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

State rules should provide counties with clearer definitions of maltreatment.

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:

- **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 and performance measures might help strengthen accountability.

external reviews should be conducted by people with a sufficient understanding of relevant laws, rules, and social work practices.

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

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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 one part 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.**