned case numbers to its child protection records in a way that was contrary to DHS instructions. Because of this practice, we were unable to use the DHS maltreatment information system to evaluate repeated maltreatment within families in that county. We recommend:

- **Hennepin County should revise its case numbering system so that DHS and others can track instances of repeated maltreatment within families.**

Although we did not comprehensively examine the accuracy of data within DHS' statewide maltreatment information system, we found that about half of the cases coded as child deaths in this system did not, in fact, involve a death. DHS relies largely on counties to enter data into this system. Given the errors we found, we recommend:

- **DHS should regularly audit the accuracy of maltreatment data reported by counties.**



Minnesota Department of **Human Services**

January 5, 1998

Roger Brooks, Deputy Legislative Auditor
Office of the Legislative Auditor
First Floor South
Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

Dear Mr. Brooks:

Thank you for the opportunity to review and comment on the draft legislative program audit of child protective services in Minnesota. We appreciated the opportunity to talk with your staff during the audit and to review and comment on surveys and other materials.

The report thoroughly outlines the federal and state legal framework for directing child protection practice and accurately describes the response and service delivery system in Minnesota. You have also clearly articulated the critical issues facing child protection today.

As noted in the audit, Minnesota is unique in that we are one of only ten county-administered child protection systems in the country. Furthermore, the social service system in Minnesota is funded with more local property taxes than most states' systems.

The audit confirms what many have suspected; there is variation in county practice. Variation occurs in screening, investigation, record keeping, and services. While some variation is acceptable and expected, based on community standards, availability of resources, and the individuals making decisions, we can and should do more to ensure statewide standards in critical areas. There needs to be consensus about whether, when, and how government should intervene in the lives of families in order to protect the interests and safety of children.

More guidance can and should be given on what constitutes child maltreatment or what circumstances or conditions place a child at risk of maltreatment.

The issue of accountability is something that the public demands and has the right to expect given the expenditure of public funds to support families and to protect children. You note in your report that it is difficult to achieve consensus and measure performance. None the less, we must continue to move in that direction. The Department has been working with counties and others to define and achieve measurable outcomes in child welfare. The Department's Children's Initiative with representatives from counties, communities, and service agencies has recently completed a strategic planning process. One of the goals of the plan is to increase accountability for achieving positive outcomes for children by identifying and measuring outcomes.

Competency based training of child protection staff is also essential to ensure that people have the knowledge, skills, and ability to do this most difficult work. As you know, the Department in partnership with the Minnesota Association of County Social Services Administrators and the University of Minnesota are implementing a statewide foundation and specialized training program for child welfare staff and managers. The training is available on a regional basis and is based on the needs of staff and agencies. This training system, although developed over a period of time, is a major accomplishment and is the first training of this kind available in Minnesota. Adequate training and support is particularly important for new staff entering the field of child protection.

I also want to reiterate that the recommendations for specific revisions to the administrative rule for child protection are underway. We expect final promulgation in February 1998.

Thank you for the opportunity to comment on the report. We look forward to continuing to work with the Legislature, the counties, and many others to make needed improvements in child protective services in Minnesota.

Sincerely,

David S. Doth
Commissioner