

# **MICHIGAN CHILD WELFARE NEEDS ASSESSMENT**

Final Report

Submitted by:  
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To:  
**Michigan Department of Human Services**  
**Child Welfare Services**

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# **Executive Summary**

## **Introduction**

At the request of Michigan's Department of Human Services, the Child Welfare Resource Center at Michigan State University conducted a needs assessment of the Michigan child welfare system. The needs assessment is a requirement of the settlement agreement entered by the United States District Court for the Eastern District of Michigan on October 24, 2008 as part of a settlement agreement between Children's Rights and the State of Michigan.

The needs assessment is intended to assist decision-makers in developing those services and programs that are essential to improving the safety, permanency, and well-being of children in Michigan's child welfare system and that will achieve the outcomes set forth in the settlement agreement. The full needs assessment:

- Evaluates the current DHS service array, availability and utilization.
- Briefly reviews those programs and service approaches that positively impact child welfare outcomes in Michigan.
- Identifies un-met service needs for children and families served by Michigan's system.
- Identifies evidence-based practices and approaches that are in use in Michigan or may warrant consideration by policy and decision-makers as future funding and staffing priorities are decided.

This Executive Summary provides an overview of the approach and methodology utilized in the needs assessment process and presents a summary of the key findings from the full report. The detailed information and analysis that underlie the findings summarized here can be found in the body of the report and the Appendices.

## **Needs Assessment Approach and Methodology**

The needs assessment process was designed to examine the present array of available services and foster and adoptive homes, and identify areas in which resources are needed to improve care, placement, and permanency of children. In addition, a goal of the process was to identify opportunities for collaborative financial and/or service approaches, and provide a literature review that identifies evidence based and promising practices in the field of child welfare.

This assessment also integrated the findings from assessments conducted by other stakeholder groups in Michigan. As the data for the needs assessment was gathered, the Child Welfare Resource Center built a matrix of nationally relevant literature and information from which to draw. This matrix included information from online resources available through the federal National Resource Centers, the Child Welfare League of America, Adopt US Kids, the Annie E. Casey Foundation, and other nationally recognized research and resource centers. Additionally, consideration was given to those strategies that build upon alternative funding streams to support child welfare programs.

The needs assessment was conducted using both quantitative and qualitative methodology. The CWRC collected and analyzed information from new and existing sources to determine historical performance, accomplishments and challenges, and personal perspectives of those directly involved in the child welfare system. The following data collection methods were used to develop the analytical base for the assessment.

### ***Administrative Data***

The CWRC analyzed administrative data from the Department of Human Services (DHS) and the Department of Community Health (DCH) to identify current child welfare population, demographics, current service needs, and service usage levels. This data included aggregated reports from the agencies about the extent of services available statewide, funding available and used for service delivery, and, where available, prevalence data related to the estimated existence of specific needs. In addition, information provided by DHS included specific data about needs and services provided at the child and family level.

### ***Online Surveys***

Three separate surveys were posted online through SurveyMonkey.com. All DHS child welfare personnel were invited to participate in the survey as well as executives, managers, supervisors and workers within private and tribal social services agencies. Executives for each of the agencies received a specific request that they forward the survey link to their managers and social workers. Both the president of the Association of Accredited Child and Family Agencies and the Michigan Federation for Children and Family Services encouraged their member agencies to participate in the surveys.

The nature of the distribution method precludes any conclusion regarding the number of people who were actually notified of the survey and able to access the online link. It is estimated that between 3,000 and 5,000 people likely received the notification of the survey and had the opportunity to participate. A total of 531 persons responded to at least a portion of the surveys. Of these respondents, 351 completed their surveys entirely.

### ***Focus Groups***

Numerous focus groups provided information about effective services, barriers to accessing services, and availability of needed services. Some of the focus groups had been conducted for other projects but included relevant information, while most were conducted for the purpose of this needs assessment. The focus groups were conducted around the state and included government workers and supervisors, private agency workers, managers and directors, tribal representatives, adoptive parents, foster children, mental health providers, child assessment and advocacy providers, and birth parents.

### ***Interviews with Subject Matter Experts***

In addition to the surveys and focus groups, the Child Welfare Resource Center consulted numerous experts and stakeholders in the field of child welfare in Michigan as it gathered information and conducted its analysis.

## ***Analysis***

In reviewing the qualitative and quantitative information collected, the analysis followed four primary areas of emphasis – 1) Preventing Entry; 2) Supporting Placements and Expediting Permanency; 3) Maintaining Permanency and Stability; and, 4) Health and Education Needs Across the System. Within each of these areas of emphasis, the team looked at the aggregate data in light of the following questions:

- What do we know about current caseloads and outcomes?
- What do we know about current programs and services that are effective?
- What can we learn about current service gaps and unmet needs?
- What recommendations have been made by others to address identified needs?

The organization of the full report is framed around answering the questions above, based on data collected in Michigan but within a national context. The analysis takes into consideration the national trends and research that provide the best context for discussion as Michigan considers its options and the resources needed for implementing reform that is impactful and aligns with Michigan’s Child Welfare Philosophy and the settlement agreement.

## **Key Findings from the Report**

As data was gathered and reviewed, it became clear that multiple factors contribute to the current service needs and gaps in Michigan’s child welfare system. These factors are interdependent, requiring a multifaceted approach in addressing them. The most prevalent service needs and gaps emerging from the data collection and analysis process fall within the following primary themes:

- Systemic barriers impeding effective service delivery.
- Insufficient funding that negatively impacts availability and wait times for effective programs.
- Geographic differences in delivery and availability of services across the state.

The key findings in the report are summarized below, followed by brief descriptions of the identified needs and gaps that underlie the finding. The presentation of the findings in the Executive Summary follows the same general organization of the full report.

### ***Systemic Barriers***

**Finding: Systemic barriers adversely impact Michigan’s ability to consistently deliver effective, timely services to children and families.**

Perhaps the most difficult challenge in implementing statewide child welfare reform are the systemic barriers that require new legislation, additional financial resources, or effective partnerships across major systems with intersecting responsibilities within the child welfare population. If not addressed, Michigan’s ability to address the direct service needs and gaps identified in this report will likely be severely limited. These barriers, summarized below, emerged repeatedly throughout the data gathering process in Michigan:

Substantial short term investments are needed that will bring about long term cost savings. Numerous studies have shown a demonstrable link between focusing resources at the “front end” of a case to prevent incidents of abuse and neglect and the short and long term cost savings to the state over the life of that child and family.

Children’s overall well-being and developmental functioning, as well as their safety and health, need to be protected. Safety and permanency are important components of a child’s well-being, but insufficient to ensure a child’s stability and success in life. More flexible approaches are needed that recognize the relationship between safety, health, family connections, and overall growth and development, and the impact of each of those factors on child abuse and neglect outcomes.

Community partnerships are needed that provide seamless coordination and delivery of service and support across the public and private sectors. There is a need for improved integration of services and sharing of information among public and private sector systems, including the courts, schools, public assistance and mental health, as well as more informal community support networks. Virtually all focus group and survey participants identified needs related to improved communication, better coordination of case planning, assessment and service delivery, and expansion of those services proven to be effective. Coordination among the multiple staff and agencies that may be involved in a given case is needed to reduce unnecessary service delays and miscommunications.

Staffing, training and administrative supports that allow caseloads to remain at reasonable levels, and promote consistent high quality, culturally competent service delivery. Achieving the goals set forth in Michigan’s Child Welfare Philosophy and the settlement agreement requires a knowledgeable, trained workforce in both the public and private sectors. Numerous focus groups expressed a need for improved staff continuity, retention and training, as well as relief from onerous daily administrative demands such as onerous and redundant data input and reporting requirements.

Providing adequate education and support to birth parents, foster parents, adoptive parents and kinship caregivers. Regardless of where the child is living, the caregiver needs adequate training and support to provide for that child’s care, education, safety and overall well-being.

### ***Preventing Entry into Foster Care***

**Finding: Prevention and preservation services are needed in Michigan that are effective in supporting families and reducing the need for removal from the home.**

Studies have established that when parents have the skills and supports that enable them to be good parents, they and their children are more likely to grow to be well-adjusted, healthy, productive citizens, with less need for intervention and placement. “Front loading” services at the beginning of a case, even before placement, can reap significant cost savings over the long term with regard to future criminality, education attainment, productivity in the workforce, and use of public resources later in life. (Olds, et al. 1997, 1998; Rand Corp. 2008; Reynolds, et al. 2002, 2003, 2007).

Certain identified characteristics are common to the majority of prevention programs that researchers have found to be most effective (Lee, et al. 2008). These include:

- *Targeted populations.* Successful programs tend to be targeted toward a specific group of people who might be expected to benefit the most from the services provided.
- *Intensive services.* Programs with strong impacts on child welfare outcomes tend to provide intensive services. Michigan's Families First program, which has been consistently found to be a high impact program, is an example of this type of service. (Walters, 2006; Blythe & Jayaratne, 2002).
- *Focus on behavior.* The most effective programs are likely to take a behavioral approach (as opposed to an instructional approach), such as coaching parents one-on-one during play sessions with their children. (Weisz, et al. 1987).
- *Inclusion and engagement of both parents and children.* The most successful programs acknowledge the central role of the parent-child relationship in child outcomes, and fosters positive, collaborative relationships between the family and the organizations and professionals that conduct investigations and provide services. (Lee, et al. 2008).
- *Program fidelity.* Successful programs have demonstrated the importance of maintaining adherence to the original program model and intent.

Examples of programs that meet the above criteria, some of which are in use in Michigan, are described in detail in the full report. They include:

- Structured Decision-Making – in use in Michigan.
- Differential Response.
- Family Group Decision-Making – in use in Michigan.
- Healthy Families America.
- Nurse Family Partnership for Low Income Families.
- Intensive Family Preservation Services (Homebuilders®) – in use in Michigan (Families First).
- Chicago Child Parent Centers.

**Finding: Prevention and preservation services in Michigan are effective in supporting families and reducing the need for removal from the home, but are not sufficiently available to meet the needs of children and families across the state.**

There seemed to be a consensus among all participant groups that prevention programs generally were high quality and effective, when available. Survey and focus group respondents consistently identified mental health and substance abuse services, Families First, Family Group Decision Making, Team Decision Making, parent and in-home services, and wraparound, as being important and effective services. Needs and gaps raised by the administrative data and expressed by survey and focus group participants related to regional availability, waiting lists, and unevenness and inconsistency between workers. Overall needs relating to prevention and preservation services are summarized below:

### ***Geographic Disparity***

Geographic disparities in the availability and delivery of services means a child and family is not able to get the same level or type of services in every community they may be in over the life of

a case. In some geographic locations there are no local prevention workers, and CPS is the only doorway to services. Differences were also reported in how services are coordinated between counties and differences in the way counties understand and interpret policy. There are very few medical examiners that specialize in abuse exams and they currently serve multiple counties. There is a need to train additional doctors in this specialty, so there can be one doctor per county.

### ***Assessment***

Open ended responses from CPS staff indicate that a variety of assessment tools are used; however, it appears that not all tools are available to all workers, and additional training is needed regarding the use of alternative assessment tools and the different purposes served by each. Focus group participants expressed a need for assessments, especially mental health and substance abuse assessments, to be individualized to the needs of the particular child or family member. Birth parents expressed a need to have access to services prior to the time a crisis arises and also raised concerns that they were not consulted or involved in their case planning.

### ***Prevention and Preservation Services***

There is a clear need to increase accessibility to services and to decrease the wait times for enrollment. A substantial number of workers in all responding groups reported waits in excess of four weeks for many physical, mental, and behavioral health related services. The wait time for physical health services was typically 5-6 weeks. Dental services and transportation were most frequently reported as not sufficient or unavailable. Dental care commonly requires a wait of 5-6 weeks, and 13% of survey respondents reported that it can take more than 12 weeks to get a child to a dentist. Home visiting programs, which provide many tangible supports such as housing, financial and transportation assistance in addition to parenting and health related supports, were identified as among the most effective prevention interventions. However, they typically require a 3-4 week wait to get started, and substance abuse and employment training generally take 4-5 weeks to begin. These numbers are significant given the impact that problems with substance abuse, mental health, transportation and housing can have in the decision to remove a child and the decision to return a child to the family.

Caseworkers identified a need for mentorship programs for parents, especially those with cognitive difficulties. Mental health providers expressed a need for intensive services to improve the parents' ability to understand, cope with, guide and manage their own children's development. Respite care was identified as a critical preservation service need, especially helpful for families coping with children and youth with serious behavioral health problems.

### ***Supporting Placements and Expediting Permanency***

**Finding: Services are needed in Michigan that are effective in supporting children in placement and their caregivers, and that promote timely reunification and permanency.**

Needs of children in care vary by age group, along with the types of services their parents need. Based on administrative data provided by DHS, the percent of children currently in foster care in children in the 0 to 3 age group comprise over twenty percent of children in care, followed by children between 15 and 17, at almost eighteen percent. Intensive, customized approaches that

involve family members in identifying strengths and needs as well as planning for appropriate services are important throughout the life of the case. Where reunification is the goal, timely identification and delivery of services and supports to the entire family is critical. At the same time, there is an important need to focus on the child's health, development and well-being.

Foster children as a group are an extremely vulnerable population, and care in addressing their needs effectively is essential in order to minimize the negative impact of foster care and increase their chances of growing into successful, productive adults. Evidence is clear that the longer and less stable a child's tenure in the foster care system, the more likely he or she will experience negative long term outcomes (Bruskas, 2008, Doyle 2007). These negative outcomes include higher rates of criminal behavior, serious mental illness, lower academic achievement, high unemployment, and higher rates of homelessness and use of public welfare resources.

Certain characteristics are common to interventions focused on placement stability and reunification and include:

- *Family engagement.* Engaging the family in a collaborative way is extremely important when placement has occurred and reunification is the goal. The three critical relationship dimensions to family engagement are:
  - Caseworker and family, and the development of a trusting, mutually respectful partnership in supporting the needs of the child.
  - Parent and child, and the support of frequent, quality parenting time.
  - Foster parents and child, birth family and caseworkers, to ensure positive and appropriate level of skill and involvement by substitute caregivers.
- *Assessment and case planning.* Assessment and service planning that is customized to each family's needs and involves the family in the planning and decision-making is essential.
- *Evidence-based, comprehensive services.* Services which involve the whole family, are cognitive-behavioral in approach, focus on skill building, and address family functioning within multiple systems (home, school, community, etc) are more likely to support timely and long lasting reunification.
- *Concrete and practical services.* Examples include assistance with transportation, housing and utilities.
- *Substance abuse treatment.*
- *Mental health treatment.*
- *Home based services.* Intensive home-based services can be especially important where extreme poverty, lack of social supports, or substance abuse are factors.

Examples of programs or approaches, some of which are in use in Michigan, that meet the above criteria and achieve significant impact with regard to reunification, placement stability, and recurrence of maltreatment include:

- Concurrent Planning – currently being implemented in Michigan.
- Family Reunification Program – in use in Michigan.
- Wraparound or Systems of Care Services – in use in Michigan.
- Kinship Care and Subsidized Guardianship
- Project KEEP

Foster care workers responding to the survey identified specific programs such as Wraparound, Family Reunification, and Families First, as well as mental health and in-home services more generally, as effective services that support families after the child has returned home. In-home services most frequently cited by survey respondents as effective include parenting education, homemaker services, and parent aide assistance. Both caseworkers and managers participating in focus groups confirmed the survey results and stated that the Family Reunification Program funding in particular is an important resource for families and needs to be expanded. Team Decision Making and other team-based approaches were also emphasized as effective and important.

**Finding: Services in Michigan that are effective in increasing placement stability, promoting reunification, and supporting caregivers, are not sufficiently available to meet the needs of children, families and caregivers across the state.**

Many programs and approaches mentioned as being effective were often qualified with comments relating to availability, accessibility, waitlists, lack of resources to fully support the program in all areas of the state, or effectiveness that was dependent on the skill and experience of the assigned worker. There is a need to identify effective programs developed locally and expand them to other appropriate venues. Specific categories of need are summarized as follows:

### ***Concurrent Planning***

Concurrent planning inherently involves conflicting goals, which can create tensions not only within the agency, but also between the agency and the families and communities with which they are working. To increase rates of reunification as well as permanency for children who cannot be reunified, these competing goals must find a balance in actual practice. Managers need to communicate a unified message about the need to pursue competing goals simultaneously. Due to the shortened time frame that a birth parent has to achieve reunification when concurrent planning is being implemented, traditional family assessment protocols and timelines may not be appropriate. Workers need the resources to adequately assess the family and provide early and intensive services to a parent, thus maximizing the opportunity for reunification. Inclusion of birth parents in the process from the beginning is essential, but requires adequate levels of trained staff to ensure consistency managing the complexities inherent in concurrent planning.

### ***Placement Stability***

Placement stability can have a dramatic impact on a child's chance for permanency or reunification. In order to reduce placement disruptions and increase the opportunity for permanency, Michigan will need to do the following:

- Develop targeted strategies for recruiting and training resource families with the skills and experience to handle the needs of all the children in care, including those with special needs such as those with behavioral or mental health issues.
- Coordinate educational services with other service systems, thereby reducing the need to move children because of their educational needs.
- Develop effective mentoring and other volunteer-based programs that can provide an ongoing connection with a caring adult regardless of where the placement is.
- Expand the use of home based services to provide much needed support to a family.

- Improve cooperation and integration of services between service providers, particularly those providing home based services, mental health and substance abuse services, residential and group home care.
- Set up a foster parent to foster parent liaison system to support foster parents, especially in the early days of fostering.

### ***Assessment and Concurrent Planning***

For the most part workers are using the required FANS and CANS assessment tools. However, other assessment tools available to identify child or parent needs more specifically are much less frequently used. A significant number of survey respondents confirmed the need for specialized assessment tools that would assist them, particularly in cases involving trauma, mental health and substance abuse issues. This suggests that education and training on the existence and proper use of additional, more specialized assessment tools is an area requiring further attention.

### ***Family Engagement***

Team Decision Making (TDM) protocols are generally seen as effective, but workers expressed a need for a larger pool of facilitators and some flexibility in how and when they get scheduled. According to some focus group participants, parenting classes not as effective as they could be because classes often do not involve interaction, modeling, or provide opportunities for parents to practice what they have learned. Several focus groups expressed a need for specialized, interactive and culturally sensitive parenting classes, as well as more father and mother/baby programs. Workers also expressed a need for more appropriate sites for supervised family visits, and raised concerns about the ability to meet the mandate and accommodate the needs of the family within current limitations of practice.

### ***Reunification Services***

There is a need to address access to programs and services. Workers commonly experience significant wait times and limited availability when trying to access those services they report as being most needed and most effective, such as health (especially dental), education, financial assistance, transportation and mental health services. When services slots are not available, or when funding to pay for services is not available, options for families are limited, and the length of time in care is often extended for reasons unrelated to a parent's willingness to comply with the service plan.

Birth parents reported that their most common barriers to reunification are transportation, daycare to attend services and employment, finding employment, and clear and consistent communication from all involved (worker, service provider, court) about expectations, chronology of events, and positive and negative outcomes. Mental health providers identified a need for better preparation of parents and children for reunification, with parents actively involved with their children throughout the placement period.

### ***Foster Parent Support***

Through surveys, focus groups and work groups, a number of needs emerged with regard to the lack of capacity of current foster homes to meet the needs of children placed out of home. Given the substantial number of older youth in care, as well as those who are reported to have serious mental and behavioral health problems, workers have limited options for children who need

caregivers with the skills and experience to manage those issues. This means that many children are placed in homes ill equipped to address their unique circumstances. Workers expressed the same lack of capacity with regard to relative caregivers, indicating the need for not only targeted recruitment of caregivers, but also more training and support to all substitute care providers.

In addition to recruitment and training issues, there is a clear need for improved supports for foster parents in general. Focus group participants voiced concern about their ability to support foster parents, and expressed a need for in home services, improved timeliness of paperwork, and faster payments to foster care providers. Mental health service providers indicated a need for foster parents to be part of the therapeutic team for children receiving mental health treatment, including participation in treatment sessions. More frequent and direct communication with foster parents is needed, and a need was expressed for both foster parent and foster child support groups.

### ***Material Assistance: Housing, Financial & Transportation Needs***

Multiple sources and reports note that clients have limited transportation access, which can have a dramatic and negative impact on a parent's ability to comply with the service plan and parenting/visiting opportunities. Lack of housing options is a common barrier to reunification and children end up staying in care longer as a result. Wait lists for public housing in some areas can be many months or even years.

### ***Maintaining Permanency and Stability***

**Finding: Intensive, customized approaches to establishing permanency are needed when termination of parental rights has occurred. Extended family members and foster families need to be involved in identifying potential permanent connections and continuing service needs that will ensure the child's continuing health, safety and functional development.**

The number of parental rights terminations typically exceeds the number of adoptions and other exits of permanent wards from foster care. The statewide average length of time in care for children with parental rights terminated is 4.38 years. As described previously, long periods of placement and frequent moves increases the likelihood that a child in the foster care system will experience negative long term outcomes. In order to increase children's chances of growing into successful, productive adults, youth need to be able to establish a permanent family connection and prepare for the time when they will be living independently. The older a youth is, the more important both of these goals become.

Adopted children are more likely to be younger than those who are placed with legal guardians or who are waiting for permanent homes, and fewer adopted children are members of ethnic minorities. Thus, the older a child is, the more likely that child will languish in the child welfare system waiting for a home, and the longer the child waits, the more likely that child will eventually age out of the system before a home is found. This can then lead to many of the negative outcomes described above (Testa 2004).

### ***Kinship Care and Guardianship***

Relatives are becoming the fastest-growing source of permanent homes for foster children (Testa 2004). The success of kinship and guardianship placements are impacted by the level of post-placement services and supports as well as the level of available financial support. (Terling-Watt, T 2001). If kinship care and guardianship are to be viable options in Michigan, particularly for the older, harder-to-adopt child, appropriate levels of support and compensation to the caregiver will be needed.

**Finding: Post permanency and youth transition services are insufficient to fully meet the needs of Michigan's families and children.**

### ***Post Permanency Services***

Many former foster children, even if adopted as infants, have special health, learning or behavior issues that do not become apparent until years later. Many of these children carry multiple risk factors with them, and research has shown that the number of special needs is the most significant predictor of child outcomes and family adjustment to adoption (Wind, et al. 2007). When clinical issues arise that require intervention, families need services that are sensitive to the specialized issues relevant to the child's trauma and placement history. While most adoptive families or guardians never experience an emergency or crisis requiring intervention, those that do typically have exhausted their informal networks of family, physicians, religious leaders, etc. before contacting their adoption provider. Services commonly requested include:

- Respite care.
- Support groups.
- Educational support.
- Counseling.
- Assistance in finding and accessing residential care.

Adoption and permanency workers consistently identified health related services (mental health, psychiatric, dental and physical health, and substance abuse services) as not sufficiently available to the children and families in their care, or unavailable altogether. These services also often require long wait times, sometimes more than 12 weeks. Other services, including employment, transportation, and programs such as wraparound and Families First, also have limited availability and long wait lists.

### ***Services to Aid Transition to Independence***

Survey respondents and focus group participants generally agreed that youth transition and life skills services were effective when utilized, but they also identified those same services as not being sufficiently available to the children in their care. Most provider focus groups felt that services to transitioning youth were one of the areas of greatest need. Services that were identified as effective, but limited in availability or accessibility included:

- Housing program for teens (Wayne County).
- Ingham County Independent Living Program.
- Michigan Works!
- Youth in Transition
- Education tuition incentive program.
- Michigan Adoption Resource Exchange (MARE).

- Reconnect program, a program for case mining and finding relatives or other important potential connections for older youth (Kent County).
- Michigan Youth Opportunity Initiative.

Numerous focus groups expressed a need for affordable, suitable housing for transitioning youth. A need was also expressed regarding the fact that most youth who age out of foster care do so with no mentors and no permanent connections. There is a need for volunteer mentors within a youth's community to help aging out foster care youth. There is a need for more information sharing, collaboration and communication among youth, child welfare professionals and other systems personnel that serve the aging out population.

### ***Adoptive Parent Services and Capacity***

There is a need for more families of color and families that can care for children with special needs. Perhaps not surprisingly, over 70% of survey respondents identified older children and those children with behavior problems as the most difficult to place. Given this overwhelming response, also confirmed through the focus groups, caregiver recruitment strategies need to focus on finding families with the interest and skills to manage this hard to place group of children.

Other needs relate to the recruitment, retention and support of adoptive families. For example, there are geographic "dead zones" across the state where there is no easily accessible adoption agency for families. No agency means there is no recruitment and no services. Training and support is needed to solidify families and help them stay together. Adoptive parents need support groups and connection with other experienced adoptive parents. Affordable respite and child-care is needed. Parents are spending large amounts of time transporting youth to therapies, school activities, enrichment activities and responding to relational issues.

### ***Service Needs Across the Continuum of Care***

Physical abuse and neglect, together with the resulting instability and uncertainties created when a child is removed from the family home, can have significant adverse impacts, both short and long term, on a child's ability to grow and develop into a productive, successful, stable adult. When the uncertainties and instabilities often inherent in the foster care system continue over long periods of time, which in a young child's life can be a matter of mere weeks, the child can experience severe depression, difficulty forming attachments to others or developing healthy, trusting relationships with adults and peers. These feelings are often manifested through acting out and other antisocial behaviors and can also have dramatic negative impact on their ability to be successful in school (Berrier 2001).

Children in foster care, especially those who have experienced trauma before coming into the system, and those who have experienced multiple moves after coming into the system, are much more likely to be developmentally delayed in all areas – physical, cognitive, social & emotional (Child Welfare Information Gateway 2008). The emotional and physical effects children experience when they are removed from the family home can have dramatic impact on that child's ability to be successful in school, particularly when multiple placements cause multiple disruptions and changes in the child's educational environment. As a group, children in foster care perform much more poorly than their non-foster care counterparts (Christian 2003).

Children and families involved with the child welfare system experience significant stress and uncertainties along a number of dimensions. Frequently, they have needs for which available services fall outside the direct administration or control of the child welfare agency. Notable among these are needs for help with mental health, physical health, dental health, substance use disorders and education. In addition these families and their children often experience concrete service needs such as need for housing assistance, employment services, transportation and others not easily met through existing programs or funding mechanisms.

Availability and wait times appear to be significant factors impeding accessibility to services. Given that reunification or family preservation is often dependent upon a birth parent receiving services for a serious mental, substance abuse, or behavioral health disorder, there is a need to increase availability and accessibility to those services that are most effective and most needed.

**Finding: Accurate and timely multidimensional assessments are needed to facilitate planning that will identify the services needed to address the emotional, behavioral, physical and educational needs of children and families.**

Accurate and timely assessments, followed by appropriate, timely services to address the needs identified, are key to understanding and treating the full scope of a child's needs. Without effective tools to aid in developing the most appropriate treatment plans, children are at severe risk of not receiving the treatment they need, thereby exacerbating the problems which will continue to plague them over their lifetime. These issues are relevant at all stages of a child welfare case, even before placement occurs, and particularly after reunification or adoption.

A collaborative project of the Saginaw County Community Mental Health Authority (SCCMHA) and the local office of the Department of Human Services in Saginaw County (DHS) in 2008 assessed the extent and types of mental health needs of Saginaw County children in foster care. The Devereux Early Childhood Assessment (DECA) was selected as the assessment instrument for children up to age six and The Child and Adolescent Functional Assessment Scale (CAFAS) was used for assessment of children and youth of full-time school age. The study concluded that between one-half to two-thirds of all Saginaw County children in foster care have moderate or critical mental health needs. Of the children assessed, 56.6% had been referred for some type of mental health services. However, of those children found to have moderate or critical needs, only 69.4% had been referred while 30.6% had not been referred for mental health services at the time of the study. Even though this study was limited to one county, these results nevertheless suggest that the scope of the mental health problems for foster children in Michigan may be larger than previously thought. The most frequently identified problem for children in the sample was behavioral concerns, suggesting that services targeted to educating caregivers on effective parenting techniques are indicated for this type of concern.

**Finding: Services are needed in Michigan that are available, accessible and effective in supporting and addressing the mental health needs of children and families in the child welfare system.**

Strategies are needed for addressing some of the concrete and systemic challenges to providing mental health services to their foster care populations. Effective strategies need to include the following (McCarthy, et al. 2004):

- *Assessment* – Increasing the number of children in foster care who receive mental health assessments and developing comprehensive assessment tools that include the family.
- *Training* – Improving training of child welfare staff, clinicians and foster parents on evidence based practice guidelines, service planning, addressing specialized issues such as developmental disabilities, domestic violence, sexual abuse and substance abuse.
- *Collaboration* – Improving the collaborative partnerships and sharing of information and resources across systems.

A need exists to develop more complete array of services for children to include 1) more accessible services for all children who meet the test for SED services, 2) specialty care for children with particular needs, such as physical and developmental disabilities, histories of sexual abuse, and serious mental illness and 3) services for children who need minimal support that don't qualify for CMH services. Services needed for specific segments of the child welfare population include:

**Children/Youth**

Therapeutic services are needed for children who experience mild to moderate mental health problems not currently available to children who do not meet the SED standards required to receive services from CMHSPs. This may be partially addressed by expanding the number of allowed counseling sessions beyond 12. Specialized cognitive and behavioral therapies that address the needs of children within their family systems, focusing on helping parents develop successful behaviors for working with the child and managing the child's problems were identified by focus group respondents. Additional needs identified by the data include therapeutic services that address trauma, separation anxiety and attachment disorders experienced by children who have been subject to maltreatment, removal from their parents' homes and, sometimes, multiple moves among foster care placements. Treatment for specific disabilities such as speech and language disorders and cognitive impairments are also needs.

**Older Youth**

Accessible mental health services need to be expanded and accessible to youth transitioning from foster care

**Family/Child Counseling:**

Trained family and child therapists who understand the specialized needs of families and children in the foster care system and know how to work in the system.

**Adults:**

The waiting lists for low cost mental health services for adults need to be eliminated or shortened.

**Adoptive Families, Relatives and Foster Care Providers:**

Adults caring for children need to be part of the treatment team for the children in their care and need more mental/emotional support and assistance, especially in-home assistance. Therapists are needed who have knowledge and skills related specifically to adoptive families.

In addition, a need exists to ensure availability and effectiveness of treatment foster homes. Creative marketing and recruitment strategies designed to increase the number of treatment foster care families is needed. Once recruited, treatment foster families need to be adequately trained and supported.

**Finding: Services are needed in Michigan that are effective in supporting and addressing the substance abuse needs of children and families in the child welfare system.**

For families involved in both the child welfare and public mental health and substance abuse treatment systems, obtaining timely, coordinated and effective treatment can be challenging. Both systems operate under different and even conflicting mandates, priorities, time lines and treatment philosophies. Effective programs targeting substance abuse needs include dependency/drug courts, which are already used in some locations in Michigan and have been proven useful here and across the country in addressing substance use disorder problems in a cross-system collaborative manner.

Substance abuse assessments need to be tailored to determining the individual care needs of children and families. Additional education is needed throughout the child welfare system, the courts, and other service providers about the “clinical nature” and treatment of substance abuse. Treatment plans need to be aligned with realistic treatment goals, and designed to overcome barriers that impede recovery, such as transportation or childcare issues. Substance abuse funding and resources are needed to make services accessible to all who need and seek services, as well as additional in-patient substance abuse treatment for parents trying to reunify in settings that allow children to stay with parents when appropriate.

**Finding: Dental care service availability and accessibility needs to be expanded to ensure that all children in foster care receive timely services:**

Special consideration of expanding the Healthy Kids Dental program to cover all children may be useful at this time, given the increase in Medicaid Federal Financial Participation now available to Michigan.

**Finding: Improved coordination between child welfare, mental health and education providers is needed:**

Schools need a better understanding of the emotional needs of foster children and the behavior that results, particularly limit-testing behaviors that occur among children who experience disruption in personal attachments with caring persons in their lives. DHS and schools need to

work collaboratively and maintain effective communication regarding the needs of children in care.

**Finding: Service and resource accessibility needs to be expanded for concrete services families and children need to ensure stability, participation in service and treatment plans and success upon reunification of children with birth families:**

Support for transportation, housing, respite care, child care and financial assistance are of particular concern. Communications about the methods for accessing the resources currently available and any that are added to the current array need to be developed to promote understanding among service providers and service recipients.

## I. Introduction

The Michigan Department of Human Services (MDHS) requested that the Child Welfare Resource Center (CWRC) at Michigan State University (MSU) conduct a needs assessment of its child welfare system. A needs assessment is required by the settlement agreement entered by the United States District Court for the Eastern District of Michigan on October 24, 2008 and is the result of a settlement agreement between Children's Rights and the State of Michigan. The settlement agreement establishes the scope of the assessment and timeframes for completion. The assessment process began in November 2008 and was completed in May 2009. CWRC worked in consultation with MDHS to ensure a comprehensive and integrated approach to addressing the requirements of the settlement agreement.

The results of the needs assessment are presented here to assist decision-makers in developing those services and programs that are essential to improving the safety, permanency, and well-being of children in Michigan's child welfare system and that will achieve the outcomes set forth in the settlement agreement. The needs assessment will:

- Evaluate the current DHS service array, availability and utilization.
- Briefly review those programs and service approaches that positively impact child welfare outcomes in Michigan.
- Identify priority un-met service needs for children and families served by Michigan's system.
- Identify evidence-based practices and approaches that are in use in Michigan or may warrant consideration by policy and decision-makers as future funding and staffing priorities are decided.

A six month time frame allows for an initial assessment. However, the necessary limitations on the breadth and depth of this project, the time constraints, and the nature of an assessment of this scope suggest that additional data collection and analyses will further illuminate needs and services. It is not the purpose of this assessment to develop and present an array of recommendations or steps for implementation. The information and findings presented in this report are intended to inform the Department's development of an effective service array to address the permanency planning and other needs of children, youth and families.

There are a number of limitations to this report. These limitations include:

- In some areas, there is insufficient data or the available data requires further analysis and scrutiny to inform the needs assessment.
- There is the need for further in-depth analysis of certain aspects of the child welfare system's needs due to time and information constraints.
- Care is warranted in interpreting information gathered from surveys and focus groups. However, the validity of the information is supported by the frequency and consistency of responses.
- Information gathered from existing reports is intended to provide further validation of observations as well as provide some expanded discussions.

