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# Variation in County Practices

## CHAPTER 2

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**B**ecause child protective services are administered by county agencies in Minnesota, there actually are 84 child protection systems in the state, not one.<sup>1</sup> 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

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<sup>1</sup> 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.<sup>2</sup> 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.

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**County screeners evaluate which reports of maltreatment should be investigated.**

## SCREENING PRACTICES

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.<sup>3</sup> 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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<sup>2</sup> 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.

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

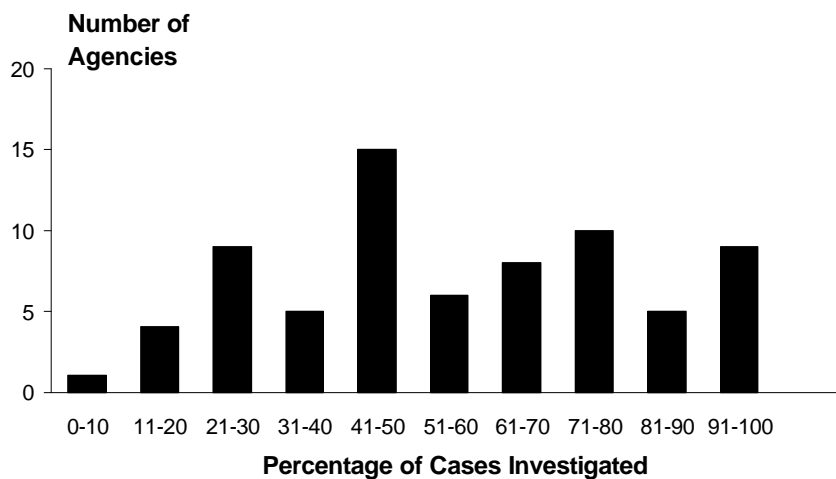
about 50,000 maltreatment allegations during 1996, or 42 allegations per 1,000 Minnesota children.<sup>4</sup> Statewide, 32 percent of these allegations were investigated by the child protection agencies. However,

**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

<sup>4</sup> 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.

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### **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.<sup>5</sup> 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

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<sup>5</sup> *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.<sup>6</sup> In addition, some criteria specify that counties will *not* investigate allegations that constitute “reasonable force” under the criminal code.<sup>7</sup>

## 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.”<sup>8</sup> 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,

<sup>6</sup> *Minn. Stat.* §609.255, subd. 3. One agency’s criteria identifies specific conditions that constituted unreasonable restraint or confinement.

<sup>7</sup> *Minn. Stat.* §609.379.

<sup>8</sup> *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.<sup>9</sup> 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.<sup>10</sup>

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;

<sup>9</sup> *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."

<sup>10</sup> *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.<sup>11</sup>

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.<sup>12</sup>

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.<sup>13</sup> 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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<sup>11</sup> *Minn. Stat.* §626.556, subd. 2 (c).

<sup>12</sup> *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.

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

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

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

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.<sup>14</sup>

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

<sup>14</sup> 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  $r = -0.41$ .

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

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

<u>County</u>	<u>Percentage of Investigations with a Finding that Maltreatment Occurred</u>
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.<sup>15</sup>

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.**

<sup>15</sup> 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.

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

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.
- 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.

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.<sup>16</sup> 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.<sup>17</sup> 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.<sup>18</sup> Five counties began less than 70 percent of their investigations within three days, and Hennepin County began only 44 percent within three days.<sup>19</sup> Excluding Hennepin County, 91 percent of the state’s maltreatment investigations began within three days.

<sup>16</sup> *Minn. Stat.* §626.556, subd. 10 (a).

<sup>17</sup> *Minn. Rules* 9560.0216, subp. 5.

<sup>18</sup> 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.

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

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

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.<sup>20</sup>

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.<sup>21</sup>

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

- 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

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

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<sup>20</sup> 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.

<sup>21</sup> 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.<sup>22</sup> 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.<sup>23</sup>

## 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."<sup>24</sup> 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.<sup>25</sup> In addition, the rules require that agencies use the risk assessment tool when considering when to terminate protective services for a family.<sup>26</sup>

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

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

<sup>23</sup> 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.

<sup>24</sup> *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.

<sup>25</sup> *Minn. Rules* 9560.0220, subp. 6.B.

<sup>26</sup> *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."<sup>27</sup> 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.<sup>28</sup>

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.

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**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.<sup>29</sup>

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

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<sup>29</sup> 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**

<u>County</u>	<u>Percent of Investigations Where the Family Was Determined to Need Services</u>	<u>Percent of Investigations Where Maltreatment Was Determined That Were Found to Need Services</u>	<u>Number of Cases Determined to Need Services Per 1,000 Population Under 18</u>
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.