The findings from this needs assessment may not be seen as new or revolutionary. Keeping families together safely, temporarily placing children in nurturing foster homes, addressing the well being of children and families, helping and restoring families when safely possible, or promoting alternative permanency plans, is the challenge for Michigan's child welfare system. There is more to learn about the needs of the system and the families served by the system but this assessment also finds that there is much that is known and the challenge is to effectively provide the services that promote safety, permanency, and well being.

### ***A. Settlement Agreement Requirements***

Section IX.A of the settlement agreement requires that the assessment demonstrate the need for additional services and placements. This includes the need for adequate:

- Family preservation services.
- Foster and adoptive placements.
- Wraparound services.
- Reunification services.
- Medical, dental, mental health and substance abuse services.

Additionally, the settlement agreement requirements include a review of the availability and use of flexible funds that caseworkers have at their disposal to purchase specific goods for families, and recommendations on how to maximize this funding availability. The intended purpose of flexible funds is to meet specific identified needs and/or remove barriers to achieving reunification or permanency in an expeditious manner.

### ***B. Needs Assessment Approach***

The settlement agreement assumes that Michigan's system reform efforts will substantially decrease the number of children in placement awaiting reunification or legal permanency and will decrease the number of children entering the foster care system. The reduced entries will result from improvements in intake services, prevention services and in-home preservation services. These efforts will also decrease the caseload ratio for public and private agency workers, permitting MDHS to reduce caseloads to the specified levels. Recommendations made to address service gaps and needs will take into account the goals of the settlement agreement and the ability to achieve those outcomes with current resources.

The needs assessment analysis is designed to:

- Explore the extent to which the present array of available foster and adoptive homes is appropriate to the characteristics and needs of the foster care population.
- Identify areas in which resources are needed to improve care, placement, permanency, and supervision of children who have experienced abuse and/or neglect including resources for special populations such as children with special needs, older youth, sibling groups, and children who have experienced multiple placements.
- Identify opportunities for collaborative financial and/or service approaches with other departments or partners to develop and/or provide needed resources.

- Provide a literature review that identifies evidence based and promising practices currently in use and under study in the field of child welfare, particularly in the areas of prevention, placement stability, and permanency. The services and approaches described in this report may have particular relevancy to current reform efforts in Michigan, and some of the proven practices that are both cost effective and high impact are already in use in Michigan. Feasibility of new or expanded programming for Michigan is not addressed in this report as that will be dependent upon funding and staffing priorities yet to be determined at both the legislative and MDHS administrative leadership levels.

This assessment also integrated the findings from assessments conducted by other stakeholder groups in Michigan. For example, one study completed by the Ingham County Child Maltreatment Advisory Project in 2003 sought to explore several questions related to the rising number of foster care children in Ingham County. The project was a collaboration of the Ingham County MDHS, Ingham County MSU Extension, and the MSU School of Social Work. A cross section of professionals and lay persons involved with the child welfare system were interviewed and included parents, judges, DHS caseworkers, private agency workers, and mental health providers. The interviewees were asked questions relating to the number of children in out of home care, resources needed to keep them safe in their own homes, and opinions regarding changes needed that would reduce the time spent in out of home care.

Responses from the interviews were summarized according to the different patterns and themes that emerged. Interestingly, many of the service and system needs that were reported anecdotally by child welfare stakeholders in Ingham County six years ago are mirrored in this current report on statewide issues and needs. These needs include:

- Expansion of existing in-home services to reach more families, including those families needing services after reunification has occurred.
- Development of additional intensive and home-based services that include visiting nurses, home-based parenting skills training, mental health counseling and substance abuse services, and more and better services for birth parents and foster parents.
- Initiation of multi-disciplinary approaches to assessment and service delivery that would foster collaboration and cooperation among the mental health, child welfare, substance abuse and court systems so that professionals are better able to work together by being informed and understanding how each system is involved with each family.
- Caseload size reduction and training of caseworkers, to reduce the variations seen in the levels of commitment and effort to work with marginal families and keep children at home. This may also help reduce stress and burnout which can lead to high staff turnover rates.
- Applying a family-centered approach, particularly after removal, to assure parent participation and reduce the tensions that can exist between parents, foster parents and caseworkers.
- Improvement in the court system to reduce delays and speed up decisions.
- Improved funding for the child welfare system.

As the data for the needs assessment was gathered, CWRC built a matrix of available literature from which to draw. This matrix included information from online resources available through

the federal National Resource Centers, the Child Welfare League of America, Adopt US Kids, and the Annie E. Casey Foundation, as well as the following organizations:

- Washington State Institute for Public Policy.
- Children’s Research Center in Madison, WI.
- National Resource Center for Family-Centered Practice and Permanency Planning, Hunter College School of Social Work.
- Georgetown University Child Development Center.
- National Center for Children in Poverty, Mailman School of Public Health, Columbia University.
- Children’s Law Center of Los Angeles.
- National Resource Center for Foster Care and Permanency Planning, Hunter College School of Social Work.
- Center for Social Services Research, University of California at Berkeley.

The review sought information on best practices relative to the scope of this needs assessment. The literature review identified approaches, programs, and services that have been found to improve outcomes for children in various states across the nation, including Michigan. Additionally, consideration was given to those strategies that build upon alternative funding streams to support child welfare programs. The CWRC also gathered assessments and available reports and recommendations from other active Michigan stakeholder groups, including:

- Child Welfare Improvement Task Force (CWITF), a state appointed group of 85 lawmakers, child welfare advocates and university officials, which met extensively throughout 2008 and early 2009.
- Michigan’s three Citizen Review Panels (CRP), the Child Death CRP, Prevention CRP and CPS, FC, and Adoption CRP.
- Foster Care Review Board (FCRB), a third party review program administered by the State Court Administrative Office (SCAO) of the Michigan Supreme Court. The FCRB comprises citizen volunteers who randomly review specific cases and issue annual reports of their activities and findings.

### ***C. Methodology***

The needs assessment was conducted using a research design consisting of quantitative and qualitative methodology. The CWRC collected and analyzed information from new and existing sources to determine historical performance, accomplishments and challenges, and personal perspectives of the child welfare system. The following are descriptions of the data collection methods that were used to develop the assessment and some illustrative examples of information gathered using those methods.

#### **1. Administrative Data**

The needs assessment analyzed administrative data from the Department of Human Services (DHS) and the Department of Community Health (DCH) to identify current child welfare population, demographics, current service needs, and service usage levels. The administrative data includes aggregated reports from the agencies about the extent of services available

statewide, funding available and used for service delivery, and, where available, prevalence data related to the estimated existence of specific needs. In addition, the data includes specific data sets available from DHS databases about needs and services provided at the child and family level. This latter data enabled the CWRC to develop a variety of data views that permit some in depth analysis about service delivery needs in Michigan.

#### **a) DHS Administrative Data**

This assessment relies upon DHS published program data from the following sources:

- MDHS Annual Report of Key Program Statistics 2008
- MDHS 2008 Child Care Fund Annual Report
- MDHS Program Descriptions 2008
- MDHS Information Packet April 2008
- Overview of Special Services – MDHS Web Site
- DHS L-07-051(L Letter is an official communication tool issued to inform all DHS employees of matters contained in the letter).
- DHS L-07-141 (L Letter communication)
- Bureau of Adult and Child Licensing
- US Census Data 0 2007 Child Population Estimates

In addition, DHS has provided eight data sets drawn from the data warehouse that provide child and family specific data for further analysis. While these data sets do not include personally identifying information about children and families served by DHS, they do include case and individual identifiers that permit linking data across the data sets, aggregating data by county or other service delivery area, and aggregating data along a number of service need and delivery dimensions. The data sets are drawn from data warehouse records for active cases at the beginning of April 2009. Figure 62 in Appendix 3 provides a complete listing of the data elements included in each of the data sets. The group data provide the following information:

- Placement data about children for whom parental rights have been terminated.
- Demographic data about children placed in foster care.
- Two data sets relating to the reason for removal for children in foster care.
- Child protection data about abuse finding and risk levels for children receiving ongoing CPS and foster care services.
- Family Assessment of Needs and Strengths (FANS) and Child Assessment of Needs and Strengths (CANS) data for children in the current CPS and foster care caseloads.

#### **b) DCH Administrative Data**

The Department of Community Health has provided the following administrative and program data for use in this Needs Assessment:

- Statewide early periodic screening, diagnosis and treatment (EPSDT) data on foster care recipient participation in EPSDT screenings for health needs, periodic health exams, preventive dental services and dental treatment services for FY 2007 and 2008.
- March 2005 data by county on foster care recipients with Medicaid coverage.
- Program data on Healthy Kids dental program use and effectiveness in reaching Michigan children in need of dental care.

- Published program data on expenditures for substance abuse treatment at the regional coordinating agency level and statewide.
- FY 2008 county level data on services provided to child welfare involved parents and children.
- Published mental health data on prevalence of mental health problems among Michigan children and delivery of services to those children.

### c) **Other Mental Health Data**

The Saginaw County Community Mental Health Authority (SCCMHA) and the local office of the Department of Human Services in Saginaw County collaborated in 2008 to conduct an assessment of a representative sample of children in foster care using the Child and Adolescent Functional Assessment Scale (CAFAS) and the Devereux Early Childhood Assessment (DECA) to determine prevalence of mental health service needs among the population of Saginaw County foster children. SCCMHA issued its report in March 2009 and provided aggregated data on the results of that study.

## **2. Online Surveys**

Three separate surveys posted online through SurveyMonkey.com were administered to various workers, supervisors/managers and county directors/CEOs in DHS, private child and family service and placing agencies and tribal social services agencies. Copies of the communications inviting participation are included in Appendix 5. All DHS child welfare personnel were invited to participate in the survey through an “L-Letter” issued by DHS on March 20, 2009. In addition, the Child Welfare Resource Center invited executives, managers, supervisors and workers within private agencies and tribal social services agencies through two separate emails distributed on March 17, 2009. The emails were distributed to the executives for each of the agencies with a specific request that they forward the survey to their agency’s managers, supervisors and social workers. In addition, the president of the Association of Accredited Child and Family Agencies and the Michigan Federation for Children and Family Services encouraged their member agencies and their staff to participate in the surveys.

### a) **Worker surveys**

The Worker Survey was divided into beginning and ending general components and five components specific to the worker specialty area:

- The beginning general component asked all workers to respond to questions related to mental health and substance abuse treatment needs and services for children and families. This component also requested information from all workers about educational needs of children and worker perception of adequacy of educational services.
- Specialty-specific information was requested of workers related to the size of their caseload, the portion of their caseload with specific service needs, the degree to which those needs are met with existing services or supports and the additional services or supports needed to meet client needs. The specialty service areas included child protective services, foster care, family preservation, certification, purchase of service (POS) monitor, and youth transition services. Workers were asked to respond only to those questions related to their particular specialty assignments. In order to minimize the number of questions any individual worker needed to review, the survey used “skip

logic,” in which the survey automatically advanced workers to the sections that related to their specialty areas.

- The ending component of the worker survey asked all workers for any additional concerns, comments or ideas.

**b) Manager and Supervisor Survey**

This survey requested responses to questions about services currently provided within the county or counties to which each respondent was assigned, the usefulness of those services, priorities for expanding service availability and level of need for each of the prioritized services. Managers and supervisors were also asked to provide information about the extent to which the current array of foster and adoptive homes meet needs of the children served in their areas.

**c) County Director, Tribal Director and Private Agency CEO Survey**

These respondents were asked to provide information about services purchased or provided by their agencies and the services with limited accessibility in the county. The survey also asked respondents to rate the effectiveness of collaboration among key child welfare partners within their counties.

**d) Survey Response**

A total of 531 persons responded to at least a portion of the surveys. Of these respondents, 351 completed their surveys entirely. Partial participation yielded useable information to the extent provided in this report. The figure below breaks out survey response data by participant group.

**Figure 1: Survey Participation**

Survey	Total Starting Survey	DHS Respondents	Private Agency Respondents	Tribal Agency Respondents	Unknown	Total Completing Survey
Worker	335	251	71	8	5	190
Manager/Supervisor	145	68	65	1	11	120
County/Tribal Director or CEO	51	21	28	2	0	41
Column Totals	531	340	164	11	16	351

**3. Focus Groups**

The needs assessment draws from the results of several focus groups conducted for other projects. These include:

- Child and Family Services Review (CFSR) state assessment focus groups conducted over the past 18 months.
- Youth focus groups and interviews by John Seita, Ed.D. and Angelique Day, MSW, of the MSU School of Social Work, conducted from 2006-2008, which included 72 former foster youth.
- Adoptive couples focus groups conducted by Gary Anderson, Ph.D. and John Mooradian, Ph.D. of the MSU School of Social Work. The focus groups were conducted between April and June 2007 and surveys were conducted between April and June 2008, and included adoptive couples from across the state.

Additional focus groups were conducted by the CWRC in March and April 2009 with:

- Substance abuse treatment providers (including case managers, directors, therapists, and administrators from public and private agencies in Jackson, Ingham, Ionia and Kent Counties).
- DHS employees (including managers, supervisors and workers from Kent and Wayne Counties).
- Private agency child welfare employees (including CEOs, managers, supervisors and workers from Oakland, Wayne, Ingham, Jackson, Kent and Calhoun Counties).
- Child Advocacy and Assessment Center employees (including directors and supervisors from Bay, Allegan and Kent Counties. Additional follow-up was conducted with directors/coordinators from Washtenaw, Shiawassee, Ottawa, Macomb, Isabella, Calhoun, Kalamazoo, and Muskegon Counties).
- Tribal social service representatives (including professionals from the Little River Band of Ottawa Indians, Ingham County Health Department - Native American Outreach, Ingham County Power of We Consortium and Michigan State University. Additional follow-up was conducted with tribal social service representatives from the Sault St. Marie Tribe of Chippewa Indians, the Saginaw Chippewa Indian Tribe, and American Indian Health and Family Services of Southeastern Michigan).
- Birth parents from Ingham County with children who are or have been placed in foster care.

Focus group demographics and statistics, as well as protocols followed for each, are included in Appendix 7. Each of the focus groups:

- Used a modified form of the Appreciative Inquiry method when conducting focus groups with birth parents, foster and adoptive parents, youth, and workers to determine services, supports, and activities. Appreciate Inquiry is an approach to organizational change that focuses and builds on the strengths and potential of an organization. Thus, in the focus groups, facilitators solicited information about what is perceived as effective and useful in the child welfare system, in addition to information about needs and challenges.
- Gathered information on successful and less successful services, supports, and activities and perceived gaps in the service array. DHS and private agency employees were specifically asked to rank their top three effective and top three ineffective child welfare services or supports.

#### **4. Interviews with Subject Matter Experts**

In addition to the surveys and focus groups, the Child Welfare Resource Center consulted numerous experts and stakeholders in the field of child welfare in Michigan as it gathered information and conducted its analysis.

**Figure 2: Individuals Consulted for Needs Assessment**

Association of Accredited Child and Family Agencies			Reason for Contact
Denise	Baldwin		Private Agency Focus Groups
Michael	Williams		Private Agency Focus Groups
Department of Community Health			Reason for Contact
Phil	Chvojka		Substance Abuse
Logan	Dreasky		Medicaid and MiChild
Sherry	Falvay		Mental Health Services
Chris	Farrell		Healthy Kids Dental Program
Ed	Kemp		Medicaid Policy
Mary	Ludtke		Statewide Coordinator for the Human Services Collaborative Bodies
Mark	Steinberg		Substance Abuse
Department of Human Services			Reason for Contact
Sherie	Bailey		Youth Manager
Martha	Ballou		Adoption Services
Wendy	Campeau		Data Collection
Mary	Chaliman		Foster Care Manager
Barb	Chapman		Kent County Focus Group
John	Evans		MI Bureau of Juvenile Justice
Jim	Gale		BCAL
Shannon	Gibson Brown		Data Unit
Laurie	Johnson		Administrative data
Kim	Kerns		Child and Family Service Review
Carol	Kraklan		Child and Family Service Review & Tribal Focus Groups
Laurie	Ludington		Child Protection
Zoe	Lyons		Strong Families/Safe Children; Early On
Connie	Norman		Foster Care (foster parent recruitment and retention)
Nancy	Rygwelski		Preservation & Tribal Focus Group
Linda	Schmidt		Family Resource Centers
Savator	Selden-Johnson		Kent County Focus Group
Mary	Somma		Foster Care (re: SWSS access/webI reports)
Stacey	Tadgerson		Tribal Affairs
Shelly	Wood		Preservation & Tribal Focus Group
Michigan State University			Reason for Contact
Joseph	Kozakiewicz		Child Welfare Legal Support Needs
John	Mooradian		Adoptive Parent Needs
Other Organizations (listed)			Reason for Contact
Matt	Wojack	Impact, Ingham County System of Care Initiative	

Ashley	Harding	Ingham County Health Department Native American Outreach Program Coordinator	Tribal Focus Groups
Alma	Schmidt	Michigan Association for Foster, Adoptive and Kinship Parents	Surveys and Focus Groups
Kirsta	Grapentine	MI Adoption Resource Exchange	Focus Groups
Janet	Reynolds Snyder	Michigan Federation for Children and Families	Private Agency Focus Groups
Mary	Kronquist	MidSouth Substance Abuse Commission	Focus Groups
Mark	McWilliams	Michigan Protection and Advocacy Service, Inc	
Sandra	Lindsey	Saginaw Community Mental Health	Mental Health Assessment Data

## 5. Analysis

In reviewing the qualitative and quantitative information collected, discussion is divided into four primary areas of emphasis – 1) Preventing Entry; 2) Supporting Placements and Expediting Permanency; 3) Maintaining Permanency and Stability; and, 4) Service Needs Across the Continuum of Care. Within each of these areas of emphasis, the team looked at the aggregate data in light of the following questions:

- What do we know about current caseloads and outcomes?
- What do we know about current programs and services that are effective?
- What can we learn about current service gaps and unmet needs?
- What are the key findings and conclusions we can draw from our analysis?

The organization of this report is framed around answering the questions above, based on data collected in Michigan but within a national context. This analysis takes into account the national trends and research that provide the best context for discussion as Michigan considers its different options and the resources needed for implementing reform that is impactful and aligns with Michigan’s Child Welfare Philosophy and the settlement agreement.

The analysis relies upon a collective examination of data and information from all sources, including:

- Whenever possible, hard data, both administrative and program data, used as primary sources of information.
- Survey, focus group and interview information used to supplement and interpret the meaning of the administrative and program data.
- Survey, focus group and interview data used as primary sources where appropriate to increase understanding of service needs and gaps.
- Literature and previous report reviews used to provide context for primary information sources and to enhance understanding of the data as appropriate.

The focus of the analysis is on developing a picture of:

- Michigan’s child welfare service delivery approach.

- The service needs of children and families served by the child welfare system.
- The relative availability of services to meet those needs.
- The gaps in service availability.
- The systemic supports that can promote best value of the services that are available.

The question addressed throughout this needs assessment is whether or not the services in the current array adequately meets the needs of families as they strive to achieve the safety, permanency and well-being outcomes for children and their families.

### ***D. Michigan's Child Welfare Service Array***

Several core principles provide a basis for the design of Michigan's child welfare service array. These principles coincide well with Michigan's federal Child and Family Service Plan, the requirements of the settlement agreement, Michigan's Child Welfare Philosophy, and the Michigan 2020 plan. The focus of these core principles is to achieve positive outcomes for children related to safety, permanency and well-being. The core principles are:

- Maintain children safely in their homes if at all possible.
- If children must be removed, ensure the first placement is the best possible.
- Address children's needs in a manner that provides for their safety and well-being.
- Move children expeditiously to reunification or permanency.
- Maintain safety, stability and well-being for children after placement.
- Support children and youth in foster care and after foster care placement in their preparation for transition to adulthood.

**Figure 3: Michigan Child Welfare Service Array**

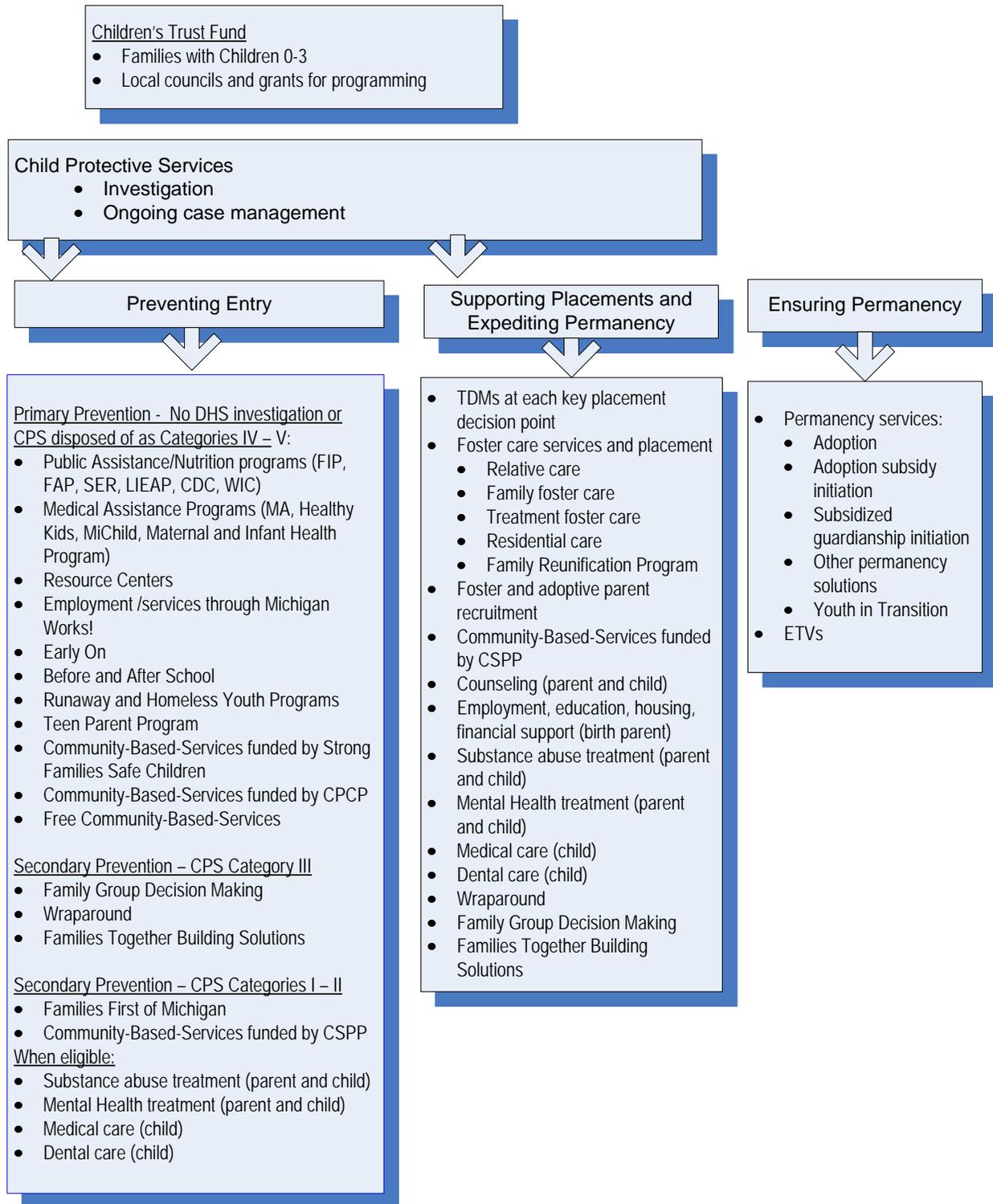


Figure 3 depicts the major elements of Michigan’s current service array. A brief description of each of the service programs listed above appears in Appendix 2.

## ***E. Significant Michigan Demographics and Program Information***

The current economic climate in Michigan provides a number of challenges to families seeking to provide safe and stable homes for their children and to the state as it seeks to improve its child welfare system. The number of children in Michigan is decreasing; however, the percent of children living in poverty is increasing.

Michigan's estimated total child population (birth to age 18) was 2,446,856 in 2008, slightly lower than the estimated 2,590,767 in 2007.

KIDS COUNT reported 19% of Michigan's children as living in poverty in 2007, an increase from 18% in the previous year. Since the end of 2007, the state has experienced increasingly difficult economic circumstances which are likely to increase the level of financial stress for the State's impoverished families.

The national KIDS COUNT 2008 Data Book shows Michigan holding its relative ranking for a third consecutive year at 27 among all states for child well-being for the 2005-2006 time period. The State's ranking was 24 in the 2001-2002 period and 26 in 2002-2003. The ranking is based on Michigan's relative position among the states on ten indicators: percent low birth-weight babies; infant mortality rate; child death rate; rate of teen deaths by accident, homicide, and suicide; teen birth rate; percent of children living with parents who do not have full-time, year-round employment; percent of teens who are high school dropouts; percent of teens not attending school and not working; percent of children in poverty; and percent of families with children headed by a single-parent. (The Annie E. Casey Foundation, KIDS COUNT Data Center, [www.kidscount.org](http://www.kidscount.org).)

Even in the face of serious fiscal challenges, Michigan has been able to increase funding available to provide increased staffing levels within DHS and increased per diem rates for private foster care providers over the past two years. These changes improve the prospect of better outcomes for children and their families through 1) reductions in caseload size; 2) improved case planning and management; 3) increased levels of child, family and community engagement; 4) improved fiscal and program viability for private child serving agencies; and, 5) increased levels of outcome oriented oversight across the child welfare system.

Figure 4 documents a five year history of basic child welfare program data.

**Figure 4: Overview of Program Statistics**

	2004	2005	2006	2007	2008
CPS Complaints	135,775	128,854	126,690	123,149	124,716
CPS Investigations	76,694	72,286	71,784	77,012	72,418
Substantiated Reports	17,847	16,889	17,534	18,893	17,630
Families Served by FFM	2,813	2,696	2,864	2,732	
Children in Foster Care	19,140	18,733	18,347	18,771	17,946
Adoptions	2,744	2,883	2,589	2,602	2,585
Adoption Subsidies	23,984	25,029	25,840	26,652	27,021

## ***F. Systemic Barriers that Affect Delivery of All Services***

### **1. Understanding the Nature of Systemic Barriers**

Perhaps the most difficult challenge in implementing statewide child welfare reform are the systemic barriers that require new legislation, additional financial resources, or effective partnerships across major systems with intersecting responsibilities within the child welfare population. Many systemic barriers are common to reform efforts across the country, and much has been written about them in order to aid individual states as they implement changes (see bibliography). These barriers emerged repeatedly in various forms throughout the data gathering process in Michigan, suggesting the value of separately exploring in more detail some of the approaches other states have applied in addressing them. For the purpose of this needs assessment, and to inform further consideration of the policy concerns raised by these issues, a summary of the systemic barriers to and the facilitators of child welfare reform most commonly experienced around the country are listed below:

- **The “political will” to make substantial short term investments in order to achieve long term cost savings.** It is exceedingly difficult to justify large expenditures of cash when the short and long term cost benefits are not known. However, numerous studies have shown a definite link between reducing the incidents of child abuse and neglect and both short and long term cost savings to the state. Programs and approaches known to help families and reduce the need for out of home placement in the short term have demonstrable long term impacts of reducing public dollar costs associated with homelessness, juvenile and adult criminal behavior, use of public resources, and unemployment.
- **Policy changes at the legislative level are necessary to support needed changes at the administrative and service delivery level.** Laws in place that support the flexibility needed to customize the delivery of services to each family or child’s needs may assist a state’s response to a range of situations in a manner that promotes effective decisions based on multiple options.
- **Making a philosophical shift in understanding that the state’s responsibility is to not only protect the safety and health of children in state care and custody, but also their overall well-being and developmental functioning.** Safety and permanency are important components of a child’s well-being, but insufficient to ensure a child’s stability and success in life. Including overall well-being and developmental functioning as a top priority of the child welfare system changes perception in terms of when and in what manner the state needs to intervene, and recognizes that instituting effective preventive services does not necessarily depend upon a formal referral to CPS or the outcome of a formal investigation.
- **Community partnerships that are truly collaborative, and that link resources together in a way that provides seamless delivery of service and support to families and children.** Currently, the system ties expenditures to the number of children in foster care, which may unintentionally provide a disincentive to either work toward

reunification or provide aftercare services following reunification, a time when they are most needed. In Michigan, as in many states, there is the need for integration of services or sharing of information among systems such as the courts, schools, public assistance and mental health, not to mention more informal community support networks.

- **Staffing, training and administrative support that allows caseloads to remain at reasonable levels, promotes consistent high quality, culturally competent service delivery, and reduces inefficiencies and redundancies.** Achieving the goals as expressed in Michigan’s Child Welfare Philosophy and the settlement agreement requires a knowledgeable and adequately trained workforce in both the public and private sectors. Coordination among the multiple staff who may be involved in a given case is needed to reduce unnecessary delays that adversely impact child outcomes. Daily administrative demands such as data input and reporting requirements can also create stress and redundancies if not addressed in a systemic, coordinated way.
- **Providing adequate education and support to birth parents, foster parents, adoptive parents and kinship caregivers.** Regardless of where the child is living, the caregiver needs adequate training and support to provide for that child’s care and well-being.

## **2. Systemic Barriers in Michigan Identified by Focus Groups**

The focus group questions centered on service needs and approaches that were working well and identifying those that were less effective or not available in Michigan. However, most if not all of the focus groups identified numerous administrative or systemic challenges they felt impeded their ability to provide high quality services and meet the needs of the children and families in their communities. These barriers are summarized below, and apply in greater or lesser degree to all areas of service discussed in this report. Detailed descriptions of participant responses regarding these systemic issues can be found in Appendix 8.

Many focus group participants spoke of areas of tension among public, private, and tribal agencies. A review of the most commonly experienced systemic-related problems center around communication issues, high staff turnovers, lack of coordination, and waitlist for services, any one of which could contribute to tension between systems. Taken together, these barriers identified suggest a need to examine the underlying relationships between the public, private and tribal sectors.

**Figure 5: Systemic Barriers That Impede Service Delivery Identified by Focus Groups**

Systemic Barrier Identified by Focus Group	SE MI PA	Central MI PA	SA Group	CAC	Kent DHS	Wayne DHS	Tribal
Lack of coordination across systems	*	*	*	*			*
Lack of coordination county to county, state to state and with tribes	*	*	*		*		*
Caseloads are too high	*	*			*		
Ineffective communication across systems	*	*	*	*	*	*	*
DHS phone call response rate is inconsistent	*	*	*	*			
Policy change communications from DHS are not always timely or complete	*	*					*
Reported tensions in the working relationship between public & private agencies and across systems	*	*	*	*	*	*	*
Perceived lack of trust between DHS and private agencies	*	*	*				
High rate of staff turnover impedes continuity in care	*	*	*	*	*		
Competitive bid process does not support highest quality service		*					
Bureaucratic responsibilities are too burdensome (data collection & input, reporting requirements have redundancies)	*	*	*			*	
State emergency relief process needs improvement						*	
Too many pilot programs with insufficient knowledge of their effectiveness					*	*	
Waitlist for services is too long	*	*	*		*	*	
Perceived underreporting of child welfare services by tribal members							*
Lack of coordination between SWSS and tribal information systems							*
ICWA requirements not currently embedded into MI law and practice							*
Geographically based ICWA specialists needed							*
DHS workers need better understanding of tribal law and governmental structure						*	*

Key: SE MI PA = Southeast Michigan Private Agency Workers and Supervisors  
 Central MI PA = Central Michigan Private Agency Workers and Supervisors  
 SA Group = Substance Abuse Provider Focus Group  
 CAC = Child Abuse Assessment Centers Focus Group  
 Kent DHS = Kent County DHS Workers and Supervisors  
 Wayne DHS = Wayne County DHS Workers and Supervisors  
 Tribal = Tribal Focus Group

The following sections of this report are organized by the three primary areas of child welfare practice, namely:

- 1) Preventing Entry into Foster Care.
- 2) Supporting Placements and Expediting Permanency.
- 3) Maintaining Permanency and Stability.
- 4) Services Across the Continuum of Care.

These four sections are followed by the CWRC's primary findings and conclusions, with more detailed information and data available for review in the Appendices. Each of the following three sections offer information first about information about Michigan's current caseloads and outcomes relevant to the topic heading, then discusses best and promising practices in the field, followed by an analysis of Michigan's needs and findings and conclusions related to the topic heading.

## II. Preventing Entry into Foster Care

### A. Current Caseloads and Outcomes in Michigan

Prevention Services: The Children's Trust Fund (CTF) in Michigan administers a grant program that funds local councils to develop services and programs that meet the child abuse and neglect prevention needs in their communities. These grants are supported through an income tax check box, tax deductible donations, fundraising, state and federal grants, and interest from the trust account. CTF also administers a number of other prevention initiatives and events including a collaborative program with the Michigan Departments of Community Health (DCH), Education (MDE) and Human Services (DHS) to prevent abuse and neglect for families with children aged zero to three.

To strengthen families, DHS has established 54 Family Resource Centers within or in close proximity to neighborhood schools to coordinate services to improve parental involvement and family functioning and improve academic performance. In addition, DHS administers a range of public assistance programs, including the Family Independence Program, Food Assistance Program, Child Day Care, State Emergency Relief, and Low Income Home Energy Assistance Program. These programs are important assets in the effort to prevent abuse, neglect and entry to the child welfare system, in that poverty-related issues often contribute to a family's inability to reunite.

These are important and valuable programs for children, families and communities. However, survey and focus group respondents confirmed that current resource levels do not provide for sufficient availability of these primary and secondary prevention services across the state or across systems.

**Child Protective Services:** In 2008, the Michigan Department of Human Services received a total of 124,716 reports of suspected abuse and neglect. Of these, 72,418 were investigated and 17,460 were substantiated. Michigan uses a five category system for categorizing results of abuse and neglect investigations (Source: Michigan Child Protective Services Manual, as revised in March 2009):

- **Category I:** Preponderance of evidence of child abuse or neglect, and certain aggravating circumstances also exist; court petition is required; perpetrator is listed on Central Registry.
- **Category II:** Preponderance of evidence of abuse or neglect with an intensive or high risk to the child (established through the use of a Structured Decision making assessment tool); a child protective services case must be opened and services provided; perpetrator is listed on the Registry.
- **Category III:** Preponderance of evidence of abuse or neglect with a low to moderate risk to child; DHS must assist the family in obtaining community services to address the risk; perpetrator is not listed on the Registry.
- **Category IV:** No preponderance of evidence; DHS must assist family in voluntarily accessing community based services.

- **Category V:** No evidence of abuse, family not located, or family did not cooperate and was not required by court to do so; services not required to be provided.

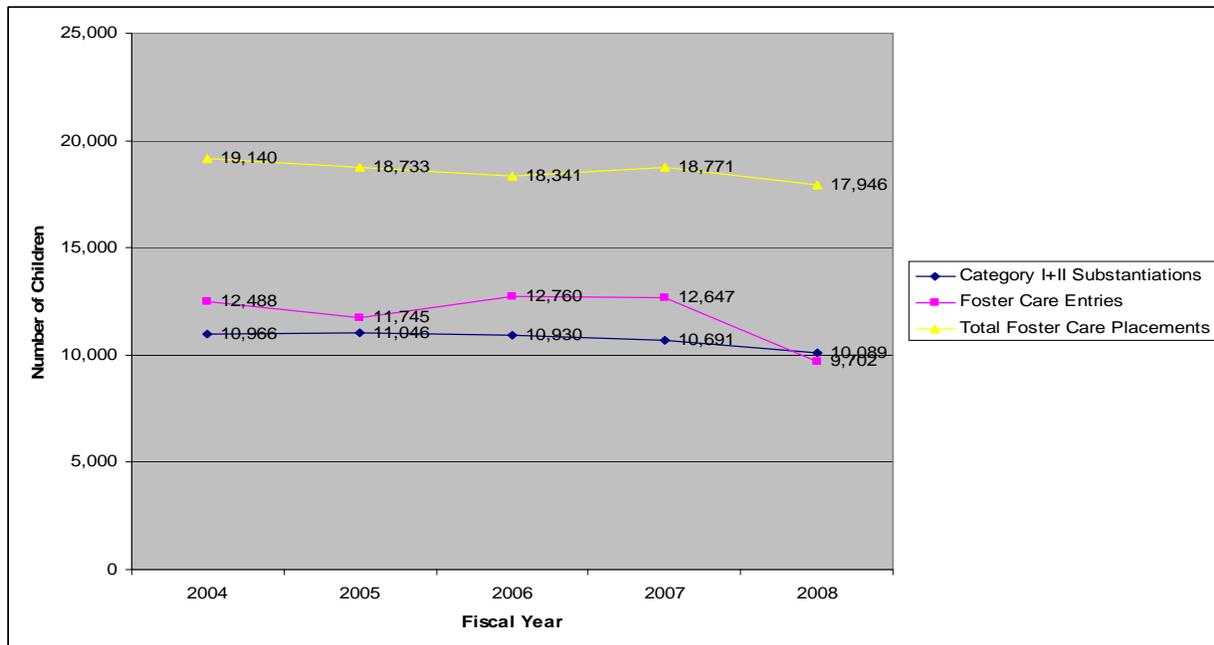
**Figure 6: CPS Category Trends**

	2004	2005	2006	2007	2008
Category I	5,368	5,114	5,530	5,049	5,253
Category II	5,598	5,932	5,400	5,642	4,836
Category III	6,881	5,843	6,593	7,057	7,371
Category IV	45,564	46,030	44,538	40,461	46,761
Category V	13,283	9,367	8,008	8,031	7,820

Of the substantiated reports in 2008, 10,089 were Category I and II (58% of substantiated reports), requiring the highest level of intervention and services. Figure 7 shows the positive relationship between the total number of Category I and II findings and the entries into foster care during the same years. It also shows the relationship between total Category I and II findings and the total number of children in foster care during the same years.

It is important to note that for the first time in recent years, the number of child entries to foster care in 2008 is lower than the number of children with Category I and II abuse/neglect findings. During 2008, the total number of children in foster care declined by 4.4%. This follows an increase in children in care of 2.3% in 2007, a decrease of 2.3% in 2006 and a decrease of 2.1% in 2005. Other factors being equal, if the 2008 relationship between abuse findings and foster care entries continues, the total number of children in foster care could see continued decreases relieving the level of demand for these services.

**Figure 7: Comparison of Abuse and Neglect Findings, Foster Care Entries and Total Foster Care Placements**



**Family Preservation Services:** Michigan uses a complement of evidence based programs and funding streams intended to maintain families intact while protecting at-risk children, including:

- Child Protection/Community Partners (CP/CP)
- Child Safety Permanency Plan (CSPP)
- Strong Families/Safe Children (SFSC)
- Family Group Decision Making (FGDM)
- Families First of Michigan (FFM)
- Family Reunification Program (FRP)
- Wraparound service planning and delivery

A description of each of these programs and funding streams is included in Appendix 2. A concern voiced by all stakeholders consulted throughout this needs assessment process is that the resource levels available for these programs have eroded compared to previous years. For example, Families First of Michigan, the state's premier preservation program, served 3859 families across in the State in 1998. In 2007, only 2732 families could be served with available funds.

CP/CP, CSPP and SFSC funding is allocated to individual counties to provide support for prevention services, safe alternatives to out of home placement, and services to promote reunification and other legal permanency arrangements for children. A question for consideration may be whether the current formula used to allocate these funds is appropriate to today's needs and concerns related to improving child welfare outcomes for children and families. When comparing the allocations across counties, the amount allocated to the five urban counties in proportion to the total number of children in the counties and in proportion to the number of children in foster care in those counties is substantially lower than the state average. Further, no relationship is apparent when comparing the proportion of funds allocated to counties and the number of children or length of time in foster care. The state level funding amounts available for these programs along with the allocations for the five urban counties appear in Appendix 3.

**Family Assessment of Needs and Strengths Comparisons.** Some workers have reported in focus group sessions that they are not able to access sufficient home-based services on a timely basis. In order to be provide assurance for the safety of the children they serve, they resort to using foster care in some cases. Survey responses from CPS workers did not identify a large number of situations in which this occurred. However, a preliminary analysis of administrative data suggests that this issue needs to be carefully explored.

During the child protection intake and investigation process, Child Protective Services workers complete a Family Assessment of Needs and Strengths (FANS) and a Child Assessment of Needs and Strengths (CANS). Upon completion of the assessment tool, workers may enter up to three top three needs identified by the FANS into the Service Worker Support System (SWSS). In April 2009, DHS provided data to CWRC on the needs identified on the FANS for 3,955 family groups. These families included 3658 from which one or more children were removed and 297 from which no child was removed.

In a preliminary analysis of this data, the number of times each need was identified as a first, second or third top need was totaled for the entire group of recipients involved in a case involving a child removal. The same calculations were performed for recipients involved in cases where no child was removed. The percentage of recipients in each group for whom each need was identified appears in Figure 8.

**Figure 8: Comparison of Top Three Needs on FANS**

NEEDS IDENTIFIED ON FANS	FAMILIES FROM WHICH CHILDREN ARE REMOVED	FAMILIES FROM WHICH CHILDREN ARE NOT REMOVED
	% of Families for which Need is Identified among Top Three Needs	% of Families for which Need is Identified among Top Three Needs
Child Characteristics	0.64	1.84
Communication / Interpersonal Skills	5.75	6.87
Domestic Relations	18.87	15.45
Emotional Stability Behavior	39.61	37.49
Employment	20.99	20.06
Housing	18.31	15.80
Intellectual Capacity	4.99	5.46
Literacy	2.99	1.13
Parenting Skills	74.63	72.01
Physical Health Issues	3.97	4.04
Resource Availability / Management	15.61	14.60
Sexual Abuse	8.28	9.43
Social Support System	9.45	9.57
Substance Abuse	28.68	32.25

Because this preliminary analysis shows similarity between the ratio of needs identified for each group as a whole, CWRC conducted further examination of this data set determine the extent of similarity when the data are grouped according to the full constellation of needs identified for each family. Figure 9 provides overview information about the number of families in each group for which each constellation of needs was identified.

**Figure 9: Families with and without Children Removed by Need Groupings**

Number of Top Needs Identified	Number of Need Constellations	Number Families – No Child(ren) Removed	Number Families – Child(ren) Removed	Total Families
One	13	50	515	565
Two	70	57	702	759
Three	417	190	2,441	2,631
Column Totals	500	297	3,658	3,955

Of the 297 families with no children removed, 285 had constellations of needs that matched needs groupings for families from whom children were removed. A complete listing of the need constellations and the number of families in each group for which each constellation was identified appears in Figure 63 in Appendix 3.

Of greatest interest are those groupings of needs which, on the surface might indicate a lower level of concern about child safety and risk. Figure 10 displays the number of families with and

without children removed in these need groupings. This data needs to be reviewed in conjunction with worker perceptions about the availability and timeliness of family preservation services later in this section of the report.

This area of analysis might be flagged for further work in the future. The number of families for which data are provided may or may not represent the entire population of children investigated over the course of the year. Because entry of FANS data in the child welfare automated system, it is possible that workers do not enter data for a substantial number of families. If attention is given to uniform collection and reporting of this data, collection of quantifiable information about child and family needs for future assessments of this type might be simplified. Qualitative review and analysis that looks behind the data would still be necessary to fully understand the areas of need and the services that might address the needs.

**Figure 10: Potential Low Level FANS Need Groupings for Families with and without Children Removed**

FANS Need Groupings Identified for both <ul style="list-style-type: none"> <li>• Families from which Children Are Removed and</li> <li>• Families from which Children Are Not Removed</li> </ul>	Number Family Groups with Child NOT Removed	Number Family Groups with Child Removed
Total Families	68	656
Parenting Skills	23	262
Parenting Skills, Employment	9	96
Employment	7	39
Housing, Resource Availability, Parenting Skills	7	113
Housing	4	14
Parenting Skills, Housing, Social Support System	3	14
Parenting Skills, Social Support System, Employment	3	10
Resource Availability, Employment	2	3
Parenting Skills, Employment, Housing	2	9
Parenting Skills, Social Support System	2	23
Social Support System	1	3
Parenting Skills, Housing	1	41
Social Support System, Employment	1	3
Parenting Skills, Employment, Resource Availability	1	18
Housing, Resource Availability, Employment	1	4
Parenting Skills, Employment, Communications/Interpersonal Skills	1	4

## ***B. Effective Programs and Approaches***

Although a substantial number and variety of programs around the country are devoted to the goal of preventing children from entering care, relatively few program interventions have been rigorously and extensively evaluated for effectiveness. There are numerous reasons why this is so, and many ongoing efforts are attempting to address the challenges of conducting meaningful evaluations into the efficacy of promising practices in the field of child welfare. (Gira, et al. 2001, Lee et al. 2008). Despite the difficulties inherent in the study of human service interventions, a growing body of data is nevertheless available to inform policy and programmatic decisions.

In the area of prevention, studies tend to evaluate a program's ability to impact the rate of out of home placement and the occurrence or recurrence of maltreatment. In addition to these indicators, evaluations of early intervention efforts often also look at other outcomes, such as improvements in parenting and improvements in child functioning (mental and physical health, growth and development, academic success, etc).

Prevalent theories underlying many child welfare prevention programs assert that when parents have the skills and supports that enable them to be good parents, it follows that they and their children are more likely to grow to be well-adjusted, healthy, productive citizens, with less need for intervention and placement. After extensive review of the literature relevant to prevention, it is clear that these theories are well founded. In addition, the longitudinal studies have clearly established that "front loading" services at the beginning of a case, even before placement, will reap significant cost savings over the long term with regard to future criminality, education attainment, productivity in the workforce, and use of public resources later in life. (Olds, et al. 1997, 1998; Rand Corp. 2008; Reynolds, et al. 2002, 2003, 2007).

## 1. Common Characteristics of Successful Programs

Certain identified characteristics are common to the majority of prevention programs that researchers have found to be most effective (Lee, et al. 2008). These include:

- *Targeted populations.* Successful programs tend to be targeted toward a specific group of people who might be expected to benefit the most from the services provided. Expansion of a program beyond the original intended population group is less likely to be successful.
- *Intensive services.* Programs with strong impacts on child welfare outcomes tend to provide intensive services, which translates to a high number of service hours. This intensity is often coupled with a requirement for a high level of engagement from participants. Michigan's Families First program, which has been consistently found to be a high impact program, is an example of this type of service. (Walters, 2006; Blythe & Jayaratne, 2002).
- *A focus on behavior.* The most effective programs are likely to take a behavioral approach (as opposed to an instructional approach), such as coaching parents one-on-one during play sessions with their children. This characteristic holds true regardless of client age, therapist experience or treated problem. (Weisz, et al. 1987).
- *Inclusion and engagement of both parents and children.* The most successful programs take an approach that acknowledges the central role of the parent-child relationship in child outcomes, and fosters positive, collaborative relationships with the organizations and professionals that conduct investigations and assessments, and provide services. Engagement of family members in case planning is positively associated with better overall outcomes and fewer placements. Family centered practice also reduces the amount of resistance and mistrust that can impede success. (Lee, et al. 2008).
- *Program fidelity.* Several of the successful programs mentioned below have demonstrated the importance of maintaining adherence to the original program model and intent. For example, analysis of intensive family preservation programs found that those that maintained fidelity to the Homebuilders® model (including Michigan's Family First

program) significantly reduced subsequent child maltreatment and out-of-home placements. However, other similar family preservation services with much looser criteria around service provision did not significantly impact either maltreatment results or out-of-home placement. (Lee, et al. 2008).

## 2. Specific Examples of Model Programs and Approaches

The following are some examples of rigorously evaluated programs or approaches that meet the above criteria and achieve significant impact with regard to maltreatment and/or placement reduction goals, as well as other important outcomes.

### ***Assessment and Response Programs***

Assessing risk of future harm is an important reason to have a formalized assessment tool or process that is highly accurate and consistently applied. Similarly, it is also important to have a process for assessing a family's unique strengths and needs in a way that will facilitate the most effective and appropriate service delivery. A family centered approach when conducting either of these types of assessments is essential to gathering the most honest and complete information possible (Rycus & Hughes, 2003).

**Structured Decision-Making (SDM).** The structured risk assessment model developed for use in Michigan is a research based approach to decision-making and has been extensively evaluated (Baird, et al. 1995 and Wagner, et al. 2002). The model has been replicated in other states and is proven to be effective in assessing the risk to children in the early stages of a case as well as effectively guiding reunification decisions after placement has occurred. Following the decision protocols ensures a high degree of consistency in assessing risk, and leads to better outcomes for children in terms of service provision, the decision to place a child, and the rates of reunification. Key elements of the approach include:

- *Simple* – decision protocols that are clear, easy to follow, and utilize criteria related specifically to the decision at hand.
- *Flexible* – to allow overrides of the protocol, with supervisor involvement and approval.
- *Evidence-based* – tool used should be tested for reliability, equity and efficacy.
- *Structured with training* – high degree of structure is required to support the proper use of the protocol and the individual decision factors it contains.

**Differential Response (DR).** Differential response, also known as Alternative Response or Assessment Response, is an approach to assessment and case planning that emphasizes a customized, timely assessment of a family's strengths and needs, coupled with provision of appropriate services to meet those needs. It is an alternative to a traditional forensic investigative approach when a report may not meet the criteria for CPS or involves a low safety and risk level, but suggests a need for community services. This strategy provides a flexible way to provide support and services to families without an incident-focused investigation of harm, and has been found to be effective in improving the timeliness and quantity of services to families. (Child Welfare Information Gateway, 2008). Key elements of a successful alternative response system include:

- *Well-defined response tracks* – recognizing the variation in the nature of reports and the value of responding differently to different types of cases, the response path depends

upon the severity of the initial report of harm to the child. Responses can range from a formal forensic investigation to a less invasive assessment of the family's strengths and needs and offering services, to providing a resource referral/prevention track for reports that do not meet the screening criteria for CPS or involves a low safety and risk level.

- *Assessment focused* – substantiation of an alleged incident is not the focus, but rather assessing the family's overall strengths and needs.
- *Individualized and family centered* – the family is seen as a unique entity that must be fully engaged in the process of assessing strengths and needs. Families are referred to services that fit their particular needs and issues, which require coordination and availability of appropriate community services.
- *Selective and flexible* – alternative response is not used when the most serious types of maltreatment are alleged, and the response track can be changed based on changing circumstances and ongoing risk and safety considerations.

In comparison to other states and nationally, Michigan has a significantly high rate of investigations per 1000 children (75.4 vs. 49.1; Figure 54 in Appendix 3). At the same time, Michigan's rate of substantiated findings is almost equal to the national average (11.0 in Michigan vs. 11.5 nationally). This finding suggests that a form of differential response is being utilized in Michigan, and that the state is aggressively pursuing alternatives to substantiation and placement within the resources it currently has to work with.

**Family Group Decision-Making (FGDM).** Family Group Decision Making, also called Family Group Conferencing, is an approach that began in New Zealand and has spread throughout the Western world, including the United States. It recognizes the value of involving the family and community stakeholders in designing individualized plans to protect children and strengthen the family system. Evaluation results have been mixed in terms of overall impact on child welfare outcomes and subsequent maltreatment referrals, and this is primarily due to limitations of previous studies, small sample sizes, and lack of appropriate comparison groups. Despite these limitations in evaluating long-term outcomes, the studies have consistently found that families who experience FGDM receive more services for longer periods of time than their non-FGDM counterparts. In addition, because of its focus on involving both family and community stakeholders, FGDM promotes a more culturally appropriate protection plan for children represented disproportionately in the system. (Weigensberg, Barth & Guo, 2008). Key features of FGDM that are common across jurisdictions that use it include:

- *Strengths-based and culturally sensitive* – the FGDM strategy acknowledges and builds on strengths of the family and community, with cultural issues identified, assessed and considered as the plan is being crafted.
- *Team-based* – a broad based team of individuals that includes family members, community members, service providers and child welfare workers work together to discuss and develop a plan for the child and family.
- *Family-focused* – the goal of the meetings is to ensure the child's safety and well being, with an emphasis on keeping the child with the family; responsibility for drafting the family plan lies with the family and is reviewed and clarified by DHS before everyone agrees to it.
- *Timely response* – meetings typically take place within 30 days of referral.

For the past ten years the Michigan Department of Human Services has operated FGDM programs on a limited basis. The family plans crafted at the FGDM meetings address the primary needs identified by the family members at the meeting and include:

- Professional intervention in the form of counseling for children, parent and family, and substance abuse treatment.
- Child care and visitation, including placing children with relatives for respite care or longer term safety and well being.
- Concrete assistance, such as housing, transportation, food, financial assistance and job employment training and placement.
- Family support, such as opportunities for family members to interact together and communicate in a positive manner.
- System assistance, in relation to education, medical care, or criminal justice.
- Information and referral for other needed services.

### ***Early Intervention Programs Prior to CPS Referral***

**Healthy Families America (HFA).** HFA is a network of programs based upon a set of critical program elements defined by more than 20 years of research, and proven to reduce incidents of abuse and neglect. (Duggan, et al. 2007, 2004) At-risk mothers are identified and enrolled either during pregnancy or shortly after the birth of a child. The intervention involves home visits by trained paraprofessionals who provide information on parenting and child development, parenting classes, and case management. The critical elements represent the field's most current knowledge about how to implement successful home visitation programs and include the following:

- *Early service initiation* – Services are initiated prenatally or at birth and use a standardized assessment tool to systematically identify families who are most in need of services. This tool assesses the presence of various factors associated with increased risk for child maltreatment or other poor childhood outcomes. The services are voluntary and positive outreach efforts are used to build family trust.
- *Intensive service delivery* – Intensive services are provided with well-defined criteria to guide frequency of service over the long-term (three to five years).
- *Customized and family centered* – Services reflect the cultural, linguistic, geographic, racial and ethnic diversity of the population served and focus on supporting the parent as well as supporting parent-child interaction and child development. Families are linked to a medical provider to assure optimal health and may also be linked to additional programs that provide financial, food, and housing assistance, address school readiness, child care, job training, family support, substance abuse treatment, and domestic violence.
- *Staff characteristics* – Staff have limited caseloads (maximum of 10-15 cases depending on intensity of needs) to ensure that home visitors have an adequate amount of time to spend with each family to meet their unique needs and plan future activities. Direct service staff are paraprofessionals who are selected based on their personal characteristics to work positively with the families served. They are trained intensively for their role and responsibility in delivering the customized services needed.

**Nurse Family Partnership for Low Income Families.** The Nurse Family Partnership program has been rigorously studied for over 30 years (MacMillan, et al. 2005; Olds, et al. 1997, 1998, 2004, 2007). There is strong evidence that a nurse home visiting program that begins during pregnancy and continues through the child's second year results in numerous long term benefits for both mother and child, including reduction of abuse and neglect. The program goal is to promote the child's development by providing support and instructive parenting skills to the parents. The program is designed to serve low-income, at-risk pregnant women bearing their first child. Key elements include:

- *Trained Staff* – Home visits are provided by nurses, beginning during pregnancy and continuing through age 2.
- *Service content* - Interventions are evidence-based and designed to facilitate change in families' attitude, knowledge and skills.
- *Clear Goals* – Overall goals focus on improving pregnancy outcomes, improving child health and development, and improving families' economic self-sufficiency.
- *Flexible guidelines* – The visits follow prescribed guidelines that reflect the challenges parents often confront, but allow flexibility for nurses to use professional judgment in addressing the areas of greatest need.

It should be noted that there is strong evidence of prevention of maltreatment when the program is implemented as originally designed and the focus is on first time mothers and infants. Similar results have not been found, however, when the model has been applied to prevent recurrence of maltreatment in families involving older children who are already involved in the system.

### ***Intervention after CPS Referral***

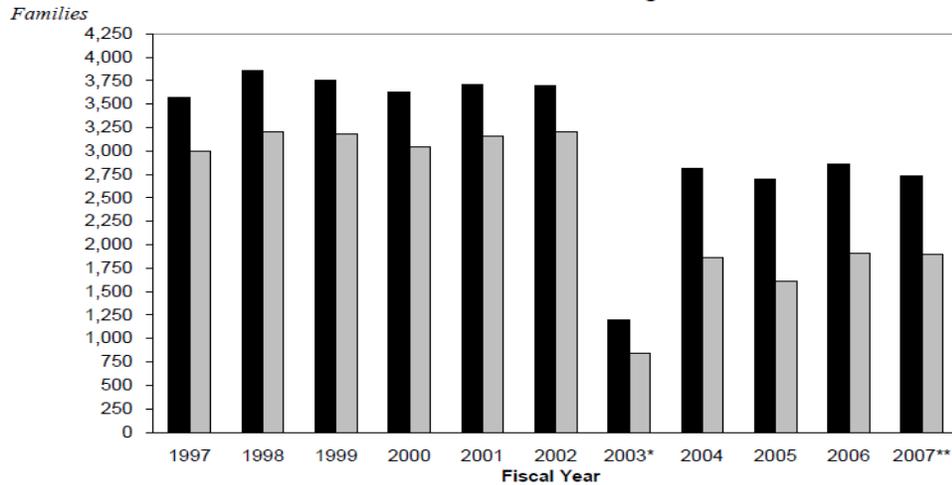
**Intensive Family Preservation Services.** The original program, Homebuilders®, was developed in 1974 and has been replicated around the country, most notably in Michigan through its Families First program. Homebuilders programs have been studied extensively and have been found to significantly reduce the need for out of home placements and instances of subsequent abuse and neglect (Olds, et al. 1997, 1998, 2004, 2007). Studies have shown that success of the model depends upon the level of adherence to the original design. Less rigorous adherence to the program model will likely not result in the positive outcomes experienced by those programs that do strictly follow the model. Critical program elements include:

- *Intervention at the crisis point* – Professional therapists are assigned at the point of crisis and see clients within 24 hrs of referral.
- *Accessibility and responsiveness* - Therapists are accessible round the clock.
- *Low caseloads* – Therapists carry only 2-3 cases at any given time.
- *Intensity of service* – Service duration typically lasts a maximum of four to six weeks.
- *Research-based interventions* – Therapists utilize evidence-based interventions known to improve family functioning.
- *Flexibility* – Services are tailored to each family and provided when and where they are needed most.

Families First of Michigan was one of the first such programs studied and is consistently identified as a highly impactful program that adheres to the program components essential to success (Lee, et al. 2008). The figure below illustrates the positive impact this program has had over the years.

Figure 11: Michigan Families First Outcomes

**STATEWIDE FAMILIES FIRST SERVICES**  
Number/Percent of 12-Month Successful Program Outcomes\*



	1997	1998	1999	2000	2001	2002	2003*	2004	2005	2006	2007**
Families w/12 Mo. Placement data.	3,570	3,859	3,748	3,623	3,703	3,697	1,196	2,813	2,696	2,864	2,732
Number Successful Outcome	2,995	3,199	3,176	3,040	3,158	3,202	842	1,859	1,613	1,913	1,902
Percent Successful Outcomes	83.9%	82.9%	84.7%	83.9%	85.3%	86.6%	82.9%	85.3%	78.0%	84.9%	85.1%

The percent of successful outcomes was 84.9% in FY 2006.

\* Successful outcome is defined as those families where no child was placed in foster care during the 12-month follow-up period.

\* Complete fiscal year data are not available from FY 2003 due to conversion process. Contract capacity reduced by 204 from FY 2002. In FY 2004 it is further reduced by 968 from FY 2003.

\*\* 12-month follow-up period is not completed.

The percentages are calculated by the total number of 12 months follow-ups minus the total unable to locate or determine and then divided into total intact.

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### School Based Approach

**Chicago Child Parent Centers.** The Chicago Longitudinal Study has shown that school-based child-parent centers can significantly lower rates of reported and substantiated maltreatment. (Reynolds and Robertson, 2003) These school-based centers begin in preschool and provide educational and family support services for families living in high poverty neighborhoods. The centers aim to provide a stable learning environment through third grade and provide support to parents so that they can be involved in their children's education. Key elements of the model include:

- *School-based* – locating a child-parent center within the school attended by the child that is staffed with a head teacher who oversees the delivery of the services.
- *Multi-year* – Children participate from preschool through third grade (ages 3-9) in a learning curriculum which emphasizes acquisition of basic skills in language arts and math.
- *Parent involvement* – Parents participate at least ½ day each week by volunteering in the classroom and school activities, participating in vocational and educational training, receiving home visits, and taking advantage of the services offered.
- *Multi-level services* – Services and training include consumer education, community outreach, home visits, nutrition, personal development, health and safety, and educational (GED) opportunities.
- *Customized approach* – Family support activities are tailored to accommodate the different needs and schedules of the parents.

A cohort of Chicago Child Parent Center (CPC) graduates has been studied for over 19 years, and the positive impact of the program has been both consistent and dramatic. CPC has been shown to positively impact not only rates of abuse and neglect, but also a range of outcomes relating to mental health, academic achievement, and criminality for the children who have participated in this important program.

### 3. Survey and Focus Group Perceptions About Effective Programs

Child welfare workers were asked to name those services they found to be most effective in protecting the child and preserving the family. Survey results are shown below and indicate that mental health and substance abuse services, Families First, parent and in-home services were consistently identified by respondents as being effective.

**Figure 12: Most Effective Preservation Services**

Source: Worker Survey, Question 25.5		
What services have you found to be most effective in protecting the child and preserving the family?		
Number of Respondents = 84	Total Responding	Percent of Respondents
Mental Health Services	36	42.9
Families First	33	39.9
Parent Services	26	30.9
In-Home Services	14	16.7
Substance Abuse Services	13	15.5
Wraparound	10	11.9
Families Together Building Solutions	7	8.3
Family/Team Decision Making	7	8.3
Transportation*	3	3.6
Prevention	4	4.7
Financial Assistance	3	3.6
School Services	3	3.6
Family Reunification Program	2	2.4
Employment Services	2	2.4
Other	14	16.7

The focus group protocol included a structured discussion to identify programs and approaches that workers in the field, as well as their supervisors and managers, found to be working well and supporting positive outcomes. The focus groups included both public and private workers across a range of disciplines and specialties that included mental health, substance abuse, protective services, residential and foster care, and child assessment and advocacy centers. There were a

number of areas of agreement across those groups regarding certain programs that participants felt worked well when they were available. Many participants expressed frustration with regard to successful programs that did not reach enough families, or that did not have enough staffing or funding resources attached to be consistently high performing. The programs that were mentioned most often across groups as high quality and high impact included:

- Family Group Decision Making.
- Families First.
- Team Decision Making.
- Wraparound.

There seemed to be a consensus among all the focus groups that prevention programs generally were high quality and effective, when available. For example, tribes report that their early intervention services work well in addition to the Family to Family Model and Family Group Decision Making. Private agencies reported that Family Group Decision Making, Wraparound, and the Family Reunification Program are effective. On-site forensic interviews at child advocacy and assessment centers offer effective early intervention in abuse cases, a service that child assessment and advocacy center directors across the state voted their number one effective service.

Challenges expressed in focus groups in regard to services they identified as effective related to waiting lists that impeded accessibility, and some unevenness and inconsistency between workers. Several prevention programs available only regionally were mentioned by participants who worked in those regions. For example, the Kent County DHS focus group felt that their P21 and Advanced Early Impact programs were very high quality, and expressed a desire to have those programs formally evaluated for efficacy. Wayne County DHS staff identified their Parent Partner Program as a very effective program that serves as an important bridge between DHS and the family during the critical early stages of a case.

The focus group participants were also asked their views on why certain programs and approaches worked better than others. Many of their responses reflect the observations and common characteristics previously mentioned in this report regarding effectiveness. For example, all groups identified home based services as offering many benefits, such as convenience and accessibility to the family (Southeast Michigan Private Agencies), providing a lens into the family situation in their home environment (Wayne, Kent County DHS). Most groups identified a team based approach to planning and decision-making as being preferable to a more traditional top-down approach, and saw the value of information-sharing across stakeholder groups, including the family. Bringing people together to work on cases was seen as an important way to share responsibility and decision-making (Central Michigan Private Agencies), get important information out in the open (Kent County DHS), reduce tensions between the family and DHS (Wayne County DHS), and keep caseworkers “honest” about what has or has not been done for a family (Southeast Michigan Private Agencies).

## ***C. Michigan's Service Gaps and Unmet Needs***

### **1. Factors that Influence Program Impact**

As described above, many states, including Michigan, offer a variety of services designed to preserve the safety and stability of families and avoid the need for placement out of the home. Programs with proven success, such as Michigan's Families First program, Family Group Decision Making, and Wraparound, are in widespread use around the country, with varying degrees of effectiveness. Several factors have been identified as affecting the level of impact these programs have, and are listed below (National Family Preservation Network 2003, Center for Social Services Research 2004):

- Inter and intra agency collaboration is needed to reduce fragmentation in service delivery, and to foster community involvement in supporting the children and family. Multiple organizations and individuals with a stake in the outcome must be able to come together in a coordinated and integrated way to provide the services that each family needs.
- Clear program objectives and outcomes must align with organization goals and accountabilities across the different systems that are involved in providing services to the families.
- Operational procedures must support efficient and cost effective implementation. Clear criteria for enrollment and conclusion of services, centralized intake processes, and ongoing recruitment and training of specialized staff are strategies used in many states.

The focus groups, surveys, and Child Welfare Improvement Task Force (CWITF) identified several specific needs in the area of prevention and preservation. These are grouped into relevant categories and described below.

### **2. Survey and Focus Group Perceptions of Needs**

#### **a) Geographic Disparity**

- The CWITF considered geographic disparity in the availability and delivery of services to be a significant issue. DHS central office contracts are available in limited areas causing the counties to purchase whatever is available locally (this varies greatly). Since current contracts require single contractors to cover broad geographic areas (i.e. Upper Peninsula, northern Lower Peninsula) this creates barriers to agencies that must either pay increased travel costs for staff or open multiple office locations capable of dispatching staff across several counties.
- Differences in geography, county management, and court philosophy, as well as the level of participation by private agencies in providing child placement services creates a state where no two counties look alike. Such a patchwork system of care means a child and family is not able to get the same level or type of services in every community they may be in over the life of a case (CWITF).
- Both Kent and Wayne County DHS focus groups described difficulties coordinating services between counties and differences in the way counties understood and interpreted policy. Southeast Michigan Private Agencies stated that in Macomb County, for example, there is a community representative who works with families from that particular community and attends the team decision making meetings (TDMs) as an advocate for

the parent. The group felt this approach benefited the TDM process and gave the parent more of a voice at the meeting. However, this was not a common practice in other counties in which they operated.

- The parent focus group conducted in Ingham county identified parent advocates available through Wraparound services as important contributors to the parents' successful navigation of the child welfare system.

#### **b) Assessment**

In the survey, CPS workers were asked to identify screening and assessment tools they have used in their current open cases. Out of the 27 CPS staff who responded to this question, 11 reported using assessment tools. Open ended responses from staff indicate that a variety of tools are used, such as the family history questionnaire and information form, the DHS1613 case screening and family assessment guide, eco-maps, which maps out important family and community connections for a child, and the tribal social services assessment.

One respondent commented in the survey that "It would be nice to have the other tools (listed in the question) at our disposal." While only one person made this particular statement, the comment suggests a need to ensure that all tools are known and accessible to all workers. Additional training may be needed regarding the use of alternative assessment tools and the different purposes served by each.

Focus group participants identified the following concerns and needs related to assessment:

- DHS workers would like to see more individualized assessments, especially substance abuse assessments, from their contractors in order to more effectively serve their clients. Private agencies report the importance of good substance abuse assessments as key in determining the care needs of children in the family. (Kent County DHS and Central Michigan Private Agency Focus Groups).
- Private agencies report a need for access to good psychological assessments for youth. (Central and Southeast Michigan Private Agency Focus Groups).
- Substance abuse treatment centers and child advocacy and assessment centers report a need for greater access to confidential information about their cases from DHS. This would help foster a team approach to helping the child. Central Michigan private agencies report needing timelier access to release of information. (Child Advocacy and Assessment Center, Substance Abuse and Central Michigan Focus Groups).
- Ingham mental health service providers identified a need to develop a collaborative approach to assessment and case planning between DHS and mental health agencies.
- The mental health provider focus group expressed concern that DHS workers seldom have time to participate in the kind of case staffing that yields the best plan. Several also expressed concern that uniform processes and protocols do not necessarily support this kind of collaboration.
- Birth parent focus group participants indicated a belief that workers need to listen to and accept what parents know about the needs of their own children in the assessment and case planning process. They also expressed concern that workers don't get a complete understanding of the full needs of the family as a whole, sometimes focusing on the needs of one child, excluding consideration of other family members' needs or needs related to interaction with a child with more difficult needs.