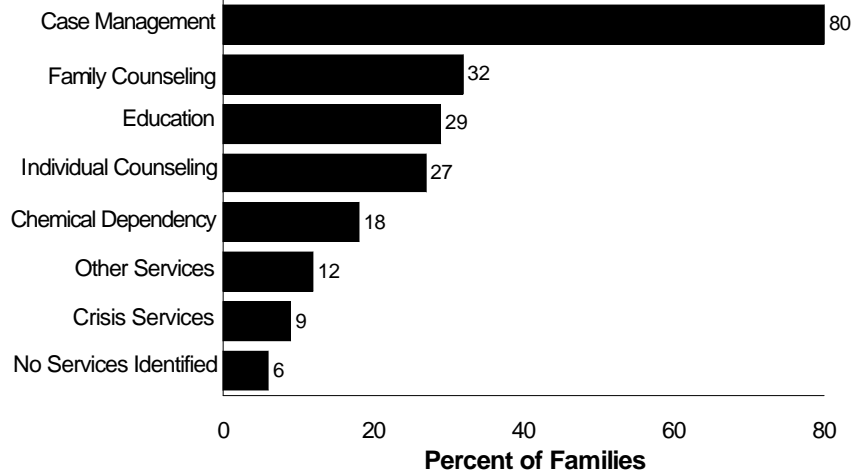
protection agencies found that 10,955 families needed child protective services during this period. The most commonly recommended services were case management (80 percent of families) and family counseling (32 percent).<sup>30</sup>

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.<sup>31</sup> 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,

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

<sup>31</sup> *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.<sup>32</sup> 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

<sup>32</sup> 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.

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**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.<sup>33</sup> 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."

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**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.<sup>34</sup> 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

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<sup>33</sup> *Minn. Rules* 9560.0228, subp. 6.

<sup>34</sup> 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**

<u>Annual Number of Maltreatment-Related CHIPS Petitions</u>		
<u>County</u>	<u>Filed Per 1,000 Children</u>	<u>Granted Per 1,000 Children</u>
Watsonwan	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.<sup>35</sup> 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).

<sup>35</sup> 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.

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

**Ten percent of victims were recommended for foster care placements.**

Type of Placement	Number of Victims Placed <sup>a</sup>	Percent of Victims Placed <sup>b</sup>
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

<sup>a</sup>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.

<sup>b</sup>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.<sup>36</sup> 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.”<sup>37</sup> Children usually left the shelter facility after a few days and either returned home or moved to a longer term foster home.

<sup>36</sup> 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.

<sup>37</sup> 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 surrounding 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**

<u>County</u>	<u>Annual Number of Victims Placed in Foster Care Per 1,000 Children</u>	<u>Percent of Victims Placed in Foster Care</u>
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.<sup>38</sup> 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.<sup>39</sup>

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 .**

<sup>38</sup> 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.

<sup>39</sup> 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.

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**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.<sup>40</sup> 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.<sup>41</sup>

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

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

<sup>41</sup> 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:

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**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.<sup>42</sup> 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.<sup>43</sup> Courts granted 68 percent of the petitions.<sup>44</sup> 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

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<sup>42</sup> 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).

<sup>43</sup> 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.

<sup>44</sup> 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.

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**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.<sup>45</sup> The rules indicate that a report is any allegation of maltreatment, not just those that are eventually investigated by the child protection agency.<sup>46</sup> 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:

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<sup>45</sup> *Minn. Rules* 9560.0230, subp. 1.

<sup>46</sup> 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.<sup>47</sup>

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**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

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

<u>Report Information</u>	<u>Number of Agencies Maintaining Information</u>
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).

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<sup>47</sup> *Minn. Stat.* §626.556, subd. 11c (a) and (b) only indicate how long agencies should keep records of cases that were investigated.

the vast majority of records for such 1996 investigations were still in county files in mid-1997.<sup>48</sup> 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.<sup>49</sup> 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.<sup>50</sup>

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.”<sup>51</sup> In cases we reviewed, some of the

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

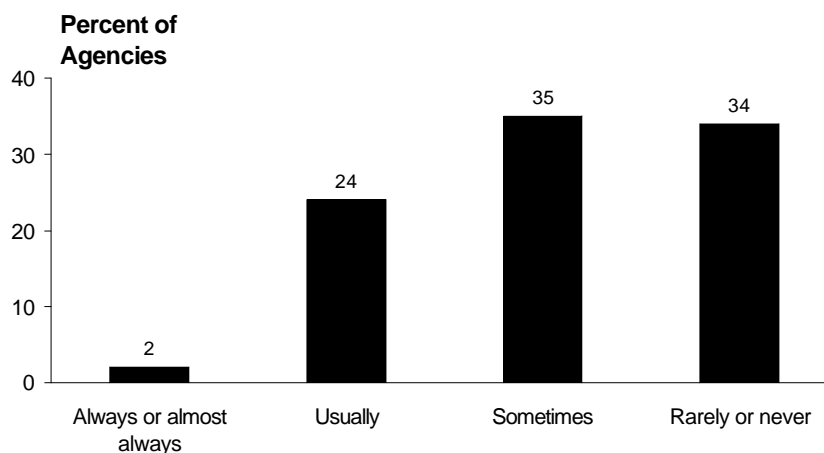
<sup>49</sup> The counties were Clay, Kandiyohi, Rice, and Washington. It is possible that these agencies were following the requirements of earlier child protection laws that directed agencies to destroy records of false reports within 30 days unless the alleged perpetrator requested that the records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

<sup>50</sup> 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).

<sup>51</sup> *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.