- Given the often indistinct line between poverty and physical neglect, DHS Eligibility Specialists (ES) and Financial Independence Specialists (FIS) staff funded through the Temporary Assistance for Needy Families (TANF) program need to be included as part of the child welfare team. All ES/FIS staff serving families with open child welfare cases need to be included in all team decision-making (TDM) meetings. Given already high caseloads for ES/FIS staff, additional staffing would be required.

### **c) Prevention and Early Intervention Needs**

Most focus groups stressed the importance of Michigan’s prevention and intervention programs, but felt that there were a number of concerns related to availability, continuity and effectiveness.

#### ***Prevention:***

- Most focus groups advocated for more prevention services and education to help deter crises later on in the system. Many groups had clear ideas about which types of programs they thought were effective and which types of programs they thought needed improvements or support.
- Private agency directors in Central Michigan report a need for prevention services for pre-crisis cases. They see CPS as being the only current doorway to services.
- Some DHS supervisors report not knowing if prevention services are effective and would like to see solid evaluations (exception: mentioned that Wayne County prevention services are working). (Kent and Wayne County DHS Focus Groups).
- Child Advocacy and Assessment Center directors would like to see education and training for people who work with children about body safety and abuse: Headstart workers, churches, caregivers, etc.
- Child Advocacy and Assessment Center focus group respondents strongly advocated for funding to have, maintain and expand prevention services through the centers:
  - The Personal Safety Awareness Program (PSAP) and other similar school programs work with elementary children to teach them about safe and unsafe touching and what to do about it.
  - Parent education programs teach parents how to protect kids (e.g., Darkness to Light). It is difficult to get an avenue to educate adults about abuse and how to keep their kids safe. Studies show many adults don’t believe children when they self-disclose abuse. Parents need to be educated and to learn what to do if their children report abuse.
  - Computer internet safety programs.
- The Ingham County birth parent focus group spoke about their need to have services prior to the time a crisis arises. They identified transportation, housing, utilities and other financially related needs. They expressed a desire for services to address their own or their children’s mental health, their coping skills, and their parenting skills – especially related to caring for children who exhibit behaviors they find difficult to manage. Some participants were familiar with the Love and Logic Discipline program and believed that something similar would be useful for older children.
- Every birth parent participant expressed concern they were not consulted or involved in their case planning, and every participant said they had been asked from the onset of their case to agree to termination of parental rights.

### ***Home-based Services:***

Most focus groups commented on the value that home-based programs provide – eliminating transportation and childcare barriers and helping to increase rapport with clients.

- Field workers thought home-based prevention and early intervention services were effective including Age 0-3 programs, Families First, etc., and need to continue to be funded. (Kent County DHS, Child Advocacy and Assessment Center and Substance Abuse Focus Groups).
- Wayne County DHS supervisors reported that Families First agencies are not always as effective as they could be while both Kent County DHS supervisors and workers voted Families First as their number one effective program.

### ***Early Intervention:***

Focus groups highlighted the value of programs that bring families and workers together to solve problems.

- Tribes report that their early intervention services work well in addition to the Family to Family Model and Family Group Decision Making.
- Private agencies rated Family Group Decision Making, Wraparound, and the Family Reunification Program as very effective. (Central and Southeast Michigan Private Agency Focus Groups).

### ***CPS Investigation Services:***

Because of their close working relationship with CPS, Child Advocacy and Assessment Center directors from across the state offered their insights into how they and CPS might work more efficiently to prevent abuse and keep kids safe. Birth parents also contributed their feedback based on their personal experiences with CPS.

- Child Advocacy and Assessment Center (CAC) directors report a need to address cases where children are abusing other children in the home and believe these cases should be investigated by DHS. They also expressed concern that perpetrating children cannot be left in the home with other children regardless of how few years apart the children are from each other.
- CAC directors see a need for youth offender services and programs for youth who are pre-adjudicated. These youth cannot be served at the Child Advocacy and Assessment Centers because of their “no perpetrator on the premise” policy. Many perpetrating youth will not be adjudicated but still need help so they don’t continue the cycle of abuse. Those who are adjudicated receive mandated treatment. There needs to be an intermediary youth treatment program to fill the gap for those who are not court-ordered to receive treatment.
- On-site forensic interviews at Child Advocacy and Assessment Centers offer effective early intervention in abuse cases. CAC directors across the state voted this their number one effective service. Funding is always needed to maintain forensic interviewers. One site reported doing 200 forensic interviews per year. Directors advocate that if CPS needs to be involved in forensic interviewing (which they say is not optimal), they would like to see workers better trained.
- There are very few medical examiners that specialize in sexual and child abuse exams and, those that exist have to serve multiple counties at once. Funding is desired to train

other doctors in this specialty, so there can be one doctor per county. (Child Advocacy and Assessment Center Focus Group).

- CAC directors say that they are seeing a trend in which physical abuse cases are often not dealt with at CPS unless multiple referrals or calls are made.
- Multiple CAC directors advocated for greater access to reimbursement for medical exams, especially medical emergency exams. Doing exams without reimbursement makes continuing to operate their programs on limited budgeting difficult.
- CAC directors reported a need for better communication and collaboration with CPS, better follow-up from CPS on cases (in some counties) and a need for new CPS workers to be better educated about CACs and their work.
- Multiple CAC directors reported a lower number of referrals from CPS. They would like to see more referrals from CPS.
- Birth parents participating in a county focus group expressed concern that DHS needs to be more clear and direct about abuse allegations being investigated. All participants said they found statements in the investigation reports they believed to be inaccurate. The parents want to make sure investigating CPS workers understand the whole picture and that the report is accurate.

**d) Preservation**

The survey asked CPS workers to estimate their total caseload size and then to identify services being provided to children and families in their caseloads. Average caseload size for DHS and private agency workers is 15 and 13, respectively, while tribal agencies report much lower caseloads of 5 per worker.

**Figure 13: Child Protective Service Workers Caseload Size**

Source: Worker Survey, Question 25.1				
Answer Options	Mean Numbers in Caseload			
	DHS	Private	Tribal	Avg Across Groups
Average number of children in caseload	15	13	5	14
Average number of birth families in caseload	7	7	3	7
Number of Respondents	129	40	7	178

The figure below indicates that services targeted to preserve families and prevent placement are regularly used by CPS workers. Services for children most frequently accessed include FGDM and home visiting programs, as well as transportation and physical and dental health services. Services for birth parents most frequently utilized include home visiting, parent education services, counseling, dental health and concrete services such as transportation, financial assistance and employment training.

**Figure 14: Percent of Children and Birth Families Receiving Prevention Services**

Source: Worker Survey, Question 25.3		
Percent of Current Caseload Receiving Specified Services		
Number of Respondents = 98	Child Caseload	Birth Parent Caseload
Wraparound	17.2	31.4
Families First	20.5	28.8
Family Group Decision Making	53.2	48.3
Home Visiting	59.7	80.3
Parent Education	34.7	57.6
Anger Management	15.0	33.2
Counseling	36.7	59.1
Physical Health	42.9	49.8
Dental Health	47.8	55.5
Psychiatric	20.3	37.3
Mental Health	27.7	48.0
Substance Abuse Treatment	37.7	48.9
Financial Assistance	72.0	58.4
Transportation	44.9	53.3
Employment/Training	20.6	56.3
Education Services	32.7	44.8

When asked about the length of wait time for service availability, a substantial number of workers in all responding groups reported waits in excess of four weeks for many health and behavioral health related services. CPS workers were asked their perceptions regarding availability of services and wait times to initiate service. While FGDM, counseling and physical health services were reported as having the highest levels of availability, it should be noted that physical health services typically require a wait time of 5-6 weeks. Dental health services and transportation top the list of services most frequently reported as not sufficient or unavailable. Perhaps more significantly, over 50% of all respondents reported that 9 out of the 16 listed services were not sufficiently available or were not available at all.

Home visiting programs, identified as among the most effective interventions, typically require a 3-4 week wait to get started. Substance abuse and employment training generally take 4-5 weeks to begin, which is significant given the impact that substance abuse in particular can have in the decision to remove a child. Access to dental care commonly takes 5-6 weeks, and 13% of survey respondents reported that it can take more than 12 weeks to get a child to a dentist.

**Figure 15: Availability and Length of Wait for CPS Services to Prevent Removal**

Source: Worker Survey, Question 25.3					
Indicate whether the listed service is sufficiently available and the length of wait for each service.					
Number of Respondents = 98	Service Availability (shown in percent of respondents)			Length of Wait for Services	
	Sufficiently available	Available, but not in sufficient amount	Not available	Typical length of wait (in weeks)	Percent of respondents indicating more than 12 weeks
Wraparound	66.0	17.0	17.0	1-2	5.7
Families First	52.9	43.1	3.9	1	0.0
Family Group Decision Making	82.1	12.8	5.1	1-2	0.0
Home Visiting	75.0	14.6	10.4	3-4	5.3
Parent Education	44.7	48.9	6.4	2-3	2.4
Anger Management	50.0	40.0	10.0	2-3	0.0
Counseling	70.2	29.8	0.0	2-3	2.0
Physical Health	70.6	26.5	2.9	5-6	6.7
Dental Health	31.4	57.1	11.4	5-6	13.3
Psychiatric	25.0	70.0	5.0	3-4	10.8
Mental Health	44.4	55.6	0.0	1-2	2.4
Substance Abuse Treatment	59.6	40.4	0.0	4-5	0.0
Financial Assistance	46.5	51.2	2.3	2-3	10.8
Transportation	37.2	48.8	14.0	3-4	9.1
Employment/Training	48.6	45.9	5.4	4-5	13.8
Education Services	42.5	47.5	10.0	1-2	12.1

Child protective services (CPS) workers were asked to identify services they provided prior to removal, as well as services that they felt should be available to safely maintain children in their own homes and preserve the family. Mental health, Families First, and parent services were the most commonly cited services in their answers. Specifically, services cited as being the most used, the most beneficial, and the most needed included:

- Outreach.
- Individual and group therapy.
- Family therapy.
- Child therapy.
- Parent/teen therapy.
- Home-based.
- Intensive home-based.
- Post adoption counseling.

In addition, the following specific types of mental health services were identified as needed:

- Psychiatric.
- Families Together Building Solutions (FTBS).
- Drug screens.
- Support groups for foster parents.
- Substance abuse for birth parents.
- Indian Child Welfare Act (ICWA) counseling for parents/agencies/courts.

Focus group comments about preservation services included:

- The Substance Abuse and Central Michigan Private Agency Focus Groups would like to see the time frame expanded for biological families to meet DHS expectations in order to keep their children, provided the children can be kept safe. Currently, workers report that parents are expected to do parenting classes, find a job, complete substance abuse treatment, testing, etc., in a very short amount of time while still trying to get sober. Focus group professionals feel this is unrealistic.
- Caseworkers see a need for mentorship programs for parents (especially parents with cognitive difficulties) to help give them the support they need to be successful.
- DHS workers reported a need for resources to locate older siblings when families are split apart. (Wayne County DHS Focus Group).
- Adoptive parent and Central and Southeast Michigan private agency focus groups stated a need for services to support and maintain adoptive families staying together.
- All participants in the mental health providers focus group expressed the belief that the majority of children entering foster care would be better served with intensive services to improve the parents' ability to understand, cope with and guide their own children's development. If placement is necessary, it should be for the shortest possible time and should fully engage the parents in the planning and treatment process. Among services that they felt were essential are those that address children's separation and attachment needs.
- The Ingham County parent focus group members discussed the importance of parent advocates who can help parents understand and navigate the child protection process, participate effectively in case planning and to "be on their side" throughout the intervention process. Respite was noted as the critical preservation service need, especially helpful for families coping with children and youth with serious behavioral health problems.
- The birth parent group participants brainstormed a list of other services essential to family preservation, including Wraparound and home-based therapy to help with coping skills and to help with managing their children's behavior in appropriate ways.

#### ***D. Key Findings and Needs Relating to Preventing Entry Into Care***

**Finding: Prevention and preservation services are needed in Michigan that are effective in supporting families and reducing the need for removal from the home.**

When parents have the skills and supports that enable them to be good parents, they and their children are more likely to grow to be well-adjusted, healthy, productive citizens. Therefore, by "front loading" services at the beginning of a case, even before placement, significant reductions in the need for intervention and placement, as well as cost savings over the long term, are possible. Michigan needs to ensure that in developing new or expanding existing prevention or preservation programs, it does so in a way that maximizes the reach and effectiveness of those

efforts. Initiation or expansion of any program or service needs to be evidence based and include the following characteristics:

- *Targeted populations.*
- *Intensive services.*
- *Focus on behavior.*
- *Inclusion and engagement of both parents and children.*
- *Program fidelity to an evidence based model.*

Examples of programs that meet the above criteria, some of which are in use in Michigan, include:

- Structured Decision-Making – in use in Michigan.
- Differential Response.
- Family Group Decision-Making – in use in Michigan.
- Healthy Families America.
- Nurse Family Partnership for Low Income Families.
- Intensive Family Preservation Services (Homebuilders®) – in use in Michigan (Families First).
- Chicago Child Parent Centers.

**Finding: Prevention and preservation services in Michigan are effective in supporting families and reducing the need for removal from the home, but are not sufficiently available to meet the needs of children and families across the state.**

There seemed to be a consensus among all participant groups that prevention programs generally were high quality and effective, when available. Needs and gaps raised by the administrative data and expressed by survey and focus group participants related to regional availability, waiting lists, and unevenness and inconsistency between workers. Specific key needs and gaps are identified as follows:

### ***Geographic Disparity***

- Geographic disparities in the availability and delivery of services need to be reduced so that a child and family can receive the same level or type of services in every community they may reside in over the life of a case.
- Consistency is needed in the way services are coordinated between counties and how personnel across the state understand and interpret policy.

### ***Assessment***

- To help workers plan effectively for children and families in their caseloads, DHS needs to ensure that all CPS staff are aware of the variety of assessment tools available to all workers, and that they have the training needed regarding the use of alternative assessment tools and the different purposes served by each.
- Assessment practices and resulting service plans need to focus on meeting the individualized needs of the particular child or family member.
- Birth parents need to have access to services prior to the time a crisis arises and also need to be regularly consulted and involved in their case planning.

### ***Prevention and Preservation Services***

- There is a need to increase accessibility to services and to decrease the wait times for enrollment.
- Given the impact that problems with substance abuse, mental health, transportation and housing can have in the decision to remove a child and the decision to return a child to the family, expansion of effective prevention services is needed, such as home visiting programs, that provide many tangible supports such as housing, financial and transportation assistance in addition to parenting and health related supports.
- In Michigan, children under age one represent 14% of the substantiated victims of abuse, while children under age 3 represent 32% of victims. For children in foster care, over 20% are in the 0 to 3 age group. Home visiting prevention services targeted to new parents of children like these have proven particularly effective in preventing maltreatment before it occurs.
- Preliminary analysis of administrative data shows that the constellation of needs identified through the Family Assessment of Needs and Strengths for families from which children are removed are the same as for families from which children are not removed. Further comparison and analysis, including quality review of selected cases, may be warranted.
- The majority of children in foster care are from Michigan's largest urban counties, yet these counties receive proportionately less funding per child in foster care for community based services (CP/CP, CSPP, and SFSC) than the average amount.

### III.Supporting Placements and Expediting Permanency

#### A. Current Caseloads and Outcomes

The total number of children in foster care has decreased in 2008 as compared to the previous year and is at its lowest level over the past five years.

Figure 16: Foster Care Trends

	2004	2005	2006	2007	2008
Out-of-Home Placements	9,699	9,367	8,916	8,607	8,219
Relative Placements	6,442	6,481	6,628	7,109	6,763
Own Home/Legal Guardian	2,202	2,042	1,924	2,114	1,950
Other	797	843	873	941	1014
Total Foster care cases	19,140	18,733	18,347	18,771	17,946

An examination of the data on a county by county basis reveals great variation in the proportion of children in the counties who are placed in foster care and in the average length of time children currently in foster care have been in their current placement. Based on administrative data DHS provided to CWRC, the number of children per 1000 total population in care in the five urban counties ranges from approximately 4.5 to approximately 11.5. The range is much broader when all Michigan counties are included. The mean length of time in care by county for children currently in foster care ranges from about 1.7 years to more than 3 years for the urban counties. When all counties are included in the average, the low end of the range is approximately .6 years. Opportunities for redirecting resources to other services may be embedded in these variances.

Figure 66 in Appendix 3 provides data on the number of children placed in foster care and the rate of placements per thousand children in the total population in each county.

**Age of Children in Care.** Needs of children in care vary by age group, along with the types of services their parents need. Based on administrative data provided by DHS, the percent of children currently in foster care in Michigan, by age group, is displayed in the following table. Children in the 0 to 3 age group comprise the greatest percent of children in these three-year age groups.

**Figure 17: Percent of Children in Care by Age Group**

Age Group	Percent of Children in Foster Care
0 to 2.99	20.7%
3 to 5.99	13.3%
6 to 8.99	11.1%
9 to 11.99	12.6%
12 to 14.99	12.6%
15 to 17.99	17.8%
18+	7.7%

**Sibling Group Size.** An important consideration in the determining whether the array of current foster and adoptive homes is adequate to the needs of children served by the Michigan child welfare system is whether the current array of licensed foster and adoptive homes can accommodate the size of sibling groups placed in foster care. A first step in this process is to examine the range frequency of foster care sibling group sizes.

Data generated by the Service Worker Support System (SWSS) and stored the state’s Data Warehouse helps with this review. This automated system includes a unique recipient ID for each child in foster care and establishes a sibling group ID that is applied to each child from the same family group. This permits identification of the frequency distribution of sibling group sizes for children in foster care.

DHS provided CWRC with a current data file from April 2009 with identifiers for individual children and their associated sibling groups along with other case and demographic information. The file includes relevant data for 17,179 children in foster care. Figure 16 shows the frequency distribution for the number of children in foster care at each sibling group size for the state as a whole. A similar table showing the frequency distribution across sibling group sizes for each county appears in Appendix 3.

**Figure 18: Sibling Group Size Frequency Distribution for All Foster Children**

Number Children in Sibling Group	Statewide Frequency of this Sibling Group Size	Percent of Sibling Groups	Number of Children	Percent of Children
1	6,351	62.1	6,351	37.0
2	2,108	20.6	4,216	24.5
3	983	9.6	2,949	17.2
4	485	4.7	1,940	11.3
5	192	1.9	960	5.6
6	62	0.6	372	2.2
7	22	0.2	154	0.9
8	19	0.2	152	0.9
9	6	0.1	54	0.3
10	2	0.0	20	0.1
11	1	0.0	11	0.1
Total	10,231	100.0	17,179	100.0

DHS provided another data file with case and demographic data related to 6,281 children for whom parental rights have been terminated. For 4,343 of these children, distribution across sibling group sizes is shown below in Figure 17. The children in this group are a subset of the 17,179 foster children shown in Figure 13 above. For 1,937 children in this file, a sibling group identifier was not included in the data set.

Similar sibling group size frequency distribution data is provided for each county in the state in Figure 64 in Appendix 3. Data provided to CWRC on the 17,179 children in care did not include living arrangement data. Therefore, it was not possible to break out sibling group size only for those children placed outside their own homes. Annual trend data in Figure 16 shows over 37% of children in the foster care system being placed with relatives at the end of 2008 and over 10% being placed in their own homes or homes of guardians.

**Figure 19: Sibling Group Size Frequency Distribution for Children with Parental Rights Terminated**

Number Children in Sibling Group	Statewide Frequency of this Sibling Group Size	Percent of Sibling Groups	Number of Children	Percent of Children
1	2,243	21.92	2,243	51.66
2	540	5.28	1,080	24.87
3	176	1.72	528	12.16
4	66	0.65	264	6.08
5	29	0.28	145	3.34
6	10	0.10	60	1.38
7	2	0.02	14	0.32
8	1	0.01	8	0.18
Total	10,231	100.00	4,342	100.00

DHS also provided data from the Bureau of Children and Adult Licensing (BCAL) to CWRC about the number of current foster home and foster group care licenses in Michigan and the child capacity of those homes. A summary of the data for the state and the five urban counties appears below in Figure 20.

**Figure 20: Licensed Foster and Group Homes and Capacity in Urban Counties**

COUNTY:	Child Foster Family Home (Capacity 1-4)		Child Foster Group Home (Capacity 5-6)		All Facility Types	
	Count	Capacity	Count	Capacity	Total Count	Total Capacity
Genesee	360	931	18	106	378	1,037
Kent	412	1,009	19	109	431	1,118
Macomb	310	685	10	56	320	741
Oakland	384	897	13	72	397	969
Wayne	1,307	3,049	22	123	1,329	3,172
Total - 5 Urban	2,773	6,571	82	466	2,855	7,037
Total - State	6,034	14,814	312	1,799	6,346	16,613

Upon review of Figures 18 and 20 in conjunction with one another and in consideration of the approximately 10% of children who are in their own or guardian homes, it appears that the current total statewide capacity of licensed foster homes and group homes is greater than the total statewide number of children in the foster care system who are placed outside their own or guardian homes. Similarly, the current total licensed capacity for homes with a capacity of one to four children may be approximately equal on a statewide basis to the number of children in sibling groups of this size. Foster group home capacity is greater than the number of children in sibling groups of five or six. However, a total of 391 children in the April 2009 data set provided by DHS were in sibling groups of seven to eleven children. This sibling group size is outside the range of foster home and group home capacity limits.

At a statewide level, little excess capacity exists to ensure that children in each specific sibling group size can be placed together or that the range of special needs can be served within appropriately within the current capacity of licensed homes. Currently, with nearly 50 % of the children in the foster care system placed in their own homes, homes of guardians or relative care (typically unlicensed), the range of capabilities of alternate care providers may be slightly greater than without those placement resources. The data in these figures will be reviewed in light of survey and focus group responses later in this report.

A data comparison is provided in Appendix 3, Figure 66 that displays the licensed foster home and foster group home capacity and the number of children by size of sibling group for each county. Based on a review of this data, a total of 25 counties show a deficit in existing licensed capacity compared to the number of children in the foster care system for sibling group sizes one to four. For sibling group sizes five and six, 11 counties show a deficit in capacity compared to the number of children in foster care. 12 counties have sibling groups sized seven to 11. Data currently available to CWRC does not provide specific living arrangements for these children. Therefore, a more detailed comparison showing only those children who are currently placed in foster home settings is not possible. Again, these data need to be reviewed in light of focus group and survey information about the adequacy of foster home resources.

## ***B. Effective Programs and Approaches***

Many of the principles identified in the previous literature review section on prevention also apply to other phases of child welfare work, after removal has occurred. Intensive, customized approaches that involve family members in identifying strengths and needs as well as planning for appropriate services are important throughout the life of the case. Where reunification is the goal, timely identification and delivery of services and supports to the family is critical. At the same time, there is a need to minimize the negative impact of foster care on the child's health, development and well-being.

Evidence is increasingly abundant that the longer and less stable a child's tenure in the foster care system is, the more likely it is that he or she will experience negative long term outcomes (Bruskas, 2008, Doyle 2007). These less than positive outcomes can include higher rates of delinquency and adult criminal behavior, higher incidence of serious mental illness, lower academic achievement and high school or college graduation rates, unemployment, and higher rates of homelessness and use of public welfare resources as an adult. The traumatic experiences

that led to placement in the first place can be exacerbated by the removal from the home and the resulting loss, confusion, and instability. Thus, foster children as a group are an extremely vulnerable population, and care in addressing their needs effectively is essential in order to increase their chances of growing into successful, productive adults.

## 1. Common Characteristics of Successful Programs

Certain characteristics common to interventions focused on reunification have been identified in the literature as important components to consider when instituting new or expanding existing programs, regardless of the type of program (Children's Bureau 2006).

- *Family Engagement.* Engaging the family in a collaborative way is extremely important when placement has occurred and reunification is the goal. There are three relationship dimensions to family engagement that the literature has identified as critical to a successful reunification process:
  - *Caseworker and family* – The frequency of the caseworker's contact and the nature of that contact can determine the extent to which a supportive and collaborative relationship is fostered that can lead to higher rates of involvement and completion in provided services.
  - *Parent and child, and the support of visitation or parenting time* – the frequency and quality of the time parents spend with their children who are in foster care has been shown to help predict the likelihood that reunification will occur. Visitation with a therapeutic focus that helps build parenting skills and improves parent-child interactions is associated with higher rates of reunification.
  - *Foster parents and child, birth family and caseworkers* – the training and support foster parents receive can have a direct impact on the levels of stress experienced by the child and birth parent. In addition, therapeutic foster care has been shown to be an effective and cost-saving alternative to institutional care for troubled youth in the system, and can lead to successful long-term outcomes.
- *Assessment and case planning.* As with prevention efforts, assessment and service planning that is customized to each family's needs and involves the family in the planning and decision-making is essential. Approaches such as structured decision-making and differential response, described earlier, are as important in this phase of a child welfare case as they were before placement occurred.
- *Evidence-based, comprehensive services.* When the goal is reunification, services must be designed to support the child and family in achieving that goal as soon as possible. Studies have shown that services which involve the whole family, are cognitive-behavioral in approach, focus on skill building, and address family functioning within multiple systems (home, school, community, etc) are more likely to support timely and long lasting reunification. The types of services that have been proven to be most effective include:
  - *Concrete and practical* – assistance with transportation, housing and utilities, for example, are often critical elements of the reunification process.
  - *Substance abuse treatment* – parental substance abuse is a well documented factor in the removal of children from the home, and therefore must be effectively addressed if reunification goals are to be achieved.

- *Mental health treatment* – effective mental health interventions must target both parent and child needs.
- *Home based services* – building on the success of home-based prevention models, intensive home-based services have been shown to significantly and positively impact reunification rates. Studies are mixed regarding the rate of reentry into care, but post-reunification services that continue to support the family as they adjust after the children return home can be especially important where extreme poverty, lack of social supports, or substance abuse are factors.

## 2. Specific Examples of Model Programs and Approaches

The following are some examples of rigorously evaluated programs or approaches that meet the above criteria and achieve significant impact with regard to reunification and placement stability, as well as recurrence of maltreatment and other important outcomes. Substance abuse and mental health treatment approaches are discussed in more detail in Section V of this report.

### ***Concurrent Planning***

Concurrent planning involves considering all reasonable options for permanency at the time that a child enters care, and simultaneously pursuing those that will best serve the child's needs. Typically the primary goal is reunification, but a secondary goal may be adoption or kinship care, both of which are pursued together. Although somewhat controversial initially, the approach has gained support and is now seen as a preferred method to the sequential approach in which all efforts at reunification must occur before considering an alternative permanency option. Based on findings from jurisdictions that have implemented statewide concurrent planning policies, several guiding principles to facilitate success in other jurisdictions have emerged:

- *Widespread acceptance* – to be successful, concurrent planning must have the support of all levels within the child welfare agency and private service providers and must have adequate resources to support it.
- *Cooperation of the judicial system* – judicial procedures are necessary to support timely planning and casework services, and attorneys and judges must be involved early in the planning and support of concurrent planning efforts.
- *Aggressive pursuit of permanency options* – early and aggressive efforts are essential if the best interests of the child are to be achieved in a timely way.
- *Family engagement* – many agencies are adapting the Family Decision Making Model to support concurrent planning approaches that ensure engagement and active involvement of families in an atmosphere of mutual respect, honesty and openness.

While empirically-based research on concurrent planning outcomes to date has been limited, the literature suggests that concurrent planning may be effective, particularly with younger children. To achieve timely permanency utilizing the concurrent planning approach, several factors have been found to be important (Potter & Klein-Rothschild, 2002):

- *Caseworker continuity* – a change in caseworkers can have a dramatic negative effect on a permanency outcome.
- *Fewer placements* – every additional placement will reduce that child's odds of attaining permanency.

- *Extreme poverty* – the poorer a child’s family is, the less likely that child will achieve permanency within 12 months.
- *Substance abuse* – the presence of substance abuse in the family will decrease the likelihood of reunification and increase the likelihood of timely permanence.
- *Parenting time* – according to Potter and Klein-Rothschild, every day of visitation tripled the odds of permanent placement within one year.

While utilizing the concurrent planning approach to attain permanency for teens may be more challenging, it is no less important, and several factors that have been identified as important to achieving permanency for all children are also relevant specifically to older youth (Centre for Parenting and Research 2007):

- *Continuity* – maintaining safe contact between children and birth families or kin is important in the context of multiple or disrupted placements.
- *Assessment* – in-depth assessment of children is critical to ensuring the appropriate intensity and amount of support a particular child needs.
- *Children’s participation in decision-making* – older children especially need to have a voice in decisions that impact their long term futures.
- *Recruitment, training and support of caregivers* – appropriate levels of training and support of foster parents, and continuing post-permanency support and services can greatly decrease the number of placement disruptions.

### ***Intensive Support Services***

**Family Reunification Program (FRP).** In 1992, Michigan created and piloted its Family Reunification Program for families with children transitioning from foster care back to the home. Although the program evaluation has not been recognized or published in a peer reviewed journal, the Children’s Bureau (2006) nevertheless recommends the program model and recognizes that families who participated in FRP treatment programs were more likely to remain reunified than those in a control group. The program was also found to be cost effective. Key elements of the program are:

- Comprehensive assessment and case management.
- Two staff assigned per family and 24 hour availability.
- Flexible funds and in-home services provided for 4-6 months.
- Services can begin one month prior to child’s return home.

**Wraparound or Systems of Care Services.** Although these programs traditionally targeted juvenile offenders with serious emotional problems, their use more generally with the foster care population, particularly when serious emotional illness or substance abuse is involved, is growing. These services emphasize providing individualized coordinated services among a variety of agencies and organizations and allow the child to remain in the community rather than residential care or treatment. Studies show that programs directed toward children with serious emotional disturbances who are in foster care or referred by the child welfare system can result in reduced recidivism, and reduced hospitalization or residential treatment. Key components include:

- *Intersystem collaboration* – team driven service planning process includes caregivers, children, agencies and community service providers across the juvenile justice, mental health and child welfare domains.

- *Family-based* – family is involved in the planning and service delivery process.
- *Individualized services* – strength-based services utilizing natural supports such as friends, extended family, community supports.
- *Flexible approaches* – service plans are based on the unique needs of the family.

### ***Services to Promote Placement Stability***

The research clearly states that the less restrictive and more supportive the out of home placement is, the more likely that the child will be able to manage the trauma, loss, confusion and anger associated with removal from the family home. This holds true for older children with serious delinquent and emotionally disturbed behaviors as well. Comparing residential or group care with more individualized foster care based treatment studies have repeatedly shown both cost effectiveness and better overall outcomes achieved with more intensive, customized, treatment-focused foster care that integrates services and treatment within the child's own community (Chamberlain & Reid, 1998). The cost of long term residential treatment settings is very high and there is little empirical evidence of positive impact after leaving care. Despite a dearth of published outcome research, what little there is suggests that the best outcomes associated with residential care occur when 1) stays are relatively short, 2) families are involved, and 3) aftercare services are provided. (Smith, et al. 2008).

When the foster family is ill-equipped to deal with the externalizing behaviors of a traumatized child, the placement can be disrupted, creating a cycle of repeated failed placements. Whether the child is reunified with the birth family or is going to need a different permanency solution such as adoption or guardianship, the time spent in residential or foster care is a critically important period in a young person's life, and the quality and stability of the placement can significantly impact a child's chance of success in life.

**Kinship Care or Subsidized Guardianship.** This strategy for increasing placement permanency offers legal, subsidized guardianships for kin or foster care providers. Research shows that children in relative foster care are just as safe as or safer than children placed with unrelated foster families. In addition, research suggests that relative foster placements are more likely to be stable, and that children are more likely to maintain sibling connections (Testa 2008). These guardianships differ from formal adoption in that they do not always require the legal severance of the relationship between the child and his or her biological family and allow the child to maintain his or her community connections.

**Project KEEP.** This program provides training and ongoing support for foster and kin parents. The program seeks to increase stability for children in foster care by training foster parents to track child behavior and implement a contingency system for compliance. Better management of difficult behavior was shown to lead to significantly fewer negative placement changes for the children. (Price, et al. 2008) This program is an adaptation of a more intensive mental health model (multidimensional treatment foster care, described in Section V) and was found effective for foster children age 4-7 that have behavior problems but are not severely delinquent or disturbed. Key components of this program model include:

- *Training, supervision & support for foster or kin parents* – 16 week group sessions covering a range of behavior management methods.

- *Evidence-based practices* – the training curriculum focused on positive reinforcement, non harsh discipline methods, close monitoring of the child’s peers and whereabouts, and strategies for avoiding power struggles.
- *Trained and supportive staff* – trained paraprofessionals facilitate the groups, and conduct individual home-based follow up for any foster parent who misses a group session.

### 3. Survey and Focus Group Perceptions About Effective Programs

Foster care workers responding to the survey identified specific programs such as Wraparound, Family Reunification, and Families First, as well as mental health and in home services more generally, as effective services that support families after the child has returned home, indicated in the figure below. In-home services most frequently cited by survey respondents as effective include parenting education, homemaker services, and parent aide assistance.

**Figure 21: Most Effective Post Reunification Services**

Source: Worker Survey, Question 32.2		
What services have you found to be the most effective in maintaining children in their homes post-reunification?		
Number of Respondents = 44	Total Responding	Percent of Respondents
Mental Health Services	15	34.1
Family Reunification Program	10	22.2
Families First	8	18.2
In-Home Services	8	18.2
Parent Services	6	13.6
Wraparound	7	15.9
Substance Abuse Services	3	6.8
Assessment Prior to Reunification	3	6.8
School Services	3	6.8
Families Together Building Solutions	2	4.5
Continued Involvement with Agency	3	6.8
Other	7	15.9

Among caseworkers and managers in both private agency and DHS focus groups, there seemed to be uniform agreement that the Family Reunification Program (FRP) funding is an important resource for the families they serve. Stated reasons by focus group participants for its effectiveness included the public/private partnership that results between caseworkers as they work together to transition a child home, and the in-home, hands-on nature of the program. According to focus group participants, a high degree of cooperation and communication is necessary for the reunification to be successful, and through FRP the responsibility for that

success is shared, reducing the isolation that caseworkers often feel when working intensively with a family (Southeast Michigan Private Agencies). Some participants expressed a wish that FRP services could last longer than the allocated timeframes. (Southeast Michigan Private Agencies).

Other programs and approaches mentioned as being effective were sometimes qualified with comments relating to availability or accessibility issues, waitlists, lack of resources to fully support the program, or effectiveness related to the skill level of the particular worker assigned. Many programs or approaches mentioned were only available in certain areas, or were mentioned only by one or two groups. Examples include the following:

- Both Kent County DHS and Central Michigan private agencies reported residential facilities as being effective resources for children. Members of the Central Michigan private agency focus group specifically mentioned that they were “child friendly.” One respondent in the Southeast Michigan private agency group described a mentoring program at one of the residential programs which was very effective at establishing important connections between the youth at the facility and a caring adult. The respondent then pointed out that the mentor program at the facility does not have the resources to support continuing the relationship after the child leaves that program, raising a concern as to lack of connection and continuity of important relationships for children in residential care once they leave that environment.
- Two focus groups specifically mentioned kinship care and relative placements as being a very positive development (Central and Southeast Michigan Private Agencies), although these groups and others also expressed concern about the mandate to license relative caregivers (Kent and Wayne County DHS Focus Groups).
- Most groups identified programs that fostered good relationships between families and staff as being especially effective and reducing the tensions that can often be present when a child is removed from the home. These programs/approaches included: Team Decision Making and other team-based approaches (Kent County DHS, Central Michigan Private Providers, Substance Abuse Providers), foster care youth board (Kent County DHS), improved collaboration with community based resources (Substance Abuse Providers) schools (Wayne County DHS), and court personnel who were more involved in the child welfare process (Southeast Michigan Private Agencies).
- From a systemic perspective, some of the group participants were experiencing the benefits of smaller caseloads (Central and Southeast Michigan Private Agencies), improved worker training (Wayne County DHS), and better communication “when it happens” (Central Michigan Private Agencies).

### ***C. Michigan’s Service Gaps and Unmet Needs***

#### **1. Barriers to Achieving Success in Concurrent Planning**

Concurrent planning practices inherently involve conflicting goals, which can create tensions not only within the agency implementing the practice, but between the agency and the families and communities with which they are working. To be successful in achieving the goals of increasing both rates of reunification and permanency for children who cannot be reunified, these competing goals must find a balance in actual practice. States which have implemented

concurrent planning have identified barriers that must be overcome if success is to be achieved, as described below (Schene, P 2001):

- *Confusion over the roles of staff* – Managers must provide leadership in communicating a unified message about the competing goals and the need to pursue them simultaneously. Some states have actively worked to break down traditional boundaries between child protection, foster care and adoption, to a system that recognizes all workers as “permanency planning” staff who share different responsibilities and have different levels of expertise to handle the varying aspects of concurrent planning cases.
- *Traditional family assessment protocols may not work* – a concurrent planning approach necessarily shortens the time frame that a birth parent has to achieve reunification and the goals in the service plan. Using the appropriate assessment tool becomes key, as does providing early and comprehensive services in order to maximize the support to a parent and the opportunity for reunification. This has several implications:
  - The use of family group conferencing to share decision-making.
  - Stepped up visitation between parent and child in the early stages after placement, and applying the resources necessary to support the increased visits.
  - Manageable caseloads to support the higher level and intensity of service delivery and support to the parent, particularly in the early stages of the case.
  - Higher level of need for coordination of services to accommodate the aggressive timeframes required by concurrent planning.
- *Appropriate level of staff training* – states that have implemented concurrent planning tend to experience increases in both voluntary relinquishments and open adoptions. These results suggest that inclusion of birth parents in the process from the beginning can lead to positive outcomes for all, and is a good example of the need for adequate levels of staff training to ensure consistency and competency in dealing with the complexities inherent in a concurrent planning approach.

## **2. Barriers to Placement Stability**

As described elsewhere in this report, placement stability can have a dramatic impact on a child’s chance for permanency or reunification. Many states experience this problem, and have identified numerous reasons for it, including many that also affect Michigan (Lutz, 2003):

- Caregiver issues, such as:
  - Lack of resource families, or selection of homes based on availability and not on the skill level of the family to handle the needs of a particular child.
  - Inadequate training and support of caregivers caring for older children with behavior or mental health issues.
  - Lack of support, such as respite care or other services, for caregivers.
  - Caregivers with unrealistic expectations.
  - Infrequent contact between caseworkers and caregivers.
  - Too many children in the home.
- Difficulty coordinating educational services with other service systems, and then moving children because of their educational needs.
- Inadequate or varying levels of reimbursement rates based on changing “levels of care” – although this has recently changed, Michigan traditionally had varying reimbursement

rates for both the private foster care agencies and to the foster families themselves. With the intention to base the rate on the level of need a particular child has, this situation can create unstable or inappropriate placements for children who are moved based on their changing needs and changing reimbursement rates.

In efforts to improve the stability of placements, states around the country have identified resources or strategies they have instituted that have helped alleviate the problems they experience (Lutz 2003). These include:

- Effective mentoring programs that can provide an ongoing connection with a caring adult regardless of where the placement is.
- Other volunteer programs that use trained volunteers to focus on child and family needs, utilizing a strength perspective.
- Home based services to provide much needed support to a family.
- Improving relations with and cooperation between community based providers of home based services, mental health and substance abuse services, residential and group home care.
- Setting up a foster parent to foster parent liaison system to support foster parents, especially in the early days of fostering.

### **3. Survey and Focus Group Perceptions About Unmet Needs**

#### **a) Assessment and Concurrent Planning**

Foster care workers were asked to identify the assessment tools they commonly use. Survey responses are summarized below. The responses indicate that for the most part workers are using the required FANS and CANS assessment tools. However, other assessment tools available to identify child or parent needs more specifically are much less frequently used and both survey and focus group respondents expressed a need for a variety of tools targeted for specific purposes such as mental health, substance abuse, sexual abuse, trauma, and the like. This result suggests that further exploration may be warranted to determine how other assessment tools may assist workers in customizing the level, type and intensity of services to fully meet the particular needs of a child or family. Education and training on the existence and proper use of these tools is an area requiring further attention as well.

**Figure 22: Assessment Tools Currently in Use**

Source: Worker Survey, Question 28.1 and 28.2	
What assessment tools have you used to assess a child's special needs to determine the needed level and type of care? (shown in percent of respondents choosing that item)	
Number of Respondents = 121	
Family Assessment of Needs and Strengths (FANS)	90.9
Child Assessment of Needs and Strengths (CANS)	91.7
Child and Adolescent Functional Assessment Scale (CAFAS)	9.1
Pediatric Symptom Checklist (PSC)	2.5
Ages and Stages Questionnaire (ASQ)	13.2
Child Behavior Check List (CBCL)	7.4
Other (Eco-Map, Observation, DECA, Becks Inventory)	9.9
Have these (assessment tools) been sufficient to help make good decisions about how to meet the child's service needs, placement level and type? (Shown in percent of respondents choosing that answer)	
Number of Respondents = 117	
Yes	81.2
No	18.8

Survey respondents were also asked their views regarding what would help in developing good plans for out-of-home placement. Of the thirty-eight who responded to this question, nearly one third mentioned that training in the use of various standardized assessment and evaluation tools would significantly assist in assessing the child. Others would like more help from families and the schools. Some respondents specifically mentioned the need for trauma assessments, and several questioned the usefulness of the structured decision making and team decision making models, suggesting at a systemic level the need for further education and training in the purpose and effectiveness of those protocols.

Needs regarding the assessment and placement process have been identified by other work groups and by a number of the focus groups as well:

- Multiple focus groups reported that worker turnover needs to be addressed to improve the continuity of care children and families receive.
- The CWITF and previous study groups identified workers and managers in both CPS and foster care as wanting a better initial interviewing and information gathering process that would improve placement decisions, service referrals, vetting of potential relative placements, etc. This level of thoroughness currently is often not possible because of high caseloads.
- As mentioned previously, workers in Wayne County want greater funding to locate older siblings. They report that siblings are being adopted and placed separately.
- Private agency workers strongly advocate that services get started right away when kids come home from foster care including Medicaid, Bridge card, WIC, etc. They also report a need for faster authorization of services (e.g., parenting classes).
- There is a perception in some counties that relatives who are separated must obtain a legal divorce before they will be able to be licensed. These workers expressed the concern that it is not unusual for relative caregivers to be separated for long periods of time, and that requiring them to incur the financial burden of obtaining a divorce before

- Some DHS supervisors report a concern that family reunification services are not working as well as they would like.
- Both private agency and DHS employees advocate for greater access to services for families. They report that a number of services that are supposed to be available to families are so limited that most families who need them can't access them.
- Mental health provider focus group participants identified a need for comprehensive mental health assessments for every child entering care.

#### **b) Family Engagement Needs**

While family engagement was seen as crucial by focus groups, several needs emerged related to how programs can achieve that goal.

- Team Decision Making (TDM) is effective because it brings all partners involved to the table. However, workers say that coordinating and setting up the meetings is time consuming and that they would like to see more flexibility available in the process. Workers also advocate for more lead time given to parents so they can come to the meetings. It was felt that more TDM facilitators are needed so meetings do not get backed up. (Wayne County DHS Focus Group, Central Michigan Private Agency Focus Group).
- Multiple focus groups advocated for higher quality parenting classes that involve interaction, modeling, and having parents practice what they have learned. Social service professionals expressed a need for an in-home or visit component to parenting classes, especially for infants. Several focus groups asked for specialized-topic and culturally sensitive parenting classes. (See mental health section for more details). (Kent and Wayne DHS, Southeast Michigan Private Agency, Child Advocacy and Assessment, Tribal and Adoptive Parent Focus Groups).
- DHS workers report a need for more father programs. (Wayne County DHS Focus Group). Tribal members echo a concern for more father involvement in families.
- Child welfare workers would like to see sibling visits happen after termination of parental rights (TPR) to increase family engagement.
- DHS workers say the Binsfield legislation is not working; they would like to see the mandatory time frames for adjudicating a TPR to be longer and more flexible. (Wayne County DHS Focus Group). The Binsfield legislation can be found at 1997 Public Acts 163-172. This law in effect shortens the permanency time frames from previous, more flexible, standards.
- DHS workers state a need to shorten or eliminate the waiting lists for the Family Reunification Program and Families First services.
- Wayne County DHS professionals report a need for more mother/baby programs.
- Child welfare professionals say there is a great need for adequate sites for supervised family visits (Wayne County DHS, Central Michigan Private Agency and Substance Abuse Focus Groups). Caseworkers report that DHS's policies on visitation and home visits need more areas of gray and more flexibility.

**c) Reunification Service Needs**

For children in care, where reunification is not imminent or planned, the services most utilized by caseworkers are health related (physical, mental and dental) and education services. As Figure 23 indicates, for families where reunification has occurred and the child is in the home, dental health and education services top the list of services provided, followed by financial assistance and mental health services. All services, especially mental, dental and education services are reported by survey respondents to be utilized at much higher rates when reunification has not occurred.

**Figure 23: Percent of Children on Current Foster Care Caseload Who Are Receiving Services**

Source: Worker Survey, Questions 31.1 and 32.1		
Percent of Caseload Receiving Specified Services		
	Post Reunification Services N = 59	Goal Change or Placement Change Services (no reunification planned) N = 78
In-Home Services	17.1	22.9
Parenting Education	16.9	27.1
Physical Health Services	15.3	38.4
Mental Health Services	24.4	45.5
Dental Health Services	27.9	64.0
Substance Abuse Services	17.1	17.2
Financial Assistance	20.0	28.4
Housing Assistance	18.4	26.2
Transportation Services	19.0	29.1
Employment/Training	18.2	23.3
Education	27.4	51.2
Psychiatric Services	17.7	29.2
Wraparound	16.1	21.6

Despite the usage rates reported above, according to the two figures below, survey respondents experience significant wait times and limited availability when trying to access those services they report as being most needed. This result suggests a need to explore further the reasons for these barriers and to take steps that will increase accessibility and timeliness of needed services. Interestingly, DHS workers reported much more difficulty with wait times than did their private agency counterparts. The reasons for these reported differences are not clear and may warrant further investigation.

**Figure 24: Availability and Length of Wait for Services Related to Goal Change, or Step Down to Lower Level of Care (reunification not likely)**

Source: Worker Survey, Question 31.1					
Indicate whether the listed service is sufficiently available and the length of wait for each service.					
	Service Availability (percent of respondents)			Length of Wait for Services	
	Sufficiently available	Available, but not in sufficient amount	Not available	Typical length of wait (in weeks)	Percent of respondents indicating more than 12 weeks
Number of Respondents = 78					
In-Home Services	54.4	44.1	1.5	2-3	1.6
Parenting Education	52.9	45.6	1.5	3-4	4.8
Physical Health Services	69.6	25.0	5.4	2-3	2.3
Mental Health Services	48.5	48.5	3.0	3-4	3.4
Dental Health Services	44.8	50.0	5.2	4-5	7.7
Substance Abuse Services	58.2	38.8	3.0	2-3	1.8
Financial Assistance	43.1	50.0	6.9	4-5	8.3
Housing Assistance	23.3	61.7	15.0	7-8	34.8
Transportation Services	36.8	50.9	12.3	2-3	11.4
Employment/Training	43.9	43.9	12.3	3-4	9.3
Education	66.0	34.0	0.0	2-3	2.3
Psychiatric Services	32.3	59.7	8.1	5-6	14.3
Wraparound	50.0	30.4	19.6	3-4	9.3

**Figure 25: Availability and Length of Wait for Post-Reunification Services (child is at home)**

Source: Worker Survey, Question 32.1					
Indicate whether the listed service is sufficiently available and the length of wait for each service.					
	Service Availability (percent of respondents)			Length of Wait for Services	
	Sufficiently available	Available, but not in sufficient amount	Not available	Typical length of wait (in weeks)	Percent of respondents indicating more than 5 weeks
Number of Respondents = 59					
In-Home Services	42.9	51.0	6.1	3-4	12.5
Parenting Education	51.2	43.9	4.9	3-4	17.6
Physical Health Services	64.7	26.5	8.8	2-3	3.7
Mental Health Services	42.1	57.9	0.0	3-4	12.5
Dental Health Services	44.4	47.2	8.3	3	19.4
Substance Abuse Services	61.1	36.1	2.8	3	10.7
Financial Assistance	35.3	61.8	2.9	4-5	21.4
Housing Assistance	27.3	54.5	18.2	4-5	33.3
Transportation Services	31.3	50.0	18.8	3-4	21.7
Employment/Training	38.7	51.6	9.7	3	24.0
Education	58.6	37.9	3.4	3-4	12.0
Psychiatric Services	19.4	74.2	6.5	4-5	29.6
Wraparound	29.0	54.8	16.1	3-4	12.0

When reunification services are not available, a barrier to court approval of discharge from foster care may exist. More than 28% of responding workers report that the court will not allow

reunification without a Family Reunification Program plan in place. If this response is typical of experiences across the state, this means that over one-fourth of caseloads will not be allowed to reunify until appropriate services are provided.

**Figure 26: Reunification Without FRP in Place**

Source: Worker Survey, Question 32.4	
Will the court allow reunification without a Family Reunification Program in place?	
Number of Respondents = 60	Total
Yes	43
No	17

The focus groups and other workgroups identified several needs and concerns related to reunification services.

- Previous groups investigating child welfare needs in Michigan identified the following needs in the area of reunification services:
  - Birth parents’ most common barriers to successfully working toward reunification are:
    - Transportation.
    - Daycare to attend services and employment.
    - Employment.
    - Clear direction from workers and consistent messages from all involved (worker, service provider, court) about expectations, chronology of events, and positive and negative outcomes.
  - When services slots aren’t available, or when the money for services is spent, there are no other options for families. Therefore, workers and courts view out of home placement as a “safer” alternative to returning or keeping kids at home.
- The birth parent focus group members identified a need for home-based therapy, parent support groups, parent safety training for children with serious behavior problems and parent education on appropriate approaches to discipline such as the Love and Logic program.
- The mental health provider focus group participants suggested a need for better preparation of parents and children for reunification. This needs to be a gradual process, with parents actively involved with their children throughout the placement period to maintain attachment. Reunification readiness needs to be assessed through a qualitative process, not just by checking whether parents have met the minimal participatory requirements of treatment.

**d) Foster Parent Needs**

Through surveys, focus groups and work groups, a number of concerns emerged about capacity of current foster homes to meet today’s needs for the children placed out of home. When a range of professionals who work with foster parents were asked to rank the capacity on several dimensions, survey responses were clustered at the low end of the measurement scale, as reported below.

**Figure 27: Capacity of Foster Parents to Meet Needs (POS Monitors)**

Source: Worker's Survey, Question 50.2							
Please rank the capacity of current foster parents to meet the following needs.							
1 = Not at all capable	Percent of Respondents Providing Rating						6 = very capable
	1	2	3	4	5	6	
Number of Respondents = 31							Rating Average
Children in large sibling groups	16.1	35.5	25.8	16.1	6.5	0	2.61
Children with serious medical needs	20.0	43.3	26.7	10.0	0	0	2.27
Children with behavior problems	3.2	45.2	25.8	25.8	0	0	2.74
Children with mental illness	20.0	46.7	23.3	10.0	0	0	2.23
Children with developmental disabilities	23.3	33.3	20.0	20.0	3.3	0	2.47
Teenage children	10.3	24.1	31.0	20.7	13.8	0	3.03

Comparison of these responses to those elsewhere in this report indicating the substantial number of children and youth who have serious mental and behavioral health problems points to an important unmet need.

Comparisons of foster home capacity with the number of older youth in care signals another critical need area. As the two figures below illustrates, over 73% of managers and over 40% of workers think that the current foster home array is not sufficient to meet the needs of children.

**Figure 28: Manager Perception of Current Foster Home Ability to Meet Children's Needs**

Source: Manager Survey, Question 16.0	
Foster Care: How well does the current array of foster homes meet the needs of the children placed in foster care?	
Number of Respondents: 53	Percent of Respondents
1 - Not well at all	9.4
2 - Not too well	64.2
3 - Satisfactorily	3.8
4 - Moderately well	20.8
5 - Extremely well	1.9
Mean Rating = 2.42	

**Figure 29: Worker Perception of Current Foster Home Ability to Meet Children's Needs**

Source: Worker Survey, Question 30.1	
How well does the current array of foster homes meet the needs of the children placed in foster care?	
Number of Respondents = 115	Percent of Respondents
1 - Not well at all	11.3
2 - Not too well	30.4
3 - Satisfactorily	27.8
4 - Moderately well	27
5 - Extremely well	2.81

The next three figures illustrate manager and worker perceptions regarding the availability of foster homes for harder to place children. The fact that workers have limited options for placing

children with these characteristic means that more children will end up in foster homes that are ill equipped to meet their unique needs and circumstances. The lack of families in the child’s school district and neighborhood suggests that community based recruitment efforts would be warranted in geographic areas with higher concentrations of cases. Foster parents with the skills to care for older youth who can deal effectively with significant emotional and behavioral issues is critical to meeting the goals of providing nurturing, home-based care for all children. Foster parents able and willing to provide hands on education and mentoring to birth parents would not only facilitate more timely reunification goals, but would also relieve some of the burden currently on caseworkers to provide supervised parenting time.

The fact that the same question elicited similar responses with regard to relative caregivers speaks to the need to provide more education and support to all substitute care providers if they are to be the most effective, high quality care resources for children and families.

**Figure 30: Percentage of Foster Homes Able to Meet Special Placement Needs (Managers)**

Source: Manager Survey, Question 17.0				
What percentage of FOSTER homes has the following characteristics? (Results shown in percent of respondents in each category)				
Number of Respondents = 53	0-25%	26-50%	51-75%	76-100%
Will take large sibling groups (4 or more children)	88.7	7.5	3.8	0.0
Live close to the child's school and neighborhood	52.8	32.1	9.4	5.7
Can manage a child with significant emotional/behavioral issues	54.7	26.4	18.9	0.0
Have medical/health management skills	53.8	36.5	7.7	1.9
Excel at fostering older youth	64.2	11.3	18.9	5.7
Will provide mentoring and support to birth parents	54.7	32.1	13.2	0.0

**Figure 31: Percentage of Foster Homes Able to Meet Special Placement Needs (Workers)**

Source: Worker Survey, Question 30.2				
What percentage of FOSTER homes has the following characteristics? (Results shown in percent of respondents in each category)				
Number of Respondents = 111	0-25%	26-50%	51-75%	76-100%
Will take large sibling groups (4 or more children)	82.0	16.2	0.9	0.9
Live close to the child's school and neighborhood	46.4	33.6	14.5	5.5
Have medical/health management skills	47.7	22.0	19.3	11.0
Excel at fostering older youth	63.6	19.1	15.5	1.8
Will provide mentoring and support to birth parents	65.7	25.0	9.3	0
Can manage a child with significant emotional/behavioral issues	60.2	25.9	13.0	0.9

**Figure 32: Percentage of Relative Homes Able to Meet Special Placement Needs**

Source: Worker Survey, Question 30.3				
What percentage of RELATIVE homes has the following characteristics? (Results shown in percent of respondents in each category)				
	0-25%	26-50%	51-75%	76-100%
Number of Respondents = 84				
Will take large sibling groups (4 or more children)	53.3	28.6	16.2	1.9
Live close to the child's school and neighborhood	37.7	32.1	21.7	8.5
Have medical/health management skills	56.6	29.2	9.4	4.7
Excel at fostering older youth	57.1	30.5	10.5	1.9
Will provide mentoring and support to birth parents	33.0	40.6	18.9	7.5
Can manage a child with significant emotional/behavioral issues	62.9	27.6	7.6	1.9

The following two charts demonstrate in very practical terms the need for flexible placement options for children with certain needs. Most significantly, the families most needed are those with the skills to manage children with significant emotional and behavioral issues and those who can serve as mentors to birth parents. If these responses are at all typical of workers across the state, then effective and targeted recruitment of families will need to be a priority if the goals of the settlement agreement to provide adequate levels of care and to achieve permanency are to become a reality.

**Figure 33: Foster Homes Needed to Meet Special Placement Needs**

Source: Worker Survey, Question 30.5		
How many FOSTER homes do you need with the following skills to adequately care for the children in your current caseload?		
	Total number of families needed by all respondents	Average number of families needed per worker
Number of Respondents = 106		
Will take large sibling groups (4 or more children)	249	2.37
Can manage a child with significant emotional/behavioral issues	470	4.52
Can manage a child with significant physical disabilities or medical problems	220	2.1
Can mentor birth parents	507	4.92
Can take teenagers	476	4.67

**Figure 34: Relative Homes Needed to Meet Special Placement Needs**

Source: Worker Survey, Question 30.4		
How many RELATIVE homes do you need with the following skills to adequately care for the children in your current caseload?		
	Total number of families needed by all respondents	Average number of families needed per worker
Number of Respondents = 106		
Will take large sibling groups (4 or more children)	190	1.98
Can manage a child with significant emotional/behavioral issues	402	4.02
Can manage a child with significant physical disabilities or medical problems	193	2.01
Can mentor birth parents	424	4.28
Can take teenagers	311	3.27

- In addition to expressing concerns about the ability of foster parents to meet the needs of children in care, a number of focus group participants expressed equal concern about their own ability to support foster parents as they seek to serve the children in their care.
- Caseworkers report a need to expedite the services for and payments to foster care families. They say there is often a delay in services to foster care families. Caseworkers advocate for a more streamlined process to submit and receive the necessary paperwork to get services/payments going.
- Private agency workers report a need to increase funding to foster care parents and the allowances for children. Caseworkers see foster care families not being able to afford necessities, children's clothing, and fees for school activities and sports on the allowance given. (Central Michigan Private Agency Focus Group).
- Caseworkers say that the Determination of Care (D.O.C.) process needs improvements to more efficiently serve families. Workers would like to see a process that is user-friendly, has streamlined paperwork and is able to produce timely, consistent payments for all foster care providers (especially foster care providers of children with special needs). Workers report that they have to do a new D.O.C. every time a child moves. They believe that this causes delays in services and payments to families. (Central Michigan Private Agency Focus Group).
- Caseworkers say there needs to be more in-home support for foster care families. Foster care caseworkers are only in the home once a month. There needs to be something in between residential and outpatient services to provide support – something similar to biological in-home services like Families First. (Central Michigan Private Agency Focus Group).
- Private agencies report a need for their clients to have the same access to programs/services as DHS clients. (Central Michigan Private Agency Focus Group).
- DHS and Tribal focus group members say that recruiting native foster families needs to be a higher priority in the state.
- Mental health service providers indicated a belief that foster parents need to be part of the therapeutic team for children receiving mental health treatment, including participation in treatment sessions and process.
- Mental health provider focus group participants reported that, often, foster parents are not prepared for the seriousness of the behavior problems of children placed with them. They

need more and better training about what to expect and how to address these difficult child behaviors.

- Tribal social service professionals stated that relatives who are providing foster care need:
  - Respite.
  - Packets of material on resources for relatives to assist with children's needs.
  - Tribal foster care workers and programs.
  - Case workers providing frequent contact and assistance.
  - Periodic care coordination meetings between providers.
  - Mental/ emotional assistance.
  - Non-intrusive visitation procedures allowing safe and healthy contact between the children and parents; regular contact between the children and extended family and cultural programs.
  - Centralized services and information to eliminate relatives having to seek out services from several different agencies (saving time and much needed energy).
- Easy to understand documentation for children to receive services (i.e., permission to seek medical attention, court orders, etc.).
- The CWITF and other similar workgroups identified the following needs in the area of foster parent supports:
  - Concerns identified from 3/08-8/08 DHS Closed Foster Home Survey
  - 42% reported needing additional assistance with accessing the health care system.
  - 34% wanted more information regarding available services.
  - 20% stated problems with the agency caused them to stop fostering.
  - Child behavior problems were the most identified challenge to foster parenting.
  - Lack of support and partnership from child welfare agency.
  - Foster parents need/want specialized training available on topics such as sexual abuse, behavior issues, adolescents, developmental needs, etc.
  - There are no standard methods for communicating frequently with foster parents other than mass mailing.
  - There are very few foster parent support groups; there are few to no foster child support groups.
  - Workers need foster families who are able to care for children with special needs (i.e. cognitive impairments, seriously emotionally disturbed, teens/older kids, large sibling groups).
  - Some relative foster parents possess characteristics of the child's birth parent(s) (i.e. poverty, illiteracy or lack of education, chronic medical conditions, learning disabilities, etc.); supports should be in place to ensure the placement has a greater opportunity for long-term success.
  - The licensing process slows down access to potential immediate placements.
  - Recruitment and retention efforts and targets don't match the population needs.
  - Retention efforts don't address the concerns expressed by foster parents.
  - No statewide effort to manage or expand ongoing foster parent training.
  - No statewide effort to develop pools of foster parents with specialized care skills.

### **e) Material: Housing, Financial & Transportation Needs**

Focus and work groups reported several material needs, including housing, financial and transportation, that if met, could help facilitate more parents keeping and/or regaining their children.

- Multiple sources and reports note that clients have limited transportation access. A number of concrete needs were identified:
  - Even urban areas do not provide sufficient public transportation to meet the needs of residents in those communities.
  - An insufficient number of state cars for workers and limited travel allocations for counties lead to challenges and difficulties getting reimbursed for mileage when using personal vehicles for state business.
- Lack of housing assistance: This is a common barrier to reunification and kids have to stay in care longer as a result:
  - There is a real need for housing because parents are “put in an impossible situation.” On the one hand they have their children taken away because they have no housing and must have housing to get them back – on the other hand, by taking the children away they lose money which then prevents them from being able to get the housing they need to get the children back. When they don’t have the children with them, they don’t qualify for family housing. (Wayne County DHS, Substance Abuse and Southeast Michigan Private Agency Focus Groups).
  - It is hard to get on a housing list in Detroit. They may have to wait 8-10 years for low income housing; families have to wait longer than single people. (Wayne County DHS Focus Group).
  - Private agency workers advocated for the housing referral process to be easier for their low-income clients. They would like to see more support for the “working poor” who need viable housing options. They cite a difference in accessibility for those with no income verses those with low income.
  - Wayne County DHS workers report a need to support parents whose landlords are neglecting their responsibility to provide safe housing. They advocate holding landlords accountable. Landlords who have responsibility for repairs but don’t make them contribute to delays in kids returning home. Workers say that parents can’t afford to fix the problems, and it results in the child remaining in care.
  - DHS workers advocate for supporting parents in paying their heating bills when it is interfering with their ability to keep their children. (Wayne County DHS Focus Group).

### **f) Management and Planning Needs**

- Focus group members identified numerous management and planning needs that would help them to serve families more effectively.
- Private agency caseworkers would like to see an increase in the amount of DHS money to private agencies, foster care families, foster care children and services to families in order to provide adequate care.
- Tribal social service professionals report that more money is needed for programs, tools and direct financial assistance to effectively serve clients.
- According to private agency caseworkers, the differences in foster care monitors can make foster care caseloads easier or more cumbersome. Caseworkers reported a belief

that many foster care monitors seem to have too many cases to be able to effectively help and support workers. Adoption workers said that adoption monitors could likewise also be helpful or make the process more cumbersome depending on the monitor. Both sets of workers advocated for manageable requirements from the monitor and more individualized support. (Central Michigan Private Agency Focus Group).

- Central Michigan Private Agency and Wayne County DHS focus group members report that greater numbers of foster parents (and good foster treatment centers) are needed. They would like to see each county have an adequate list.
- Private agency providers stated a belief that the state needs to increase the cap on the number of kids in foster care homes above three. They say that the cap prohibits sibling groups greater than three from being placed together. It also prohibits good foster homes that have the capacity for more than three children from being able to serve. (Central Michigan Private Agency Focus Group).
- Central Michigan Private Agency focus group members reported a need for available placements for youth in unique crisis situations. They see a gap between stable birth family placement and entrance into foster care.
- Private agency directors report a need for administrative expectations (from DHS and the courts) of foster care workers to be more manageable.
  - They would like to see the paperwork required of caseworkers streamlined and lessened to enable efficient work. Directors say that they would like to see the system simplified and less regulated. (Central Michigan Private Agency Focus Group).
  - Workers would like to see DHS and the courts on the same page and have the unified expectations of case workers in order to help them be more efficient at serving families. (Central Michigan Private Agency Focus Group).
- DHS supervisors would like to see the job of managers less clerically-intensive with less redundancy in paperwork and data input in order to provide more efficient use of their time. (Kent and Wayne DHS Focus Groups)
- Private agency directors report a need for more feasible training options for their caseworkers. Currently, caseworkers are required to be trained at the same time that they are responsible for maintaining their caseloads. Directors report that this overwhelms the workers and private agencies. (Central Michigan Private Agency Focus Group).
- DHS supervisors report a belief that Purchase of Service (POS) agencies need more clarity regarding their roles and responsibilities. Supervisors cite a need for more accountability and less worker turnover at POS agencies. (Wayne County DHS Focus Group).

#### **g) Relative Licensing**

According to survey results, the birth parent, child or other relatives are sources 68% of the time for information regarding relatives who could be potential placements. Workers also frequently researched online internet people search, conducted a lien search, or consulted the central registry to locate relatives. Too little time and too few staff was a common reason cited as the primary impediment to finding relatives. Increased time for and increased reliance on other sources listed would assist in identification of potential relative placements. Tables illustrating these points are in Appendix 6.

Focus group participants identified a number of concerns and resource needs related to licensing relatives:

- DHS workers expressed concerns that many relatives who could be viable caregivers won't qualify for licensing because of the number of restrictions inherent in the licensing process. They advocate for more flexibility in utilizing relative caregivers. (Wayne and Kent County DHS Focus Groups).
- Wayne County DHS and Tribal focus group members reported a belief that some Native Americans and certain ethnic groups may not want to go through the licensing process because they do not trust the government coming out to their home, surveying it and asking questions.
- DHS workers would like to see the home study process for relative licensing made more inviting to prospective relatives. A home study takes 6 hours to complete and relatives are asked to answer detailed questions about their past that they may be uncomfortable answering about divorces and criminal records (A minor misdemeanor can disqualify someone.). Workers would also like to see the space requirements made more flexible to account for different cultural and family traditions. (Wayne and Kent County DHS Focus Groups).
- DHS workers see a need for relatives providing care to receive money right away for basic things – clothes, laundry, etc. Workers report that it is too hard to access emergency funds for these purposes. DHS focus group members advocated for paying relatives without the licensing. (Wayne and Kent DHS Focus Groups).
- DHS Workers say that relatives now must agree to get licensed when they take the child, but may not understand the requirement, and many probably have no intention of getting licensed. If the child has been with the relative a long time, they may have to be removed if they don't get licensed. Workers expressed concern that this is not optimal for the child. (Wayne County DHS Focus Group).
- The numbers of kids licensed to a relative is limited, and workers state a belief that this needs to be more flexible. (Wayne County DHS Focus Group).
- DHS workers state that support and training needs to be made available to relative caregivers. (Wayne and Kent County DHS Focus Groups).

#### **h) Courts and Legal Process**

- Courts need more ongoing education about DHS programs and policies as well as an opportunity to interact with DHS more frequently on case process and collaboration.
- There needs to be a better method to use worker time more efficiently in court. Workers spend too much time waiting for cases.
- Michigan Courts need to enhance the ability of children to have a “voice” in court proceedings that directly affect their lives.
- The following findings and needs regarding the LGAL system in Michigan are based upon a survey of LGALs conducted by the Court Improvement Program (CIP) Subcommittee on Effective Legal Representation of Parties in Michigan's Child Welfare Cases. The information below reflects earlier findings of the CIP as well as conclusions reached by the American Bar Association following an evaluation of practice in Michigan in 2002.

- LGAL compensation policies vary widely throughout the state, both regarding pay rates and services for which the LGAL may be compensated. Activities for which LGALs are reimbursed are most often limited to court hearings only, with only a few respondents indicating that they are paid for meeting with children outside of court and are reimbursed for mileage. A number of respondents indicated that they are paid a flat rate on a monthly basis.
- There is currently no mechanism for ensuring that LGALs receive training specifically geared toward the effective representation of children.
- Given the variety of responses to the survey regarding training practices, there does not appear to be a systematic approach to the training of LGALs on a statewide basis.
- High caseloads represent a tremendous barrier to effective practice as an LGAL.
- Court personnel do not always understand the complexities of the LGALs' obligations to their clients or the statutory obligations of the LGAL.

### ***D. Key Findings and Needs Relating to Supporting Placements and Expediting Permanency***

**Finding: Services are needed in Michigan that are effective in supporting children in placement and their caregivers, and that promote timely reunification and permanency.**

Intensive, customized approaches that involve family members in identifying strengths and needs as well as planning for appropriate services are important throughout the life of the case. Where reunification is the goal, timely identification and delivery of services and supports to the entire family is critical. At the same time, there is an important need to focus on the child's health, development and well-being.

Given the vulnerability of foster children as a group, care in addressing their needs effectively is essential in order to minimize the negative impact of foster care. Therefore, interventions designed to promote placement stability and reunification need to include the following characteristics:

- *Family engagement.*
- *Assessment and case planning.*
- *Evidence-based, comprehensive services.* Those proven to be most effective include:
  - *Concrete and practical services.* (assistance with transportation, housing and utilities, for example).
  - *Substance abuse treatment.*
  - *Mental health treatment.*
  - *Home based services.*

Examples of programs or approaches, some of which are in use in Michigan, that meet the above criteria and achieve significant impact with regard to reunification, placement stability, and recurrence of maltreatment include:

- Concurrent Planning – currently being implemented in Michigan.

- Family Reunification Program – in use in Michigan.
- Wraparound or Systems of Care Services – in use in Michigan.
- Kinship Care and Subsidized Guardianship
- Project KEEP

**Finding: Services in Michigan that are effective in increasing placement stability, promoting reunification, and supporting caregivers, are not sufficiently available to meet the needs of children, families and caregivers across the state.**

There is a need to identify effective programs, especially those developed locally, and expand them to other appropriate venues. Specific categories of need are summarized as follows:

### ***Concurrent Planning***

Concurrent planning practices need to include:

- Clear communication from managers about the need to pursue competing goals simultaneously.
- Adequate financial and staff resources to assist workers in assessing the family and providing early and intensive services to parents.
- Involvement of birth parents in the process from the beginning.
- Coaching families to improve or eliminate the conditions that resulted in the removal of their child.
- Adequate preparation for the child (regardless of age) to transition from reunification to termination should it be needed.

### ***Placement Stability***

In order to reduce placement disruptions and increase the opportunity for permanency, Michigan will need to:

- Develop targeted strategies for recruiting and training resource families with the skills and experience to handle the needs of all the children in care, including those with special needs such as those with behavioral or mental health issues.
- Coordinate educational services with other service systems.
- Develop effective mentoring and other volunteer-based programs that can provide an ongoing connection with a caring adult regardless of where the placement is.
- Expand the use of home based services.
- Improve cooperation and integration of services between service providers, particularly those providing home based services, mental health and substance abuse services, educational services, and residential and group home care.
- Provide support to foster parents, such as support groups, foster parent to foster parent mentoring, or other supportive services, especially in the early days of fostering.

### ***Assessment, Placement Decisions and Ongoing Case Planning***

- Targeted assessment tools to identify specific health, education, trauma or substance abuse issues need to be available and accessible to all workers.
- Workers need education and training on the existence and proper use of specialized assessment tools.

- Substantial variations exist among counties in terms of the proportion of child population placed in foster care and the length of time in care. Qualitative review of selected cases is needed to determine whether reductions in the degree of variation is warranted and, if so, the package of services needed to achieve the reduction.
- Children of color are over-represented in foster care as compared to their proportion of the total child population. These children have been in care, on average, longer than the rest of the foster care population. Culturally sensitive and appropriate services need to be directed to reduction of this disparity.

### ***Family Engagement***

- Team Decision Making (TDM) protocols, to be timely and effective, need a larger pool of persons trained to carry out the facilitation role.
- Programs that provide parenting classes should be reviewed for effectiveness and whether they follow an evidence-based practice model.
- There is a need for more father and mother/baby programs.
- There is a need for appropriate sites for supervised family visits.

### ***Reunification Services***

- There is a need to address access to programs and services and reduce wait times for services, particularly in the areas of health (especially dental), education, housing, financial assistance, transportation and mental health services.
- Birth parents need clear and consistent communication from all involved (worker, service provider, court) about expectations, chronology of events, and positive and negative outcomes.
- To promote timely reunification, parents need to be actively involved with their children throughout the placement period.
- Birth parents need assistance in obtaining concrete services such as transportation, housing, workforce, child care, and respite care in order to prepare for reunification and provide stability after reunification.
- Workers need additional tools and guidance on working with relative care providers to overcome barriers to licensing.

### ***Material Assistance: Housing, Financial & Transportation Needs***

- Transportation barriers which negatively impact parents' abilities to participate in service plans, parenting time, and overall involvement in the case need to be addressed as a high priority.
- Barriers that negatively impact housing options and prevent reunification need to be addressed as a high priority.

**Finding: Without reliance on use of unlicensed relative homes, the current capacity of licensed foster homes not sufficient in most counties for the size or level of need of the foster care population.**

***Array of Foster Homes***

- Resources need to be assigned to increase the number and capacity of licensed homes including licensed relative homes.
- Many counties need to increase the number of foster homes where all children in sibling groups can be placed together.
- An increase is needed in the number of licensed foster homes with the capability of serving children with mental and behavioral health issues and older children. Additional foster parents are needed who have the capability of mentoring birth parents.

***Foster Parent Support***

- Foster and kinship caregivers need access to in-home and other support services such as support groups, more frequent communication with caseworkers, improved timeliness of paperwork, and expedited payments to care providers.
- Foster parents need to be part of the therapeutic team for children receiving mental health treatment, including participation in treatment sessions when appropriate.
- An increase is needed in the number of foster parents who can provide culturally competent care particularly for children of color. This competence includes the ability to comply with the intent of ICWA for Native American children.

## IV. Maintaining Permanency and Stability

### A. Current Caseloads and Outcomes in Michigan

Over the past five years, the number of adoptions completed through the DHS adoption program has ranged from a high of 2,883 in 2005 to a low 2,585 (estimated) in 2008. Throughout most of the past 15 years, the number of terminations of parental rights has exceeded the number of adoptions and other exits of permanent wards from foster care. As a result, the total number of permanent court wards grew from 3,474 in 1995 to a high of 6,347 in 2003. The number of permanent court wards at the end of Fiscal Year 2007 was 6,172. Figure 35 shows the number of adoptions per year since 2004.

**Figure 35: Adoption Caseload Trends**

	2004	2005	2006	2007	2008
DHS	1,281	1,416	1,229	1,244	1,179
Private Agency	1,463	1,467	1,360	1,358	1,406
Total Adoptions	2,744	2,883	2,589	2,602	2,585

Based on administrative program data DHS provided to CWRC, the statewide average length of time in care for children currently in care with parental rights terminated is 4.38 years. The average times in care at the county level range from 2.64 to 18.34 years.

**Length of Time in Care for Children with Parental Rights Terminated.** Differences exist between African American children and other children who are permanent court wards with respect to the length of their current placement with respect to their representation within this population as compared to the general child population in Michigan.

**Figure 36: TPR Children: Length in Care by Race**

Race Code Variable		Number of Years in Care Categorized (including divisions of the first three years)									Total
		0 to 0.99 years in care	1.00 to 1.99 years in care	2.00 to 2.99 years in care	3.00 to 5.99 years in care	6.00 to 8.99 years in care	9.00 to 11.99 years in care	12.00 to 14.99 years in care	15.00 to 17.99 years in care	18.00 to 100.00 years in care	
African American	# Children	26	356	627	1,143	560	314	143	31	10	3,210
	Percent	0.8%	11.9%	31.4%	67.0%	84.4%	94.2%	98.7%	99.7%	100.0%	100.0%
American Indian/Alaskan Native	# Children	2	8	21	22	5	1	0	0	0	59
	Percent	3.4%	17.0%	52.6%	89.9%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%
Asian	# Children	0	0	4	5	1	0	0	0	0	10
	Percent	0.0%	0.0%	40.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Nat. Hawaiian/Pacific Islander	# Children	0	2	1	8	0	0	0	0	0	11
	Percent	0.0%	18.2%	27.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
White	# Children	49	618	1,004	941	240	63	19	2	0	2,936
	Percent	1.7%	22.7%	56.9%	89.0%	97.2%	99.3%	99.9%	100.0%	100.0%	100.0%
Unable to Determine	# Children	4	2	2	6	2	0	1	0	0	17
	Percent	23.5%	35.3%	47.1%	82.4%	94.2%	94.2%	100.0%	100.0%	100.0%	100.0%
Total	# Children	81	986	1,659	2,125	808	378	163	33	10	6,243
	Percent	1.3%	17.1%	43.7%	77.7%	90.6%	96.7%	99.3%	99.8%	100.0%	100.0%

**Permanent Court Wards About to Exit Foster Care.** Nearly 2,500 children who are permanent court wards have reached the age of 17. The following table displays the number and percent of children by race who are 17 years and older and who are 17.5 years of age and older.

**Figure 37: Permanent Court Wards Whom Transition from Foster Care is Imminent, by Race**

	Children in Foster Care Age 17.5 Years and Older		Children in Foster Care 17 years and older		Total Children in Foster Care
	Total Number	% of Total	Total Number	% of Total	
Total	1,869	10.9	2,429	14.1	17,171
<b>Ethnic Description</b>					
African American	1,097	15.0	1,399	19.2	7,300
American Indian/Alaskan Native	8	3.2	16	6.5	247
Asian	4	10.5	6	15.8	38
Nat Hawaiian/Pacific Islander	4	22.2	5	27.8	18
Unable to Determine	9	12.7	11	15.5	71
White	743	8.5	986	11.2	8,781
Unable to Determine	13	0.1	17	0.1	12

### ***B. Effective Programs and Approaches***

Not surprisingly, many of the principles identified previously also apply to the adoption and permanency phases of child welfare work. Intensive, customized approaches are just as important when reunification is no longer the goal, and should involve extended family members and foster families in identifying potential permanency resources and continuing service needs. At the same time, ensuring the child’s health, development and well-being while finding the child a permanent family connection must remain a priority.

As described earlier in this report, it is well documented that the longer and less stable a child’s tenure in the foster care system is, the more likely he or she will experience negative long term outcomes, such as higher rates of delinquency and adult criminal behavior, higher incidence of serious mental illness, lower academic achievement and high school or college graduation rates, unemployment, and higher rates of institutionalization, homelessness and use of public welfare resources. (Bruskas, 2008, Doyle 2007). In order to increase children’s chances of growing into successful, productive adults, care must be taken to help youth establish a permanent family connection and to prepare them for the time when they will be living independently. The older a youth is, the more important both of these goals become.

Adopted children are more likely to be younger than those who are placed with legal guardians or who are waiting for permanent homes, and fewer adopted children are members of an ethnic minority. Thus, the older a child is, the more likely that child will languish in the child welfare system waiting for a home, and the longer the child waits, the more likely that child will eventually age out of the system before a home is found. This can then lead to many of the negative outcomes described above (Testa 2004).

## 1. Trends in Permanency Best Practices

### a) Kinship Care and Guardianship

According to national statistics and reports, in recent years, relatives have become the fastest-growing source of new homes for foster children (Testa 2004). At the same time, this fact may be contributing to the growing backlog of children in long-term foster care because of the resistance of many relatives to adopt their own family members. Solutions to this problem have included subsidized guardianship programs, briefly described earlier in this report. The advantages to this alternative form of permanency include:

- The caregiver is personally responsible for the welfare of the child.
- Guardianship allows for the continued involvement of the birth family and may lessen feelings of loss and separation trauma, an important consideration for many older children.
- May be more cost effective than foster care.

Studies have shown that the success of kinship and guardianship placements are impacted by the level of post-placement services and supports as well as the level of available financial support. (Terling-Watt, T 2001). If kinship care and guardianship are to be viable options for the older, harder-to-adopt child, it is necessary to provide appropriate levels of support and compensation to the caregiver.

### b) Post Permanency Services

As mentioned above, services are an important support for children who exit the child welfare system, whether through reunification or through adoption or other permanency alternatives. While most adoptive families or guardians never experience an emergency or crisis requiring intervention, those that do typically have exhausted their informal networks of family, physicians, religious leaders, etc. before contacting their adoption provider. Services most commonly requested include:

- Respite care.
- Support groups.
- Educational support.
- Counseling.
- Assistance in finding and accessing residential care.

Studies have also shown that the need for services progressively increases over the age and development of the child, especially those adopted through the child welfare system. Many former foster children, even if adopted as infants, have special health, learning or behavior issues that do not become apparent until years later. Many of these children carry multiple risk factors with them, and research has shown that the number of special needs is the most significant predictor of child outcomes and family adjustment to adoption (Wind, et al. 2007). When these clinical issues arise, families need services that are sensitive to the specialized issues relevant to the child's trauma and placement history.

## 2. Survey and Focus Group Perceptions About Effective Programs

The survey asked permanency workers to name those programs they felt were most effective in helping children in their caseloads prepare to transition to adulthood. Responses are reported below, and indicate that over half of the survey respondents answering this question felt that youth transition services were effective when utilized, but, as discussed later in this report, they also identified those same services as not being sufficiently available to the children in their care.

**Figure 38: Most Effective Permanency Services**

Source: Worker Survey, Question 52.2	
Which services have you found most effective? (check all that apply)	
Number of Respondents = 38	Percent of Respondents
Independent Living Skills Classes	52.6
Educational Planning	76.3
Housing Assistance	50.0
Transportation	50.0
Employment Services	55.3
Other	21.1

While the focus groups in general felt that services to transitioning youth were one of the areas of greatest need, they also felt that the Youth in Transition and life skills services that were available were very good. (Wayne and Kent County DHS, Southeast and Central Michigan Private Agencies). The Southeast Michigan private agencies noted there was improved timeliness in achieving adoptions due to the “Rocket Docket,” referring to the Wayne County courts issuing orders for services with strict timelines attached, a practice designed to speed up the process of achieving adoptions where reunification is not a possibility. The Wayne County DHS focus group identified their housing program for teens as an effective program. The Central Michigan private providers group identified the Ingham County Independent Living Program and Michigan Works as being effective, and also pointed to the education tuition incentive and the Michigan Adoption Resource Exchange (MARE) as being important resources. Kent County DHS identified the Reconnect program as being an important resource for case mining and finding relatives and other important potential connections for their older youth.

### ***C. Michigan’s Service Gaps and Unmet Needs***

#### **1. Barriers to Achieving Timely Permanency and Adoption**

A key provision in the Michigan settlement agreement is the mandate to reduce the large backlog of children who have not achieved either reunification or permanent placement according to federally-imposed timelines. Achieving timely permanency for children is a challenge nationwide as well.

The Child and Family Service Reviews have included performance metrics based on the amount of time it takes for children to be adopted. The Child Welfare League of America National

Working Group to Improve Child Welfare Data conducted a national survey designed to identify important trends and data related to adoption outcomes (Friedman 2007). Commonly reported barriers to achieving timely adoption following a termination of parental rights (TPR) were identified in the study as:

- *Court issues* – overburdened court dockets, frequent continuances and rescheduled hearings; laws relating to court timeframes for reviews, termination hearings or appeals can cause delays in decisions critical to the adoption process.
- *Time allowed for reunification efforts* – longer periods of reunification efforts can delay the child’s entry into the adoption process. Concurrent planning, which is being implemented in Michigan, can aid in shortening the time frame once reunification is no longer the goal, but carries with it the responsibility of supporting more and earlier intensive services for parents who will be held to shorter reunification timeframes.
- *Time between involuntary TPR and adoption* – most states have a prescribed period following a TPR during which an appeal can be filed. Once a case is on appeal, no adoption can occur until the final ruling on the TPR.
- *Time between voluntary TPR and adoption* – generally there are fewer time barriers in a voluntary relinquishment case, but many states allow time for filing an appeal, which will necessarily delay an adoption.
- *Requirements for foster parents to adopt* – According to the Friedman study, up to 60% of foster children are adopted by their foster parents, and most states impose additional requirements before the adoption can be finalized. These requirements range from home studies, to criminal background checks, to additional training or other evaluative processes. Some states are adopting the practice of “dual licensure” that provides for the same approval procedures for both foster and adoptive parents, thus streamlining the process of approving adoptive parents who provided foster care.

## **2. Focus Group and Survey Perceptions of Needs**

### **a) Post Permanency Service Needs**

As occurred for workers involved in earlier stages of a case, adoption and permanency workers were asked to respond to questions about availability of services and wait times. Health related services (mental health, psychiatric, dental and physical health, and substance abuse services) were consistently identified as not sufficiently available, or unavailable altogether. These services also require long wait times, often more than 12 weeks. Other services, such as employment, transportation, and programs such as wraparound and Families First, also have limited availability and long wait lists.

**Figure 39: Availability and Wait Times for Permanency and Adoption Services**

Source: Worker Survey, Question 43.1					
Indicate whether the listed service is sufficiently available and the length of wait for each service. (Results shown in percent of respondents in each category)					
	Service Availability (percent of respondents)			Length of Wait for Services	
	Sufficiently available	Available, but not in sufficient amount	Not available	Typical length of wait (in weeks)	Percent of respondents indicating more than 12 weeks
Number of Respondents = 24					
Wraparound	33.3	44.4	22.2	2-3	9.1
Families First	27.8	61.1	11.1	3-4	7.7
Family Group Decision Making	70.0	30.0	0.0	2-3	0.0
Home Visiting	50.0	38.9	11.1	4-5	6.3
Parent Education	46.7	33.3	20.0	4-5	23.1
Anger Management	53.3	46.7	0.0	4-5	7.1
Counseling	64.3	35.7	0.0	1-2	0.0
Physical Health	43.8	43.8	12.5	5-6	15.4
Dental Health	21.4	71.4	7.1	5-6	16.7
Psychiatric	35.7	21.4	42.9	3-4	12.5
Mental Health	28.6	42.9	28.6	3-4	18.2
Substance Abuse Treatment	21.4	57.1	21.4	4-5	9.1
Financial Assistance	73.3	26.7	0.0	1-2	0.0
Transportation	33.3	44.4	22.2	2-3	9.1
Employment/Training	27.8	61.1	11.1	3-4	7.7
Education Services	70.0	30.0	0.0	2-3	0.0

**b) Youth Transition Service Needs**

The focus groups, as well as CWITF, identified several service needs and gaps for youth in transition:

- The CWITF reported a shortage of affordable, suitable housing for transitioning youth: agencies and youth both reported to the task force a lack of agency capacity, given the reported need. Homeless youth and those in the juvenile justice system lack access to housing support resources that are available to those in the foster care system. This was confirmed by focus groups involving youth, Wayne County DHS and private agencies, Central Michigan private agencies, and Kent County DHS.
- Michigan Youth Opportunity Initiative (MYOI) and Youth in Transition funding (YIT) and resource issues need to be addressed to ensure reliable and sustainable transition services for youth exiting foster care. YIT was one of the programs focus group members highly rated and thought was working well. (Tribal, Kent and Wayne County DHS and Southeast Michigan Private Agency Focus Groups).
- Multiple focus groups mentioned that independent living (IL) services can work but that there need to be more to meet the current needs of youth. Group members stated that they believed that funding was the reason for the shortage of IL services. (Kent County DHS, Southeast and Central Michigan Private Agency Focus Groups).
- Some private agency representatives feel that IL services need better design and implementation. (Central Michigan Private Agency Focus Group).

- Private agency workers report a need for available housing and IL for teens that are aging out of the system. (Central Michigan Private Agency Focus Group).
- Private agency workers say that there is a special need for housing and IL services for teen moms. Teens can't get cash or qualify for IL services until they are 18. (Central Michigan Private Agency Focus Group).
- DHS and private agency workers report that youth need mentors and meaningful community connections established before aging out of foster care. Most youth are aging out of care without these in place. Workers say that there needs to be more programs and community buy-in for youth aging out. (Kent County DHS and Central Michigan Private Agency Focus Groups).
- DHS workers report a special need for financial, housing and programmatic support for youth aging out of the juvenile justice system. Youth from juvenile justice who have not been found with neglect are not eligible for YIT funds, jobs corps or Family Unification Program. They are also not eligible for the military. (Kent County DHS Focus Group).
- Private agency workers see a need for community engagement to help aging out foster care youth (e.g., job placements). (Central Michigan Private Agency Focus Group).
- DHS workers see a need for better communication with older youth about the resources available to them. (Wayne County DHS Focus Group).
- DHS needs to train and employ peer educators to help implement provide training and assessments. DHS should review life skills educational and assessment resources and adopt a single system to be used statewide so all counties and private service providers use the same measures for consistency.
- In a focus group and study of 72 former Michigan foster care youth, youth did not have access to comprehensive assessments and consistent medical, dental, mental health and other specialty care. Findings from the study: (Youth Focus Group).
  - 21% of respondents reported unmet physical health care needs.
  - 49% reported unmet dental care needs.
  - 24% reported unmet vision care needs.
  - 32% of respondents were suffering from depression.
  - 14% reported feelings of being suicidal as some point during or after aging out of foster care.
  - Youth reported that health care providers were frequently not willing to accept Medicaid.
  - Youth reported being placed on long wait lists for much needed services.
  - Youth lacked coordinated transition plans and did not have access to further education and training opportunities once their cases were closed. Many youth were not even aware of or informed that their cases were closed.
  - Services were not located in the communities in which youth were placed, resulting in increased use of costly emergency room visits to address non-emergent health care issues.
  - Youth exiting care did not receive services and supports to ensure their safety, stability and well-being.
  - Youth who have aged out received little to no assistance finding housing, arranging for their health and mental health care or establishing themselves in their communities.

- There was a general lack of information sharing, collaboration and communication among youth, child welfare professionals and other systems personnel that served this population.

**c) Adoptive Parent Needs**

The survey sought to identify the extent to which certain characteristics of the child may be influencing the ability to find appropriate permanent placements. Perhaps not surprisingly, over 70% of respondents identified older children and those children with behavior problems as the most difficult to place. Given this overwhelming response, it seems clear that caregiver recruitment efforts need to focus on finding families with the interest and skills to manage this population group.

**Figure 40: Primary Reasons for Lack of Permanent Placements**

Source: Worker Survey, Question 40.1	
With regard to children who do not have identified placements, please choose the MAIN reason these children do not have identified placements.	
Number of Respondents = 46	Percent of Total Respondents
Teenagers	26.2
Behavior problems	45.2
Mental illness	4.8
Medical need	2.4
Development disability	2.4
Other (please specify)	19.0

To assess the ability of the adoptive family pool to meet the special circumstances of harder to place children, workers were asked in the survey whether there are sufficient numbers of adoptive parents to meet the special needs of children in their caseloads. Responses are provided in the figure below, and again overwhelmingly point to a significant need in the area of adoptive parent recruitment.

**Figure 41: Availability of Adoptive Parents with Capacity to Meet Special Needs**

Source: Worker Survey, Question 40.2	
Is there a sufficient array of adoptive parents available to meet the special needs of children on your caseload?	
Number of Respondents =45	Percent of Total Respondents
Yes	33.3
No	66.6

To assess the scope of need for adoptive families with specialized skills, workers were asked to identify the number of families they would need to care for the children in their caseloads who require special parenting skills, either because they were part of a large sibling group, have significant physical disabilities or medical problems, were early adolescent or older, or had significant emotional or behavioral issues. Although the number of respondents for this question was not high, if these responses are typical of adoption workers across the state, there are clear

implications in terms of recruitment needs for adoptive families that have specific skills for harder to place children.

**Figure 42: Number of Families Needed for Current Caseloads**

Source: Worker Survey, Question 41		
If there is not a sufficient number of adoption families to meet special needs, how many families do you need with the following skills to adequately care for the children on your caseload?		
	Total number of families needed by all respondents	Average number of families needed per worker
Number of Respondents = 26		
Will take large sibling groups (4 or more children)	31	1.29
Can manage a child with significant emotional/behavioral issues	171	6.58
Can manage a child with significant physical disabilities	120	5.0
Excels at parenting teenagers or early adolescents	140	5.38

The focus groups and task force groups identified several areas of need that impact the recruitment, retention and support of adoptive families.

- Michigan Adoption Resource Exchange (MARE) conducts an ongoing satisfaction survey of adoption agencies (10/08 to present). This survey has identified the following key barriers to families interested in adoption:
  - Lack of agency response (DHS and private).
  - Lack of communication by worker to update family on status of application, process, license, etc.
  - Inability to get assessments completed in a timely manner.
  - Changing agencies is very difficult for potential families – if they are unhappy with one, they have to go through the entire study process again with a new agency.
  - Some areas of the state have no easily accessible adoption agency for families, which negatively impacts recruitment efforts and services in those areas.
- Focus group respondents report a need for more families of color and families that can care for children with special needs.
- Adoption workers report a need to shorten the amount of time it takes to get adoption subsidies. Currently workers say that adoptions subsidies are taking two-to-four months. Caseworkers would like to see more education and understanding at DHS about the adoption process so it can proceed more efficiently. (Central Michigan Private Agency Focus Group).
- Several focus groups advocated for training and support for adoptive parents. Support services are needed to solidify families and help them stay together. (Adoptive Parent, Tribal and Southeast and Central Michigan Private Agency Focus Groups).
- The Adoptive Parent focus groups strongly recommended making parent support groups and connection with other experienced adoptive parents available to adoptive parents.
- Adoptive parents report a need for affordable respite care. Parents are spending large amounts of time transporting youth to therapies, school activities, enrichment activities

and responding to relational issues and need relief to support their marital relationships. (Adoptive Parent Focus Group).

### ***D. Key Findings and Needs Relating to Maintaining Permanency and Stability***

**Finding: Intensive, customized approaches to establishing permanency are needed when termination of parental rights has occurred. Extended family members and foster families need to be involved in identifying potential permanent connections and continuing service needs that will ensure the child's continuing health, safety and functional development.**

The number of parental rights terminations typically exceeds the number of adoptions and other exits of permanent wards from foster care. The statewide average length of time in care for children with parental rights terminated is 4.38 years. African American children are over-represented in this group and have a longer average length of care than the group as a whole. Long periods of placement and frequent moves increases the likelihood that a child in the foster care system will experience negative long term outcomes. In order to increase children's chances of growing into successful, productive adults, youth need to be able to establish a permanent family connection and prepare for the time when they will be living independently. The older a youth is, the more important both of these goals become. Currently, over 14 percent of the total foster care population is greater than age 17.

#### ***Kinship Care and Guardianship***

- Subsidized guardianship is needed to expand the support of relatives as a source of permanent homes for foster children.
- Post-placement services and supports as well as financial support to relatives willing to serve as permanent connections for foster children need to be established.

**Finding: Post permanency and youth transition services are insufficient to fully meet the needs of Michigan's families and children.**

#### ***Post Permanency Services***

- When clinical issues arise that require intervention, post adoptive families need services appropriate to the specialized issues relevant to the child's trauma and placement history. Specific services needed include:
  - Respite care.
  - Support groups.
  - Educational support.
  - Counseling.
  - Assistance in finding and accessing residential care.
- Accessibility to health related services (mental health, psychiatric, dental and physical health, and substance abuse services) needs to be expanded in order to reduce wait times for children and families.
- Accessibility to employment, transportation, and programs such as wraparound and Families First, needs to be expanded in order to reduce long wait times.

### ***Services to Aid Transition to Independence***

- Accessibility and availability of services to transitioning youth needs to be expanded, and needs to include:
  - Assistance in finding and accessing affordable housing.
  - Arranging for physical and mental health care.
  - Independent living skills.
  - Intensive supports to adolescents in foster care around education to reduce the drop-out rate and increase college participation.
  - Education tuition assistance.
  - Assistance in finding a mentor or permanent connection for youth aging out of the child welfare system.
  - Providing life skills training and assessment during and after high school including both “soft” and “hard” employment skills.
- There is a need for more information sharing, collaboration and communication among youth, child welfare professionals and other systems personnel that serve the aging out population.

### ***Adoptive Parent Services and Capacity***

- There is a need for more families of color and families that can care for children with special needs.
- Caregiver recruitment strategies need to focus on finding families with the interest and skills to manage hard to place children.
- Adoption agencies need to be accessible to potential adoptive families across the state.
- Training and support is needed to solidify families and help them stay together.
- Adoptive parents need support groups and connection with other experienced adoptive parents.
- Affordable respite and child-care is needed.

## **V. Service Needs Across the Continuum of Care**

Physical abuse and neglect, together with the resulting instability and uncertainties created when a child is removed from the family home, can have significant adverse impacts, both short and long term, on a child's ability to grow and develop into a productive, successful, stable adult. Much research is occurring to determine the cause and scope of the problems, and potential treatment and systemic solutions (Child Information Gateway 2008). Despite the fact that a child may be physically safer after removal from an abusive or neglectful home, the evidence is clear that children who are separated from their parents will likely experience profound feelings of grief and loss, attachment disorders, and post traumatic stress disorder. When the uncertainties and instabilities often inherent in the foster care system continue over long periods of time, which in a young child's life can be a matter of mere weeks, the child can experience severe depression, difficulty forming attachments to others or developing healthy, trusting relationships with adults and peers. These feelings are often manifested through acting out and other antisocial behaviors and can also have dramatic negative impact on their ability to be successful in school (Berrier 2001).

Studies are clear that children in foster care, especially those who have experienced trauma before coming into the system, and those who have experienced multiple moves after coming into the system, are much more likely to be developmentally delayed in all areas – physical, cognitive, social & emotional (Child Welfare Information Gateway 2008). Regardless of the age at which a child enters care, entry into foster care can interfere with a child's ability to bond normally with the caregivers in his/her life, and this deficit can have negative ripple effects when it comes to resiliency, attachment to new caregivers, and behavioral responses to various “triggering” events. For example, school age children with attachment issues will likely have difficulty with limits, and test them to the extreme. They may have difficulty accepting physical affection from caregivers and will likely find it hard to concentrate in school. Separation and loss issues can undermine a teen's emotional stability and cause more impulsive behaviors, leading them to experience problems academically, socially, and emotionally (Dupree and Stephens 2002).

It is not surprising that the emotional and physical effects children experience when they are removed from the family home can also have dramatic impact on that child's ability to be successful in school, particularly when multiple placements cause multiple disruptions and changes in the child's educational environment. Repeatedly being expected to adjust to new schools, new classrooms, new teachers and to make new friends, while suffering the loss of all that was familiar in the school environment, would be taxing on any child, but is especially stressful for a child experiencing the trauma and multiple complexities of growing up in the foster care system. Research has clearly established that, as a group, children in foster care perform much more poorly than their non-foster care counterparts (Christian 2003).

## ***A. Scope of Need and Barriers to Meeting Needs***

### **1. Mental Health**

Accurate and timely assessments, followed by appropriate, timely services to address the needs identified, are key to understanding and treating the scope of a child's physical and emotional health. Without effective tools to aid in developing the most appropriate treatment plans, children are at severe risk of not receiving the treatment they need, thereby exacerbating the problems which will continue to plague them over their lifetime. These issues are relevant at all stages of a child welfare case, even before placement occurs, and particularly after reunification or adoption.

**The Saginaw Project.** Concerned that children involved with the child welfare system have numerous unmet mental health needs, the leadership of the Saginaw County Community Mental Health Authority (SCCMHA) and the local office of the Department of Human Services in Saginaw County (DHS) in 2008 embarked on a project to determine the extent and types of mental health needs of Saginaw County children in foster care. The project was funded by a grant from the Michigan Department of Community Health. A total of 83 children were assessed, selected from the April 2008 Saginaw County foster care population of 459 children. The sample was stratified to represent the ages of children and the racial and ethnic demographics of the total foster care population.

The Devereux Early Childhood Assessment (DECA) was selected as the assessment instrument for children up to age six. The DECA is completed by a care provider, but must be scored and interpreted by someone trained in DECA assessment. The Child and Adolescent Functional Assessment Scale (CAFAS) was used for assessment of children and youth of full-time school age. The CAFAS must be completed by a trained clinical rater who must pass a CAFAS reliability test. This tool provides a total score and individual subscale scores for school, home, community, behavior towards others, moods, self-harm, substance use and thinking.

The assessments found 25.3% of children assessed to have moderate mental health needs and 33.7% of children to have critical need for mental health services. Overall, 59% of the children assessed were found to have either moderate or critical mental health service needs. Given the confidence interval for the sample, the study concluded that between one-half to two-thirds of all Saginaw County children in foster care have moderate or critical mental health needs. The table below provides a summary of findings for the children assessed by age group.

Of the children assessed, 56.6% had already been referred for some type of mental health services. However, of those children found to have moderate or critical needs, only 69.4% had been referred while 30.6% had not been referred for mental health services at the time of the study. Even though this study was limited to one county, these results nevertheless suggest that the scope of the mental health problems for children in foster care may be larger than previously thought. The most frequently identified problem for children in the sample was behavioral concerns, suggesting that services targeted to educating caregivers on effective parenting techniques are indicated for this type of concern.

**Figure 43: Saginaw Children with Mental Health Needs by Age Group**

Age in years	Number children with moderate needs	Number children with critical needs	% of children by age with moderate or critical need
0	1	0	12.5
1	0	1	33.3
2	2	1	60.6
3	2	5	100.0
4	2	2	80.0
5	1	1	66.7
6	1	3	57.5
7	1	1	66.7
8	0	0	0.0
9	2	1	100.0
10	0	2	50.0
11	2	1	60.0
12	1	0	50.0
13	1	1	50.0
14	0	3	75.0
15	1	0	50.0
16	0	2	50.0
17	2	4	66.7
18	2	0	66.7
<b>Total overall percent of children with needs</b>	<b>25.3%</b>	<b>33.7%</b>	<b>59.0</b>

Survey and focus group respondents from around the state indicate that the experience in Saginaw is not unique and that children, as well as parents, are underserved when it comes to providing appropriate assessments and health related services to address physical, mental, psychiatric, and substance abuse treatment needs.

## **2. Barriers to Effective Delivery of Services**

### ***Mental Health Barriers***

Nationwide, as in Michigan, states struggle with meeting the mental health needs of its foster care population. According to national data, mentally ill children are significantly overrepresented in the child welfare and juvenile justice systems. It is also well known that these children often go largely untreated, which can then lead to significant drains on public resource

dollars as they enter adulthood without the emotional stability needed to maintain housing, secure employment, or meet their daily needs. A disproportionate share of these disturbed children and adults turn to a life of crime, leading to further drains on societal resources (Bernstein, 2005).

Causes for this inequity and lack of access to youth mental health treatment are varied. In 2006, the Children's Law Center of Los Angeles held a foster youth mental health summit to identify and discuss the barriers to achieving effective mental health outcomes. Their report reflects not only issues affecting California and Los Angeles, but also those facing states across the country, including Michigan. This group researched and identified the following primary factors impeding mental health service goals:

- **Lack of effective accountability and data tracking systems** – data tracking systems often do not facilitate easy analysis of needs and performance measures.
  - The multiple systems involved in a given child's life (child welfare, mental health, schools, courts, for example) do not collectively agree upon the core set of principles needed to develop the most appropriate service plan and to track the quality and effectiveness of services provided.
  - Data tracking systems need to track outcomes related to the child's service plan and inform decisions related to the child's overall well being.
  - Confidentiality barriers between systems involved with youth and misunderstandings about the HIPAA privacy requirements prevent the sharing of information and integrated responses between systems.
  
- **Capacity issues** – if sufficient numbers of child welfare workers, volunteers, and caregivers are not recruited, trained and retained, then it becomes impossible to fully meet the mental health needs of the children in the system.
  - There are large discrepancies in the quality and availability of mental health providers across geographic boundaries, both nationwide and in Michigan. Availability of services in areas where they do exist is affected by caseload size, geographic boundaries, and number of workers.
  - If workers providing mental health services to children do not have the necessary training, experience or qualifications, they will not be able to provide the kind of help that the children need. This is particularly true in cases of specialized service needs, such as sexually abused or substance abusing teens. Recommended treatment modalities vary greatly depending upon the problem as well as the age of the child.
  - Caregivers need appropriate levels of support and training to work with children who have particular mental health issues and needs. Where this does not occur placements are more likely to disrupt, leading to more instability for the child and a higher likelihood that the emotional disturbances will be exacerbated rather than resolved.
  
- **Lack of monitoring of mental health providers** – perhaps more important than the mere access to mental health service for youth is ensuring the quality of those services. Monitoring the mental health service providers to make sure they are following evidence

based practices and have the requisite training and expertise for the populations they are serving, to include cultural competencies, has been identified as a problem across the nation.

- **Courts and the legal process** – can create barriers to effective mental health service delivery to children and youth. These barriers are affected by:
  - Lack of collaboration and accountability across the provider, child welfare, and court systems, which increases duplication of services, administrative delays, uneven quality, and disjointed service delivery.
  - Lack of appropriate training and education of court personnel and advocates on mental health and developmental issues facing foster youth.
  - Lack of youth and family participation – although this is changing incrementally across the country, it is still very common to leave youth and their families out of the discussion when it comes to decisions about service or treatment plans and other life-changing decisions. In Michigan, although the mandated TDM process is changing practice, there is still wide variability across the state regarding the extent to which families are involved in their own service planning and decisions.
  
- **Payment and rate structure issues** – rate structures can negatively influence placement and services and provide disincentives to providing a child or parent with needed mental health services.
  - The federal early and periodic screening, diagnosis, and treatment (EPSDT) program could be used to fund not only traditional outpatient mental health services but also more innovative approaches, such as wraparound and school based treatment.
  - Moving between counties and maintaining access to mental health services can be difficult. This is especially true in Michigan with regard to use of Medicaid funds to provide community mental health services. Eligibility, reimbursement and tracking of these services between different geographic areas can create bureaucratic and paperwork nightmares, resulting in either loss of service altogether for many children, or significant delays, not to mention loss of continuity between providers.
  - Federal reimbursement policies that favor foster care over reunification. This provides a financial disincentive on the part of agencies to provide services, particularly to birth parents, that promote reunification rather than extend foster care.
  
- **Unmet needs of children birth through age five** – Causes of gaps in serving the mental health needs in this young population include:
  - Multiple placements early in life that lead to severe emotional loss and attachment issues – this problem can be exacerbated when there is lack of adequate support for the kinship or non-kin caregiver.
  - Eligibility criteria for accessing the mental health service delivery system can be complicated and difficult – in addition, mental health agencies that serve either the infant or the parent but not both, are not able to foster healthy attachment between parent and child, a critical component in the reunification process.

- A shortage of providers trained in infant and early childhood issues.
- **Unmet needs of children 5-14 years old** – this age group is particularly vulnerable, given the high likelihood that they will experience multiple placements and multiple schools, which will increase their social isolation, and lead to more complex mental health needs.
  - Lack of understanding by school personnel regarding the effect of trauma and instability on school performance and lack of skills to identify problems early and support effective interventions.
  - Unstable placement situations can prevent a stable relationship or connection with a caring adult from occurring. Personal connection to a caring adult has been identified as one of the single most important factors in a child’s ability to be resilient and succeed in life.
  - Lack of communication across systems can severely impact the quality and appropriateness of services.
- **Unmet needs of transition age youth** – nationwide statistics indicate that inadequate support of youth during their transition to adulthood results in extremely high numbers of young adults either living on the streets or turning to a life of crime. In some large urban areas, these numbers can approach 50% of all youth transitioning out of the foster care system. These problems are caused by:
  - Lack of services that empower youth – traditional talk therapy is not always the most effective model of therapeutic intervention for older teens, who may need a more holistic approach that builds relationships with caring adult mentors.
  - Undiagnosed and untreated mental health issues – left untreated, these issues become significant barriers to a youth’s ability to live independently.
  - Lack of necessary life skills and emotional supports that continue after the transition out of the system.
  - Lack of independent living plan for youth who need help with housing, employment, continued school, and mental health support.

### ***Michigan Approach to Managing the Barriers***

In its application for the federal Mental Health Block Grant for the period, 2009 through 2011, the Michigan Department of Community Health (MDCH) documents its plans for directing attention to essential mental health needs of Michigan’s children in three areas:

- Differences in accessing the array of services available at the local level.
- Expansion of current innovative projects.
- Services to children in foster care.

A number of primary changes are already in place to address these issues:

- System of Care Request for Proposal (RFP) for 2008, 2009 and 2010 Mental Health Block Grant funds included emphasis on beginning or continuing working with community partners on comprehensive system of care planning for children with serious emotional disturbance (SED). Funded projects include expansion of wraparound, infant mental health, screening of mental health needs for youth involved in the juvenile justice system, and other evidence-based practices such as Parent Management Training –

Oregon model, Multi-System Therapy, Therapeutic Foster Care and Functional Family Therapy.

- Development of a standard policy guideline to address service access and decision making which has become an attachment to the MDCH contract with prepaid inpatient health plans (PIHPs) and community mental health service providers (CMHSPs).
- Development of a Technical Advisory for use throughout the field revising the specific access criteria for children with serious emotional disturbance. This will become an attachment to the 2010 contract with PIHPs and CMHSPs.
- The federal Centers for Medicare and Medicaid Services (CMS) approval of the 1915(b) waiver includes more than \$13 million in additional funding for children during the current fiscal year to be used for additional services to children with serious emotional disturbances and developmental disabilities with a specific focus on children in DHS foster care.
- Additional funding has been added to the substance abuse Medicaid waiver capitation for children and adults for increased access to services.
- The 2009 contract with PIHPs includes specific performance requirements related to the above planned increases in access to services for children.

Plans for additional changes in 2009 and beyond include:

- Implementation of funded projects listed above to increase the state's use of evidence based practices for children needing mental health services.
- Continuation and expansion of the Michigan Level of Functioning Project to assess progress for children and their families using the CAFAS mental health assessment tool to improve decisions about treatment in individual cases and to make systemic improvements in the system of care.
- Developing and providing training on an evaluation system that ensures fidelity to the wraparound process.
- Developing an early childhood system of care for children birth through age five using the Great Start Collaboratives convened by the intermediate school districts (ISDs).
- Increase family voice and choice in policy development, planning, training and RFP reviews to increase effectiveness in targeting programs and service delivery to consumer needs.
- Working collaboratively, MDCH and MDHS development of new approaches to blending or braiding funding that will provide intensive community based services to address gaps in mental health service available to children in foster care.

### ***Dental Care Barriers***

Michigan provides dental care to Medicaid covered recipients through fee for service (FFS) and Healthy Kids Dental (HKD). No established provider networks exist for Medicaid FFS, and the payment rates are at approximately 30% of the charges for private dental care providers. Local health departments and federally qualified health centers are expected to serve Medicaid recipients in the 22 Michigan counties that are not covered by HKD. These providers receive the HKD rates for their services, but DCH reports they are unable to expand their service availability due to capital costs and staffing shortages in the current difficult fiscal environment. Private dental care providers in non-KHD counties are unlikely to accept Medicaid coverage because of the low rates they would receive.

HKD is a program unique to Michigan cited as a national best practice. The program is available in 61 Michigan counties, not including the most populous counties in the state. DCH pays Delta Dental to manage the program, which uses the Delta Dental provider network to deliver services. These providers cannot refuse to serve recipients. The fee structure pays at approximately 60% of private provider charges.

In their responses to survey questions, a majority of CPS, foster care and permanency workers report that dental care services are either not available or not sufficiently available. They also report significant wait times for children to access the services. (See Figure 46). Focus group participants in both worker and birth parent groups spoke of concerns about the difficulty of finding dental care service providers. Birth parents and youth also indicated strong concerns about finding transportation and obtaining child care for other children during dental appointments.

Through its work with dental care services providers, DCH has identified key barriers from a provider perspective related to their reluctance to accept Medicaid coverage, including:

- Fee for service (FFS) rates established for Medicaid are seen as too low. While the rates paid by Healthy Kids Dental are higher, the HKD program is available in only 61 of 83 Michigan counties, and does not include the most populous counties of the state.
- DCH has worked to reduce administrative burdens on dental care providers by making policies, procedures and forms as similar to those of other insurers as possible. However, children still need to be enrolled in Medicaid, a requirement that differs from that of other third party payers. Dental care providers continue to cite administrative burdens as a barrier to accepting FFS coverage.
- Providers have also expressed concern that children do not show up for appointments due to transportation and child care issues.
- When parents do bring their children to the provider, they sometimes show up without appointments, not being familiar with the precise procedure for scheduling that dental care providers use.

Both providers and recipients cite transportation issues. To an extent this problem has emerged as a result of provider moves to suburban areas where public transportation options are less available.

Current overall utilization across all dental services, including both preventive and treatment services, for Medicaid clients in Michigan is at about 30%. This represents an increase over previous years. This compares to a 50% utilization rate among HKD recipients and an approximate 60% overall rate among persons covered by commercially provided dental plans. The federal CMS expects states to achieve a 45 to 50% overall utilization level for Medicaid covered dental care. For general information purposes, state level data on child utilization of dental services appears in Appendix 3 where Figure 67 reports on dental care utilization among all children eligible for Early Childhood Periodic Screening, Diagnosis and Testing (EPSDT).

### 3. Flexible Funding Considerations

The surveys, focus groups, and other previous work groups have identified concrete assistance, such as housing, transportation, child day care, food, and other financial assistance as a major barrier to family preservation and reunification services. While programs are available to families to prevent removal of children or to expedite return home they are sometimes inadequate to meet the specific, concrete needs of families.

**State Emergency Relief (SER)** is available for payment of security deposits, first month's rent, or rent arrearages to prevent eviction. The maximum total payment is \$410 for an individual, \$620 for a family of three. Payment may not be made if housing costs exceed 75% of a family's income.

**Low Income Home Energy Assistance Program (LIHEAP)** is available for assistance in meeting the costs of energy. LIHEAP has limits and may not be used for emergencies that are caused by the applicant. Arrearages and shut offs can only be paid if the household has made specific minimum payments and the cost to establish or prevent shut off exceeds that amount. Payments have annual limits for a household.

For families in the **Families First** of Michigan program, when SER isn't available there are flexible funds, up to \$300 per family, available for basic needs such as first month's rent, utility bills, food clothing, furniture, and household basics.

Access to the department's flexible funding programs and to community services can be confusing to clients. They need to know which agencies provide what services and what the requirements are for those services. Transportation is frequently an issue in accessing services, particularly when it is necessary to use multiple organizations to meet the needs. After gathering the necessary verifications clients sometimes wait for as long as 10 days to receive DHS assistance. If they have used their maximum benefit for utilities they must have a denial letter from DHS before other agencies can help. Frequently assistance from more than one agency is needed to meet the entire need. For families living in poverty, who have limited skills in navigating complex administrative systems, or who have mental health or substance abuse issues in addition to other complicating factors in their life situations, accessing these services, even where they are available, can be exceedingly difficult. If transportation, child care, employment or other barriers are present, parents trying to reunify with their children, or prevent removal, can easily be overwhelmed by the challenges placed before them.

Focus group participants reported that clients have limited access to transportation. Even urban areas are not well served. The availability of transportation is also a concern when, in order to prevent removal or return children, parents are required to attend parenting or other classes or therapy.

Also, participants reported that a lack of housing assistance is a common barrier to reunification, and children frequently stay in care longer as a result. Parents report feeling that their situations are impossible. On the one hand they have their children taken away because they have no housing and must have housing to get them back. On the other hand, by taking the children away

they lose money which then prevents them from being able to get the housing they need to get the children back. When they don't have the children with them, they do not qualify for family housing.

The housing referral process needs to be easier. In Wayne County, it is not unusual for families to wait many years for low income housing. The needs of the "working poor" who are low income are different than those with no income. Landlords who have responsibility for repairs but don't make them contribute to delays in kids returning home. Parents can't afford to fix the problems themselves and should not have to, but if they don't, lack of repairs can result in the child remaining in care.

The Wayne County DHS focus group identified their housing program for teens as an effective program. In general though, homeless youth and those in the juvenile justice system lack access to housing support resources that are available to those in the foster care system. Survey responses from all points in the service delivery continuum show a majority of workers reporting financial assistance, transportation and housing services as being either not available or not sufficient to meet the needs of their clients. In addition, workers reported significant waits for these services. These are all concrete service needs that would benefit from increased flexible funding support.

**Figure 44: Concrete Service Needs that Could Be Addressed with Flexible Funds**

INDICATE WHETHER THE LISTED SERVICE IS SUFFICIENTLY AVAILABLE AND THE LENGTH OF WAIT FOR EACH SERVICE.					
	Service Availability (shown in percent of respondents)			Length of Wait for Services	
	Sufficiently available	Available, but not in the sufficient amount	Not available	Typical length of wait (in weeks)	Percent of respondents indicating more than 12 weeks
<b>CPS Prevention Services (N = 98)/Source: Worker Survey, Question 25.3</b>					
Financial Assistance	46.5%	51.2%	2.3%	2-3 weeks	10.8%
Transportation	37.2%	48.8%	14.0%	3-4 weeks	9.1%
<b>Foster Care Services Related to Goal Change or Placement Step down (N = 78) / Source: Worker Survey, Question 31.1</b>					
Financial Assistance	43.1%	50.0%	6.9%	4-5 weeks	8.3%
Housing	23.3%	61.7%	15.0%	7-8 weeks	34.8%
Transportation	36.8%	50.9%	12.3%	2-3 weeks	11.4%
<b>Foster Care Services Related to Post-Reunification (N = 59) / Source: Worker Survey, Question 32.1</b>					
Financial Assistance	35.3%	61.8%	2.9%	4-5 weeks	21.4%
Housing	27.3%	54.5%	18.2%	4-5 weeks	33.3%
Transportation	31.3%	50.0%	18.8%	3-4 weeks	21.7%
<b>Family Prevention (N = 19) / Source: Worker Survey, Question 36.1</b>					
Financial Assistance	31.3%	68.8%	0.0%	4-5 weeks	9.1%
Housing	18.8%	62.5%	18.8%	8-9 weeks	45.5%
Transportation	26.7%	53.3%	20.0%	1-2 weeks	0.0%
<b>Permanency and Adoption Services (N = 24) / Source: Worker Survey, Question 43.1</b>					
Financial Assistance (other than Adoption Subsidy)	43.8%	43.8%	12.5%	5-6 weeks	15.4%
Housing	21.4%	71.4%	7.1%	5-6 weeks	16.7%
Transportation	28.6%	42.9%	28.6%	3-4 weeks	18.2%

## 4. Effective Programs and Approaches

### *Mental Health Programs and Approaches*

States have identified numerous strategies for addressing some of the concrete and systemic challenges to providing mental health services to their foster care populations (McCarthy, et al. 2004). These strategies include the following:

- *Assessment* – Improving the assessment of child and family mental health needs by increasing the number of children in foster care who receive mental health assessments and developing better assessment tools that are more comprehensive and include the whole family.
- *Training* – Improving training of child welfare staff, clinicians and foster parents on evidence based practice guidelines, service planning, addressing specialized issues such as developmental disabilities, domestic violence, sexual abuse and substance abuse.
- *Collaboration* – Improving the collaborative partnerships and sharing of information and resources across systems to address issues such as:
  - Integrating service plans and measuring performance and effectiveness of those plans.
  - Implementing systems of care that reduce denials by the mental health or managed care system, promote the pooling of funds and sharing of information and referrals, creating a single point of access to mental health services and a uniform intake process.

**Multi-Systemic Therapy.** This program targets serious juvenile offenders and promotes a customized approach to treating youth that is community-based and focuses on the multiple factors that can impede positive behavioral change. Studies have consistently found that this treatment model effectively lowers arrest and incarceration rates of program participants over both the short and long term. (Rowland, et al 2005). The model has been adapted successfully for seriously emotionally disturbed children who have been abused or neglected but are not delinquent, with positive results. Key components of this treatment model include:

- *Home-based* – services are delivered to youth and families where they live and are an alternative to incarceration or residential care, which can create barriers to family engagement due to transportation, scheduling and other factors. This also allows for therapists to observe and foster behavior change as they naturally occur, rather than in artificial settings.
- *Low caseloads* – master’s level therapists handle caseloads of no more than 3-5, and are available 24 hours a day.
- *Customized treatment* – intervention strategies are tailored to the specific circumstances needed, and duration and frequency vary according to need as well, and treatment approaches are based on therapies that have empirical support.
- *Family/therapist collaboration* – emphasis is on supporting and empowering parents and their development and utilization of natural support systems (extended family, neighbors, church, etc).

**Parent-Child Interaction Therapy (PCIT).** Focusing primarily on young children (ages 2-7), this therapeutic approach aims to restructure the parent-child relationship and provide the child with a secure attachment to the parent. Parents are treated with their children, skills are behaviorally defined, and all skills are directly coached and practiced in parent-child sessions. Therapists trained in the model observe parent-child interactions through a one-way mirror and coach the parent in real time using a radio earphone. This intensive treatment program has been extensively studied and is proven to positively impact the parent child relationship and reduce abusive discipline and child maladaptive behaviors (Brinkmeyer and Eyberg 2003, Eyberg, et al. 2008). PCIT is available in Michigan, but only in one location.

**Multidimensional Treatment Foster Care (MTFC).** MTFC has been extensively studied and is recognized as a highly effective alternative to group or institutional settings for severely delinquent and emotionally disturbed youth (Price, et al. 2008). Developed originally for boys with severe and chronic criminal behavior, the model has been adapted for and tested with preschoolers, girls referred from juvenile justice, and with children and adolescents with severe emotional and behavioral disorders. For each population group, the impacts have been significant in terms of increasing placement stability and reducing the behaviors that lead to more restrictive and punitive placement settings. The program has also been shown to be cost effective and more economical than placement in group care. Key elements common to all versions of the program include:

- *Positive reinforcement* – providing youth with a consistent reinforcing environment where he or she is mentored and encouraged to develop academic and positive living skills.
- *Structure and clear expectations* – foster parents are trained to provide daily structure and clear limits, with consequences that are delivered in a supportive, teaching manner.
- *Close supervision* – foster parents are trained to monitor the child’s whereabouts and peer relationships closely.
- *Long term support* – placements typically last 6-12 months, and involve each youth’s family or aftercare resource from the outset in order to ease the transition to post-treatment care.
- *Close monitoring and supervision* – a program supervisor with a caseload of 10 tracks progress and collects data daily.

Wayne County DHS and Southeast Michigan Private Agency Providers felt that treatment foster homes worked well and the training they received is high quality, but expressed concern that not enough parents were recruited to receive the training. They felt foster homes were less effective when children with emotional disturbances and behavior problems were placed with foster parents who had not received adequate training.

### ***Substance Abuse Programs and Approaches***

Substance abuse is one of the most common factors that results in a child entering the child welfare system and foster care. Mental illness in system-involved families is not uncommon, and is often a byproduct of being in foster care for children who have been removed from their homes. As the survey results confirmed, for families involved in both the child welfare and public mental health and substance abuse treatment systems, obtaining timely, coordinated and effective treatment can be challenging. Both systems operate under different and even conflicting

mandates, priorities, time lines and treatment philosophies. These inherent tensions between systems can be overcome only by focusing on the well-being of the families and children involved and by supporting a collaborative process utilizing a full continuum of service providers when determining realistic treatment goals, timelines, and placement decisions. (Green, Rockhill & Burrus 2008).

**Collaborative Approach Example: Dependency (or Family Treatment) Drug Court.**

Successful collaborative approaches have one or more of the following common and important characteristics:

- Stationing treatment workers in child welfare offices.
- Creating joint case plans between child welfare and treatment systems.
- Using official committees to guide and monitor collaborative efforts.
- Training and cross training on issues relevant to both systems.
- Establishing protocols for sharing confidential information.
- Using dependency drug courts.

Dependency Drug Court is a collaborative model that brings together the judicial, child welfare, and treatment systems to integrate the often conflicting goals of each system. Coordinating efforts to address both treatment issues for the parents and safety and well being issues for the children is a priority. (Austin and Osterling, 2008). Evidence has shown that coordinating the delivery of services in this way can result in parents entering substance abuse more quickly, staying in treatment longer, with higher rates of completion. In addition, the children of parents involved in dependency drug courts were more likely to be reunified with their parents and were less likely to return to care (Green, et al. 2007). Key elements of the approach include:

- Frequent court hearings with focus on treatment and services.
- Intensive monitoring and timely referrals to substance abuse treatment.
- A system of rewards and sanctions for treatment compliance.
- Drug court team that includes representatives from the judicial, child welfare and treatment. systems, who work together to support and monitor the parent.

**Treatment Approach Example: Residential Women and Children and Pregnant and Postpartum Women Program.** Studies indicate that child welfare outcomes can be dramatically improved if the following program components are provided to substance abusing mothers:

- Women-centered treatment that involves the children.
- Specialized health and mental health services.
- Home visitation.
- Concrete assistance (transportation, child care, etc).
- Short-term targeted interventions.
- Comprehensive programs that take a holistic approach and integrate these components.

The Residential Women and Children (RWC) and Pregnant and Postpartum Women (PPW) programs are federally funded residential programs for substance abusing women that have been shown to positively impact both treatment and child welfare outcomes. The long term (length of stay ranges from 3 months to a year) RWC treatment program is designed to keep mothers and children together throughout treatment. The treatment system is linked to primary care, mental

health and social services, and is designed to help preserve and support the family unit. Evaluations of this national multi-site program have found that when mothers have their children living with them while they are in treatment, the mothers have a much higher rate of completion of the treatment cycle, longer stays in treatment, and greater abstinence success after leaving the program (Clark 2001). Length of stay in residential treatment is a major determinant of treatment effectiveness (Greenfield, et al 2004). Therefore, as referenced above, a residential treatment program that allows women and children to remain together will foster both lower placement rates and higher probability of treatment completion.

### ***Dental Care Programs and Approaches***

As indicated previously, Michigan's Healthy Kids Dental program is cited by CMS as a national best practice. HKD has succeeded in increasing the utilization of dental care services in HKD covered counties to about 50% overall, including both preventive and treatment services. This compares to a utilization rate of about 30% of FFS Medicaid covered recipients. DCH indicates that it would be possible to extend HKD coverage to all children in foster care without a requirement to expand to the coverage of the entire Medicaid population in the current non-HKD counties.

## ***B. Michigan's Service Gaps and Unmet Needs***

Mental health services most cited by survey respondents as needed include psychological evaluations, outreach services, trauma assessment, therapeutic recreation, psychiatric services, in home counseling, and support groups.

The survey asked workers to identify from their caseloads the number of children with serious mental and behavioral health needs. Workers were then asked to identify how many of those children were currently receiving treatment. The table below shows the numbers reported by DHS, private agency and tribal workers. Focusing on the totals reported, almost 1,700 children, or 78%, of the children reported by workers as having serious emotional and behavioral health needs are actually receiving services directed at those needs, while almost one-fourth, or 373, are not. If the percentages evident in these responses typify caseloads of those who did not choose to respond to the survey, then significant numbers of children perceived by workers as having serious emotional and behavioral needs are not being treated for those disturbances. Of the 1,697 children reported as receiving services, 688 are reported to have been diagnosed as having a Serious Emotional Disability (SED) because they were assessed at a certain level of emotional disturbance that triggers mandated Community Mental Health services.

**Figure 45: Children in Caseload with Serious Mental or Behavioral Health Needs**

Source: Worker Survey, Questions 6.1, 6.2, 7.1				
Approximately how many children on your current caseload would you say have serious mental or behavioral health needs?				
	DHS	Private	Tribal	Total
Average	7.66	6.40	4.20	7.38
Total	1349	307	21	1697
Number of Respondents	176	48	5	230
How many of these children are currently receiving services for a serious mental or behavioral health need?				
	DHS	Private	Tribal	Total
Average	6.22	4.29	4.00	5.76
Total	1094	206	20	1325
Percent Receiving Services	81.1	67.1	95.2	78.1
Number of Respondents	176	48	5	230
How many children currently receiving mental health services have a Serious Emotional Disability (SED) according to your local Community Mental Health?				
	DHS	Private	Tribal	Total
Average	3.30	2.60	3.60	3.17
Total	558	112	18	688
Percent Receiving Services Who Have SED	51.0	54.4	90.0	51.9
Number of Respondents	169	43	5	217

The survey also asked workers to identify how many birth parents in their caseloads suffered from serious mental and behavioral health needs. The figure below shows the results of that question and, like the figure above, also shows how many of those parents are receiving services for the identified needs. Figure 46 shows that less than half of birth parents reported by workers as having serious mental or behavioral health problems were receiving services for those needs at the time of the survey. If reunification or family preservation is dependent upon a birth parent receiving services for his or her serious mental or behavioral health disorder, these results may help identify at least one factor impeding that goal. While the reasons why a parent does not receive mental health service can include a parent's refusal to seek treatment and other reasons outside the control of DHS, taken together with other survey and focus group responses regarding the availability and accessibility of mental health services, the numbers of those not receiving treatment are significant enough to suggest that it is more likely that accessibility factors are involved as well.

**Figure 46: Birth Parents in Caseload with Serious Mental or Behavioral Health Needs**

Source: Worker Survey, Questions 9.1, 9.2				
Approximately how many birth parents on your current caseload would you say have serious mental or behavioral health needs?				
	DHS	Private	Tribal	Total
Means	7.48	4.00	6.20	6.81
Sums	1174	144	31	1349
Number of Respondents	94	36	5	198
How many of these birth parents are currently receiving services for a serious mental or behavioral health need?				
	DHS	Private	Tribal	Total
Means	3.75	2.06	2.00	3.41
Sums	589	72	10	671
Percent Receiving Services	50.2	50.0	32.3	49.7
Number of Respondents	94	35	5	197

Figure 47 combines responses from CPS, Foster Care and Permanency/Adoption workers regarding availability and wait times for services related to health and education. Dental, psychiatric and mental health services emerge as significant areas of need among all groups, both in the area of availability and in terms of wait times for service.

**Figure 47: Availability and Wait Times for Health and Education Related Services**

Indicate whether the listed service is sufficiently available and the length of wait for each service.					
	Service Availability (shown in percent of respondents)			Length of Wait for Services	
	Sufficiently available	Available, but not in sufficient amount	Not available	Typical length of wait (in weeks)	Percent of respondents indicating more than 12 weeks
CPS Prevention Services (N = 98) Source: Worker Survey, Question 25.3					
Counseling	70.2	29.8	0.0	2-3	2.0
Physical Health	70.6	26.5	2.9	5-6	6.7
Dental Health	31.4	57.1	11.4	5-6	13.3
Psychiatric	25.0	70.0	5.0	3-4	10.8
Mental Health	44.4	55.6	0.0	1-2	2.4
Substance Abuse Treatment	59.6	40.4	0.0	4-5	0.0
Education Services	42.5	47.5	10.0	1-2	12.1
Foster Care Services Related to Goal Change or Placement Step down (N = 78) Source: Worker Survey, Question 31.1	Sufficiently available	Available, but not in sufficient amount	Not available	Typical length of wait (in weeks)	Percent of respondents indicating more than 12 weeks
Physical Health Services	69.6	25.0	5.4	2-3	2.3
Mental Health Services	48.5	48.5	3.0	3-4	3.4
Dental Health Services	44.8	50.0	5.2	4-5	7.7
Substance Abuse Services	58.2	38.8	3.0	2-3	1.8
Education	66.0	34.0	0.0	2-3	2.3
Psychiatric Services	32.3	59.7	8.1	5-6	14.3
Foster Care Services Related to Post-Reunification (N = 59) Source: Worker Survey, Question 32.1	Sufficiently available	Available, but not in sufficient amount	Not available	Typical length of wait (in weeks)	Percent of respondents indicating more than 5 weeks
Physical Health Services	64.7	26.5	8.8	2-3	3.7
Mental Health Services	42.1	57.9	0.0	3-4	12.5
Dental Health Services	44.4	47.2	8.3	3	19.4
Substance Abuse Services	61.1	36.1	2.8	3	10.7
Education	58.6	37.9	3.4	3-4	12.0
Psychiatric Services	19.4	74.2	6.5	4-5	29.6
Permanency and Adoption Services (N = 24) Source: Worker Survey, Question 43.1	Sufficiently available	Available, but not in sufficient amount	Not available	Typical length of wait (in weeks)	Percent of respondents indicating more than 12 weeks
Counseling	64.3	35.7	0.0	1-2	0.0
Physical Health	43.8	43.8	12.5	5-6	15.4
Dental Health	21.4	71.4	7.1	5-6	16.7
Psychiatric	35.7	21.4	42.9	3-4	12.5
Mental Health	28.6	42.9	28.6	3-4	18.2
Substance Abuse Treatment	21.4	57.1	21.4	4-5	9.1
Education Services	70.0	30.0	0.0	2-3	0.0

Focus group respondents across the board expressed concerns about Michigan’s ability to meet the health needs of all eligible children and parents. Their comments are summarized below.

### ***Treatment Foster Homes***

Focus groups identified several needs with regard to high quality, specialized foster care and residential options for youth.

- Both Wayne County DHS and Southeast Michigan Private Agency focus group members report a belief that treatment foster care homes can be very effective. Each group cited examples of such facilities in their respective areas.
- Wayne County DHS and Southeast Michigan private agency workers also report a need for treatment foster care families who receive specialized training and support.
- DHS workers want to see an aggressive marketing strategy for recruiting treatment foster care families. Once recruited, the foster families need to be adequately trained and supported. (Wayne DHS and Southeast Michigan Private Agency Focus Groups).
- Workers would like to see youth with mental health needs placed with treatment foster care families instead of regular foster care parents (who burn out quickly because they don't have the specialized training and support that treatment foster families receive).
- Workers recommended that some of the resources currently going to relative licensing be shifted to the recruitment and support of regular or treatment foster care.
- Kent County DHS workers report a need for short residential programs for serious problematic youth.

### ***Mental Health/Medical Needs***

#### **Medicaid**

Several focus groups recommended changes in the Medicaid system including greater access to necessary services.

- Multiple focus groups reported a need for Medicaid to cover more types of medical, dental and mental health services (e.g. braces for medical needs, having tubes put in one's ears, trauma assessments, therapy, etc.). Groups advocated for more providers who accept Medicaid to increase access and decrease long waiting lists for services. (Youth, Central Michigan Private Agency and Kent DHS Focus Groups).
- In a study of 72 former Michigan foster care youth, 21% of respondents reported unmet physical health care needs, 49% reported unmet dental care needs, 24% reported unmet vision care needs, 32% were suffering from depression and 14% reported feelings of being suicidal at some point during or after aging out of foster care. (Youth Focus Group).
- Private agencies workers report a need for closer geographic access to Medicaid-covered services. Many families have to go to Ann Arbor or great distances for Medicaid-covered services, which is a barrier for working parents who need to take off work (and a transportation issue for those without a vehicle). (Central Michigan Private Agency Focus Group).
- Central Michigan Private Agency Focus Group members report a need to address the lapse of Medicaid benefits that occurs when a child is returning home from foster care.

#### **Mental Health**

According to multiple focus groups, mental health treatment needs to be more readily accessible (at the level and quality that is needed) for adults and children. (Youth Focus Group, Kent and Wayne DHS, Southeast and Central Michigan Private Agencies Focus Groups).

- **Children/Youth:** Central Michigan private agency representatives would like more access to child psychiatrists for high quality/detailed youth assessments. Representatives report that there is a reimbursement problem that limits access to these services. Agency directors advocate that Medicaid cover a greater range of the medications currently being prescribed for youth. There is also a need for Medicaid to follow a child out of the county for mental health services.
- **Older Youth:** DHS workers recommend that mental health services be more comprehensive for kids, especially aging-out youth. (Wayne County DHS and Youth Focus Groups). Southeast Michigan Private Agency Focus Group members state that better assessments of older youth would help with better placements.
- **Family/Child Counseling:** Central Michigan private agency employees report a need for child-welfare trained family and child therapists who know how to work in the system. Workers report finding that some therapists can't help the family deal with the unique challenges of being in the system. Kent County DHS workers see a need for support to families with children who have behavior problems but do not have not abuse, neglect or delinquency problems.
- **Adults:** Multiple focus groups advocated for greater access to low-cost mental health services for adults. The waiting lists for services needs to be eliminated or shortened. (Kent DHS, Child Advocacy and Assessment Centers and Southeast Michigan Private Agency Focus Groups).
- **Relatives and Foster Care Providers:** Adults caring for children need more mental/emotional support and assistance (Tribal Focus Group). Central and Southeast Michigan Private Agency Focus Group members say that in-home mental/emotional support services are needed.
- **Adoptive Families:** Adoptive parents report that receiving detailed health/mental health information about the adoptive child is extremely helpful to them in planning for care. Adoptive parents need available therapists with knowledge and skills related specifically to adoptive families. (Adoptive Parent Focus Group). Therapy for children before, during and after adoption is crucial. Caseworkers advocate that the medical subsidy approval for these services be expedited. (Central Michigan Private Agency Focus Group).

### ***Systemic and Specialized Mental Health Needs***

Focus groups offered mental health service gaps that impact statewide needs.

- A range of supportive services are needed to complement therapy for parents with specific needs (e.g., anger management, specialized parenting classes including: interactive parenting coaching, culturally sensitive parenting classes, developmental parenting education and parent support groups for those with special needs kids, for adoptive parents, for those with children who have ADHD, etc.). (Kent and Wayne DHS, Southeast Michigan Private Agency, Child Advocacy and Assessment, Tribal, and Adoptive Parent Focus Groups).
- There is a need for an increase in the number of available mental health providers. (Wayne County DHS and Southeast Michigan Private Agency Focus Group). DHS workers say that resources are just not there. For example, there is only one hospital and no outpatient clinics for mental health in Wayne County, which is insufficient to meet the

needs of the population. (Wayne County DHS and Southeast Michigan Private Agency Focus Group).

- More long-term counseling services and supports are needed. (Central Michigan Private Agency, Child Advocacy and Assessment Center and Wayne County DHS Focus Groups). Greater funding flexibility would help when more than 12 therapy sessions are needed, which would allow flexibility for therapist to tailor their work to the needs of the individual. (Central Michigan Private Agency and Wayne County DHS Focus Groups).
- More domestic violence programs are needed (Kent DHS Focus Group). Tribal social service providers say that domestic violence programs that offer direct, interactive services are effective.
- Trauma assessments are greatly needed early on, at the prevention level. (Tribal and Child Advocacy and Assessment Center Focus Groups). Long-term, trauma-focused therapy is greatly needed. (Child Advocacy and Assessment Center Focus Group).
- Kent DHS workers report a need to better communicate with clients how to access mental health services.

### ***Substance Abuse (SA) Treatment Needs***

Several of the focus groups identified issues and concerns about substance abuse treatment service availability:

- Several focus groups reported a need for more substance abuse treatment programs, especially those that work with youth. (Substance Abuse and Kent and Wayne County DHS Focus Groups).
- Good substance abuse assessments are crucial in determining the care needs of children in the family. (Kent County DHS, Central Michigan Private Agency and Substance Abuse Focus Groups).
- Substance abuse prevention services are needed for youth (Tribal and Substance Abuse Focus Groups). SA professionals say that children need to be seen as an integral client in the treatment process. Kids are often forgotten and have equally important mental health needs. SA is a “family disease” that affects all and can become intergenerational if not treated. (Substance Abuse Focus Group).
- Parental visits with children help motivate adults with SA problems. (Substance Abuse Focus Group).
  - Workers recommend that parents in substance abuse treatment receive more contact than the one-hour per week visit with their child(ren) allowed. Moms with newborns need bonding time with the infant that only parental visits can create.
  - SA treatment providers recommend a neutral party or parent advocate for parental visits and the resources to enable this.
- SA treatment providers say that there needs to be pervasive and widespread education about the “clinical nature” and treatment of SA.
  - Providers advocate for education among DHS, the courts, and state funding administrators about SA addiction as a disease and the complexity of its treatment (with its many the co-occurring disorders and dual diagnoses). Providers would like to see a more clinically-based system rather than any tendency toward a punitive or criminal approach.
  - SA providers recommend that parents receive more time to connect with services, become stable and recover than the current year-standard – while keeping their

kids safe. Providers advocate for the system to reflect more realistic expectations about what a person in early recovery can achieve. Treatment plans that fit incremental stages of recovery are needed. Currently, parents often fail their many-pronged treatment plans because they are not yet sober and have no coping strategies to accomplish goals.

- Children need education about and mental health support regarding their parent's addiction. SA providers say that family counseling and child counseling services are needed.
- SA Providers say that earlier and more accurate referrals from DHS would better help them to give the right level of care. Providers say that wrong referrals make the treatment process ineffective. They report that services are sometimes assigned without logical assessment of what is needed. They recommend that assessments always happen first.
- SA professionals report that parent advocates and intensive case management services are highly effective at helping people navigate the system.
- SA providers would like to see DHS and the courts have a better understanding of medication-treatment protocols for recovery from certain drugs.
- SA providers would like to see clients be able to take advantage of longer stays at residential treatment facilities without it potentially being considered as punitive for parent/child relations.
- Barriers to recovery need to be removed or mitigated. (Substance Abuse Focus Group)
  - SA providers say that it would be helpful to have more streamlined processes at DHS to help parents get their basic needs met while doing treatment.
  - Providers recommend that the state keep Medicaid going or get it restarted for parents who have had their children removed due to SA. This will help parents to avoid accumulating more debt and failure – both detriments to recovery.
  - Parents need affordable housing but may not have their children in their custody to qualify for family housing.
  - SA providers advocated for more childcare programs (and childcare funding) for parents to be able to get to their treatments and appointments. More in-home substance abuse services would eliminate transportation and child care issues.
  - Providers say that those in early recovery especially need financial support – some amount of money until they can find a job. This will help them to maintain some stability in health care, continue medications, etc.
- Systemic SA changes are needed. (Substance Abuse Focus Group).
  - Private agencies and contractors want the opportunity to educate DHS about the nature of the disease so they can better work together.
  - SA providers say that child welfare professionals need to shorten the delay in getting services started for SA clients. The client must currently make the contact for assessment and, it can take up to 6 weeks.
  - SA treatment providers report that they need more information from DHS in order to quickly and efficiently do their jobs.
  - SA treatment providers say that confidentiality issues need to be addressed. They report that sometimes information is needed and not given (even to DHS contractors).

- SA providers report that their clients can't reach their DHS workers easily and need better communication access.
- Providers report a need for equal SA treatment options for dads and moms.
- Uniformity is needed is needed in the referral process for DHS contractors, non-contractors and in different geographic locations.
- SA Funding and resource needs must be addressed. (Substance Abuse Focus Group)
  - SA providers say that resolving cross-county and in-county funding issues would help clients to more easily access treatment, health care coverage, housing, etc.
  - Not all providers get block grants to provide services. SA providers say that more block grants could help with funding shortages.
  - SA providers report that more funding is needed for prevention of intergenerational SA, children's mental health services, family counseling/support, residential treatment and step-down options.
  - SA providers who attend team meetings for clients or court appointments for their clients would like to be paid for their time.
  - Providers recommend that the state address Medicaid lapses for SA clients with children who have been removed. SA professionals say that parents lose Medicaid when they lose their children and are not able to afford or access treatment. Parent clients then also lose access to needed prescriptions which destabilizes them.
- Legal System (Substance Abuse Focus Group)
  - SA providers say that courts systems vary greatly from one to the next (drug court, sobriety court, family court, etc.). Some are more based on a clinical model of treatment and others are not. Providers report that drug court seems to value a clinical model of SA treatment. SA providers feel that courts that offer a criminal model do not work.
  - SA providers recommend that parenting contracts be more goal-oriented over a longer period of time in order to be effective.
  - SA providers advocate for more judges to come to more round table discussions.

The annual report submitted in April 2008 from DCH to the legislature on substance abuse prevention, education and treatment programs reports that about 840,000 Michigan residents age 12 and older were considered to be dependent on or to have abused alcohol or drugs during the previous year. Of these residents, about one out of eleven entered treatment services paid with state administered funds. While this information is for the general population in Michigan, it may be enlightening for persons involved with the child welfare system as well. According to the report, most persons in need of treatment services did not seek or receive services, for reasons including:

- Not ready to quit use
- Could not afford services or had no health coverage
- Potential for negative affect on job.

Persons who sought but did not receive help reported several primary reasons including not knowing where to go for help, having no transportation, lack of programs with the type of treatment needed and lack of openings in existing programs.

While some child welfare involved persons may have health care coverage, many do not. DCH reports that spending power for the programs supported by DCH administered funds has not kept pace with costs. If funding had kept pace with increases in the Consumer Price Index since 2000, the funding level in 2007 would have been 24% higher.

***Dental Care Needs***

Dental care is difficult to access for many children in foster care with limited numbers of care providers available, except in counties covered by the Michigan HKD program. It is possible to expand the HKD program to all children in foster care. With the federal financial participation rate for Michigan increasing to 70%, consideration of this expansion may be timely.

***Education Needs***

All workers responding to the survey were asked about the special education needs of children in their caseloads. Key responses are summarized below in Figure 48.

**Figure 48: Education Needs of Children in Caseload**

Source: Worker Survey, Questions 16.1, 2, and 4	
Estimated percent of children on caseload with education needs (shown in percent of respondents per category)	
0-25%	38.4
26-50%	32.0
51-75%	20.2
76-100%	9.4
Number of Respondents = 203	
Percent of children per caseload with specific education service needs	
Physical disabilities	1.9
Learning disabilities	18.6
Speech and language	5.8
Autism spectrum disorder	1.7
Emotional impairments	16.0
Other	0.7
Number of Respondents = 205	
How often do you receive updates from schools about progress on a child's IEP goals? Percent of Total Respondents:	
Never	44.1
Every semester	45.9
Monthly	8.9
Weekly	1.1
Number of Respondents = 208	

When asked whether schools are meeting the education needs of children in care, child welfare managers responded affirmatively overall 54% of the time. However, private agency managers responded in the negative 62% of the time.

**Figure 49: Manager Perceptions of Whether Educational Needs are Met**

Source: Worker Survey, Question 16.5				
Do you believe schools are meeting the education needs of children in foster care? (shown in both number and percent of respondents)				
Number of Respondents = 160	Yes	% Yes	No	% No
DHS Cases	67	58	48	42
Private Agency Cases	15	38	24	62
Tribal Agency Cases	4	67	2	33
Total	86	54	74	46

The survey asked all workers whether schools were meeting the needs if foster children. Only 37% believed that some or all schools were doing a good job. Another 32% believe that the schools didn't make an effort or were biased against foster children and 14% believe the schools are not prepared to deal with special needs. Schools lack the understanding of the emotional needs of foster children and the behavior that results. They need to involve birth parents as well as foster parents. Additional concerns include the lack of communication with the department and/or GALs, the lack of funding and services such as tutoring and support services offered.

**Figure 50: Worker Perceptions of Whether Educational Needs are Met**

Source: Worker Survey, Question 16.5		
Do you believe schools are meeting the educational needs of children in foster care? [Yes/No]. Please comment on your answer.		
Number of Respondents = 92	Total Responding	Percent of Respondents
Schools are doing a good job	19	20.6
Schools don't make an effort	17	18.5
Depends on the school	15	16.3
Schools are biased against foster children	13	14.1
Schools are not prepared to deal with foster children's special needs	13	14.1
Schools don't stay in contact	13	14.1
Lack of funding	9	9.8
Schools are overwhelmed	8	8.7
Schools do not provide services in a timely fashion	8	8.7
Lack of services	7	7.6
Difficulties due to multiple moves	7	7.6
Schools cannot provide services to children who don't have a disability )	2	2.2
Other	17	18.5

Focus group participants' input on education needs include:

- DHS workers recommend that the child welfare system focus more on education to help keep kids in school. They would like to see parents held more accountable for making their kids go to school. Additionally, they say that there needs to be more support for youth getting their GEDs.
- Private agency foster care workers see a need for more educational support for younger foster children (middle school specifically) in the schools. They say there's a lack of understanding in the schools about foster children and a need for afterschool and other programming to serve them. Alternative delivery for middle school education (as there is for high school) would be helpful. Some foster care children are expelled, and there is no alternative for expulsion. (Central Michigan Private Agency Focus Group).
- Child welfare workers see a general need for more collaboration from schools for children in the system. (Wayne County DHS and Central Michigan Private Agency Focus Groups).

### ***C. Key Findings and Needs Relating to Services Across the Continuum of Care***

Children and families involved with the child welfare system experience significant stress and uncertainties along a number of dimensions. Frequently, they have needs for which available services fall outside the direct administration or control of the child welfare agency. Notable among these are needs for help with mental health, physical health, dental health, substance use disorders and education. In addition these families and their children often experience concrete service needs such as need for housing assistance, employment services, transportation and others not easily met through existing programs or funding mechanisms.

**Finding: Accurate and timely multidimensional assessments are needed to facilitate planning that will identify the services needed to address the emotional, behavioral, physical and educational needs of children and families.**

Accurate and timely assessments, followed by appropriate, timely services to address the needs identified, are key to understanding and treating the full scope of a child's needs. Without effective tools to aid in developing the most appropriate treatment plans, children are at severe risk of not receiving the treatment they need, thereby exacerbating the problems which will continue to plague them over their lifetime. These issues are relevant at all stages of a child welfare case, even before placement occurs, and particularly after reunification or adoption.

**Finding: Services are needed in Michigan that are available, accessible and effective in supporting and addressing the mental health needs of children and families in the child welfare system.**

Strategies are needed for addressing some of the concrete and systemic challenges to providing mental health services to their foster care populations. Effective strategies need to include the following (McCarthy, et al. 2004):

- *Assessment* – Increasing the number of children in foster care who receive mental health assessments and developing comprehensive assessment tools that include the family.

- *Training* – Improving training of child welfare staff, clinicians and foster parents on evidence based practice guidelines, service planning, addressing specialized issues such as developmental disabilities, domestic violence, sexual abuse and substance abuse.
- *Collaboration* – Improving the collaborative partnerships and sharing of information and resources across systems.

A need exists to develop more complete array of services for children to include 1) more accessible services for all children who meet the test for SED services, 2) specialty care for children with particular needs, such as physical and developmental disabilities, histories of sexual abuse, and serious mental illness and 3) services for children who need minimal support that don't qualify for CMH services. Services needed for specific segments of the child welfare population include:

- **Children/Youth:**
  - Therapeutic services are needed for children who experience mild to moderate mental health problems not currently available to children who do not meet the SED standards required to receive services from CMHSPs. This may be partially addressed by expanding the number of allowed counseling sessions beyond 12.
  - Specialized cognitive and behavioral therapies that address the needs of children within their family systems, focusing on helping parents develop successful behaviors for working with the child and managing the child's problems.
  - Therapeutic services that address trauma, separation anxiety and attachment disorders experienced by children who have been subject to maltreatment, removal from their parents' homes and, sometimes, multiple moves among foster care placements.
  - Treatment for specific disabilities such as speech and language disorders and cognitive impairments
- **Older Youth:**
  - Accessible mental health services need to be expanded and accessible to youth transitioning from foster care
- **Family/Child Counseling:**
  - Trained family and child therapists who understand the specialized needs of families and children in the foster care system and know how to work in the system.
- **Adults:**
  - The waiting lists for low cost mental health services for adults need to be eliminated or shortened.
- **Relatives and Foster Care Providers:**
  - Adults caring for children need to be part of the treatment team for the children in their care and need more mental/emotional support and assistance, especially in-home assistance.
- **Adoptive Families:**
  - Therapists are needed who have knowledge and skills related specifically to adoptive families.

In addition, a need exists to ensure effectiveness of Treatment Foster Homes. Creative marketing and recruitment strategies designed to increase the number of treatment foster care families is needed. Once recruited, treatment foster families need to be adequately trained and supported.

**Finding: Services are needed in Michigan that are effective in supporting and addressing the substance abuse needs of children and families in the child welfare system.**

For families involved in both the child welfare and public mental health and substance abuse treatment systems, obtaining timely, coordinated and effective treatment can be challenging. Both systems operate under different and even conflicting mandates, priorities, time lines and treatment philosophies. Substance use disorder treatment needs include:

- Dependency/drug courts are already used in some locations in Michigan and have proved useful here and across the country in addressing substance use disorder problems in a cross-system collaborative manner.
- Substance abuse assessments tailored to determining the individual care needs of children and families.
- Additional education throughout the child welfare system, the courts, and other service providers about the “clinical nature” and treatment of substance abuse.
- Treatment plans aligned with realistic treatment goals.
- Overcoming barriers that impede recovery, such as transportation or childcare issues, need to be addressed.
- Substance abuse funding and resources to make services accessible to all who need and seek services
- Additional in-patient substance abuse treatment for parents trying to reunify in settings that allow children to stay with parents where appropriate. Need to work with substance abuse treatment providers to help educate workers, foster parents, courts, etc. on the process of treatment and the timeline.

**Finding: Dental care service availability and accessibility needs to be expanded to ensure that all children in foster care receive timely services:**

- Special consideration of expanding the Healthy Kids Dental program to cover all children may be useful at this time, given the increase in Medicaid Federal Financial Participation now available to Michigan.

**Finding: Improved coordination between child welfare, mental health and education providers is needed:**

- Schools need a better understanding of the emotional needs of foster children and the behavior that results, particularly limit-testing behaviors that occur among children who experience disruption in personal attachments with caring persons in their lives.
- DHS and schools need to work collaboratively and maintain effective communication regarding the needs of children in care.

**Finding: Service and resource accessibility needs to be expanded for concrete services families and children need to ensure stability, participation in service and treatment plans and success upon reunification of children with birth families:**

- Support for transportation, housing, respite care, child care and financial assistance are of particular concern.
- Communications about the methods for accessing the resources currently available and any that are added to the current array need to be developed to promote understanding among service providers and service recipients.

## **VI. Summary and Conclusions**

### ***A. Michigan's Child Welfare Service Delivery Approach***

Even in the face of serious fiscal challenges, Michigan has been able to increase funding available to provide increased staffing levels within DHS and increased per diem rates for private foster care providers over the past two years. These changes improve the prospect of better outcomes for children and their families through:

- Reductions in caseload size.
- Improved case planning and management.
- Increased levels of child, family and community engagement.
- Improved fiscal and program viability for private child serving agencies.
- Increased levels of outcome oriented oversight across the child welfare system.

The Children's Trust Fund in Michigan administers a number of prevention initiatives, as well as a grant program that funds local councils to develop services and programs that meet the child abuse and neglect prevention needs in their communities. To strengthen families, Michigan's fifty-four Family Resource Centers operate within or in close proximity to neighborhood schools, which allows for coordinated services that improves parental involvement and family functioning as well as academic performance. The range of public assistance programs available to families in the child welfare system also has a positive impact on child welfare outcomes.

During the child protection intake and investigation process, child protective service workers perform a comprehensive assessment of the family's strengths and needs. They then make referrals to prevention or preservation programs, as available and appropriate, utilizing the broad range of evidence based programs and funding streams intended to maintain families intact while protecting at-risk children. Once the children are in foster care, the range of programs and services focus on reunification, alternate caregiver recruitment and support, meeting health and education needs of the children and families in care, and maintaining stability and permanency. If reunification is not likely, services are directed toward finding adoptive families or other permanency solutions for children in care, and preparing older children for the transition to independence. Instituting concurrent planning processes and expanding kinship care opportunities are two important developments in Michigan's efforts to reduce the time in care, increase child safety and overall functioning, and provide appropriate and timely permanency outcomes for all children.

### ***B. Michigan's Service Needs and Gaps***

Michigan utilizes many important and valuable programs for children, families and communities. However, through the review of multiple data sources, including administrative data, focus groups, surveys, and secondary data analysis, it is clear that current resource levels do not provide for sufficient availability of these primary and secondary services across the state or across systems. A concern voiced by all stakeholders consulted throughout this needs assessment process is that the resource levels available for these programs have eroded compared to previous

years. The common themes that emerged through the needs assessment process are summarized below:

## **1. Focus on Prevention**

Rather than an absence of programs or services, the assessment affirms that prevention services have insufficient staff numbers, insufficient resources, and limited geographical locations resulting in difficulty gaining access to such services. When services are available, there may be a considerable lapse in time before the services can be properly employed. There is a clear need to strengthen and expand existing prevention and family preservation services, particularly targeting a pre-crisis state for the family. Expansion of home-based services that can be accessed in a timely manner to prevent removal to foster care, with a particular focus on effective parenting skills training, supportive counseling, and concrete needs such as employment, housing, and transportation, will support the goals of the settlement agreement and the Michigan Child Welfare Philosophy.

There is a strong connection between the challenges that exist when a family experiences poverty and the barriers that often must be overcome before reunification can occur, even when those barriers are not related to the original reason a child was placed. Given this fact, there is a significant need to support families who would otherwise be reunified except for barriers related to housing, transportation, employment and financial assistance, and the like. The data collected from all sources overwhelmingly supports the conclusion that services focused on providing access to and supporting families in their efforts to lift themselves out of poverty could have a substantial impact on both the need for and the length of placements. Providing these services after reunification has occurred could impact the need for return to placement.

## **2. Health Services**

Accurate and timely assessments are critical to developing individualized service plans and meeting the needs of children and families. There is a need to provide training to child protective and foster care workers on assessment tools that are available and their use and intended purpose. This includes not only the use of assessment tools but also the ability to individualize the assessment process.

When children are in out-of-home care, there can be considerable waiting periods to receive needed physical and mental health services, particularly dental or psychiatric services. Access to dental health services has emerged as one of the highest areas of need, reported by all groups across the continuum of care. It is utilized at all stages of a case for both birth parents and children, and survey responses consistently reported that not only is it not sufficiently available, but 10-20% of all respondents report that the wait for dental services is over twelve weeks.

High numbers of respondents also report significant wait times and lack of availability for other health services, including physical health, mental health, substance abuse, and psychiatric services. The high referral rate of these services by workers over the course of their cases, together with the substantial impact that access and utilization of these services often have on the

overall health of a family and reunification and permanency timelines, suggests a significant need to address the barriers to health services described in this report.

### **3. Services Related to Foster Care and Adoption**

Unless there are adequate numbers of trained, skilled adoptive and foster families, it will be impossible to achieve the goals of the settlement agreement. All data sources identified a need for additional and more creative recruitment of both foster families and adoptive families. In particular, a significant gap was identified regarding the specialized needs of a large number of children in care and the current ability of the foster and adoptive pool of families to meet those needs. According to both managers and workers, there are very few families who have the skills to care adequately for children who are in large sibling groups, have serious medical or mental health needs or developmental disabilities, are older, or have behavior problems. The need for families to care for these children is great, both in foster homes and adoptive homes.

With regard to foster parents, there is the need for foster parent training (particularly with regard to serious physical and mental illness), need for training and coaching for foster parents to mentor and support birth families, and the need for ongoing support (including in-home support services) for foster parents. This substantial gap suggests a need to identify new strategies for recruitment and retention, and to expand or create new training and support services targeting foster and adoptive families.

### **4. Enhancement of Existing Services**

Services identified as effective, such as Families First, prevention services, wraparound services, transition services for youth, and in-home services in general, were also identified consistently as not being sufficiently available and requiring long waits. While survey respondents and focus group participants had varying levels of experience regarding availability and wait times, the unevenness of their experiences and the consistency with which it was raised as a problem, suggest that disparities within communities, between counties and across the state needs to be examined more closely and addressed.

Expanded services are needed for children at both ends of the age spectrum. With the greatest percentage of children in the in 0-3 years age group (21% of children and youth), services for infants and young children and for the birth families and foster families caring for that population group need to be a priority. At the same time, increased efforts are needed to move kids to permanency after the termination of parental rights (this now averages over 4 years). The high number of older teens in the system suggests that permanency for older youth (including adoptive homes), transitions, and independent living programs also need to be a priority.

The need for more accessible prevention, preservation and reunification services was consistently noted throughout the assessment process. These services include physical health, mental health, and substance abuse services, as well as concrete services that address employment, housing and transportation. Attentiveness to young children and to older youth poses special challenges. The quality of assessments is a crucial area for focus. When unable to prevent placement, the need to strengthen foster parenting and assist foster parents in becoming a

valuable resource to families to help facilitate reunification is an important consideration. Timely prevention services and strong reunification services may contribute to the improved trends with regard to the number of children in out-of-home care.

### ***C. Systemic Supports Needed to Address Gaps***

In order to achieve the goals of the settlement agreement and the needs described in this report, certain systemic supports must be in place that will enhance communication, increase efficiencies, reduce duplication of effort, and minimize the time required for paperwork, data collection and reporting, and other administrative tasks. Lower overall caseloads will help, but that alone will not resolve all the needs expressed by survey and focus group participants, and which are common to all jurisdictions going through similar reform efforts.

The existence of systemic challenges in Michigan were apparent throughout the needs assessment process. Most if not all of the focus groups identified numerous administrative or systemic challenges they felt impeded their ability to provide high quality services and meet the needs of the children and families in their communities. Some of the needed systemic supports to the child welfare system will require new legislation, additional financial resources, or effective partnerships across sectors with intersecting responsibilities need careful consideration. The systemic supports identified in the needs assessment are summarized below:

- **The “political will” to make substantial short term investments in order to achieve long term cost savings.** Programs and approaches known to help families and reduce the need for out of home placement in the short term have demonstrable long term impacts of reducing public dollar costs associated with homelessness, juvenile and adult criminal behavior, use of public resources, and unemployment.
- **Policy changes at the legislative level to support needed changes at the administrative and service delivery level.** Laws are needed that support a service delivery system that customizes the use of resources to each family or child’s needs and promotes decisions based on multiple options.
- **Acknowledging the state’s responsibility to protect not only the safety and health of children, but also their overall well-being and developmental functioning.** Including overall well-being and developmental functioning as a top priority of the child welfare system is needed in order to inform both policy makers and practitioners when and in what manner the state needs to intervene.
- **Community partnerships within and across systems that link resources together and provide seamless delivery of service and support to families and children.** In Michigan, as in many states, there is the need for integration of services and sharing of information across systems such as the courts, schools, public assistance and mental health. In order for such a collaborative approach to succeed, communication channels need to be open and responsive across systems, relationships at all levels within and among different organizations must be based on trust and mutual respect, and

mechanisms must be in place to resolve tension and conflict when it does occur in productive, supportive ways.

- **Staffing, training and administrative support that allows caseloads to remain at reasonable levels, promotes consistent high quality, culturally competent service delivery, and reduces inefficiencies and redundancies.** Achieving the goals as expressed in Michigan’s Child Welfare Philosophy and the settlement agreement requires a knowledgeable and adequately trained workforce in both the public and private sectors.
- **Providing adequate education and support to birth parents, foster parents, adoptive parents and kinship caregivers.** Regardless of where the child is living, the caregiver needs adequate training and support to provide for that child’s care and well-being.

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## **Appendix 2: Program Descriptions**

### ***Children's Trust Fund***

The Children's Trust Fund serves as a voice for Michigan's children and families and promotes their health, safety, and welfare by funding effective local programs and services that prevent child abuse and neglect.

### ***Community grants***

Community grants allow local councils to develop and fund programs based on the need of the community. A few examples of the programs funded are the Detroit Parent Network, Wayne County's The Loving Children Project, Wayne County's Bright Stars Early Childhood Prevention Program, Kent County's The Kids Have Rights: Your Body Belongs to You, and Traverse County's Teen Parent Training

### ***Circle of Parents***

This is a national network of mutual support and self-help programs in partnership with communities.

***Families with Children Age Zero to Three(0 – 3)*** is a statewide, evidence-based, community collaborative child abuse & neglect prevention initiative administered by the Children's Trust Fund charged with integrating a comprehensive system of services designed to promote strong, nurturing families and to prevent child abuse and neglect for families with children from birth to three years of age.

- Funding is \$6.6 m in FY 09
- CTF provided 35 grants covering 47 counties with Zero to Three funding
- FY 2008
- 140,612 prevention services delivered (47 counties)
- 99.41% of children served did not have CPS involvement prior to receiving services
- 99.86% of children that completed services did not have CPS involvement as of 9/08
- Fund source: DHS, DCH. And MDE -
- Target population: CPS categories IV and V families with children aged newborn to 3

### ***Family Resource Centers***

The Family Resource Centers are DHS service centers placed within schools to coordinate services according to the goals developed and shared by the family, community, school and other agencies involved. These centers serve as a "one stop shop" for family services located within or near a neighborhood school. Currently, there are 54 Family Resource Centers statewide.

Expected outcomes of the program include: (1) improved academic performance; (2) increased parental involvement; (3) decreased absenteeism; and (4) decreased behavior problems.

- Fund source: TANF
- Target population: Low income families with children in elementary/middle schools

### ***Public Assistance Programs***

***Family Independence Program (FIP)*** is Michigan's public assistance (welfare) program, providing cash assistance to families meeting income and eligibility requirements. Together, DHS and the Michigan Department of Labor & Economic Growth administer the Jobs, Education & Training (JET) program, helping FIP clients achieve self-sufficiency by assessing work readiness, overcoming barriers to employment, and providing the education, training, and supports necessary to obtain and sustain employment. Funding is both state and federal.

- Fund source: Federal TANF – State GF
- Target population: Families with little or no income

***Food Assistance Program (FAP)*** provides benefits to eligible low-income families and individuals to raise food purchasing power and help improve nutritional health. Benefits are 100 percent federally funded and administrative costs are shared equally between the state and the federal governments.

- Fund source: Federal
- Target population: Low income families or individuals

***State Emergency Relief (SER)*** provides temporary financial help to needy persons faced with emergency situations that (1) threaten health and safety, and (2) can be resolved with the SER payment. Payments are made for the minimum amount necessary to resolve the emergency. The program is funded with both state and federal funds.

- Fund source: State GF
- Target population: Low income families

***Low Income Home Energy Assistance Program (LIHEAP)*** provides assistance to disadvantaged households in meeting the costs of energy. Assistance can be through Michigan's Home Heating Tax Credit, crisis assistance payments for those facing energy emergencies, and energy related home repair.

- Fund source: Federal funds and State GF
- Target population: Low income families

***WIC*** provides Federal grants to States for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk

- Fund Source: Federal FNS
- Target population: Low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five

### ***Physical health / mental health / dental care***

***Medicaid*** provides medical assistance to individuals and families who meet the financial and non-financial eligibility factors. The goal of the program is to ensure essential health care services for those who otherwise could not afford them.

- Fund Source: Federal and State GF
- Target population: Low income families and individuals

Healthy Kids provides a wide range of health care coverage and support services.

- Fund Source: Federal and State GF
- Target population: Low income pregnant women, babies and children under age 19

***MiChild*** is a health insurance program. It is for uninsured children of Michigan's working families. Services are provided by many HMOs and other health care plans throughout Michigan.

- Fund Source: Federal and State GF
- Target population: Uninsured children of Michigan's working families

***Maternal and Infant Health Program*** services are specialized preventive services provided to help reduce infant deaths and illnesses. Qualified health plans (QHPs) are required to provide Maternal and Infant Health Program services to their members when they are determined to be medically necessary. Maternal and Infant Health Program services may require prior authorization from a QHP or its providers.

- Target population: Low income pregnant women, mothers, and their infants

### ***Early ON***

Early On is a collaborative system of services designed for children birth to age three who have a developmental delay or an existing condition that may result in a developmental delay. Early On is a family-focused process, with emphasis on family strengths and abilities, which requires the development of an individualized family service plan specific to each enrolled family, based on the findings of a multidisciplinary evaluation of the child and family. Available services include assistive technology device; audiology; family training, counseling, and home visits; health services; medical services; nursing services; nutrition services; occupational therapy; physical therapy; psychological services; service coordination services; social work services; special instruction; speech-language pathology; transportation and related costs; and vision services.

- Fund source: Part C of the Individuals with Disabilities Education Act (IDEA)
- Target population: Children birth to age three who have a developmental delay or an existing condition that may result in a developmental delay

### ***Before and After School Programs***

Before and After-School program (BA) funds provide kindergarten through ninth grade youth with a safe, engaging environment to motivate and inspire learning outside the traditional classroom setting. Funding is intended to offer quality before- and after-school programs that provide youth with programs that combine academic, enrichment, and recreation activities to guide learning and inspire children and youth in various activities. Each program shall include parental involvement and at least three of the following topics: (1) Pregnancy prevention ; (2) Non-medical services provided to address chemical abuse and dependency; (3) Gang violence prevention ; (4) Academic assistance, must include assistance with reading and writing; (4) Preparation toward future self-sufficiency, (5) Leadership development ; (6) Case management or mentoring ; or (7) Anger management.

- Fund source: TANF
- Target population: low-income (under 200% poverty) school-aged children that are in kindergarten through ninth grade.

### ***Family Group Decision Making (FGDM)***

FGDM is a program to protect children at risk of abuse and neglect in a culturally sensitive and family-centered way. FGDM assists families involved in abuse and neglect cases to create written plans to increase safety for the children within their family network.

- Target population: CPS categories III-IV-V

### ***Families First of Michigan***

Families First of Michigan (FFM) is an intensive home-based intervention designed to protect children by strengthening families. The purpose is to keep families with risk factors safely intact and avoid the high costs of out-of-home placement by safely removing crises, not children, and helping families make positive lasting changes. The program provides intensive, short-term services which combine both clinical services and services such as transportation, housing and access to other family necessities that are provided in the home. Caseworkers counsel only two families at a time, allowing them to be available to help a family 24 hours a day, 7 days a week for up to six weeks.

- Flexible funds (\$300 per family) for basic needs expenses to help the family (e.g. utility bills when SER isn't available, first month's rent, food, furniture, etc.)
- Evaluation was conducted to determine if the 4 week contract period was adequate to address family needs. It determined that yes, 4 weeks was adequate in most cases and the 2 week extension was appropriate.
- Families First appropriations endured cuts from FY 99 to FY 02. The program hasn't had an increase in appropriations since FY 98.
- Families First is the only true preservation/reunification program available in all 83 counties.
- Target population: At risk families on the verge of having a child removed from the home due to abuse, neglect or delinquency or as a result of domestic violence CPS categories II-III
- Funding Source

### ***Community Based Services – Local Office Contracts***

Community based services are services purchased by local DHS offices from funds allocated by Central Office. The decision as to which services are to be purchased is often made in collaboration with local partners based on community assessment. The services that may be purchased include:

- Parenting classes
- Counseling
- Anger Management
- Substance Abuse

While the same service may be purchased from multiple funding sources, the source of the funding determines the target population. The following 3 programs are specifically designed to meet the unique needs the targeted population of each community:

1. **Child Protection/Community Partners (CP/CP)** is a DHS initiated statewide collaborative effort that requires community collaboratives to plan and provide services to at-risk children and families that meet specific eligibility for low to moderate risk of child abuse or neglect.
  - Target population: CPS categories III - IV
2. **The Child Safety Permanency Plan (CSPP)** A Child Safety and Permanency Plan (CSPP) is required by DHS for safe, targeted and outcome driven community programs to increase responsibility and safe alternatives to out of home care. This fund source is for CPS category I and II cases. It provides funding for targeted, outcome driven, community-based programs to increase responsibility and safe alternatives to out-of-home placement for children and youth at risk of removal from their families.
  - Target population: CPS Category II and III
3. **Strong Families / Safe Children** is an initiative for the planning and delivery of federally mandated community-based family support, family preservation, time-limited reunification, and adoption promotion and support services. Specific services are based on an assessment of local needs by Community Collaborative groups focusing on keeping children safe within their home (when appropriate), and prevent the unnecessary separation of families. The four purposes of SFSC is to: (1) prevent child maltreatment; (2) promote family strength and stability; (3) return children in care to their families in a safe and timely manner or provide permanent alternatives for children who cannot return home safely; and (4) promote and support more adoptions out of the foster care system and help adoptive families maintain permanency.
  - Target population: At-risk families with children and families with children who have been removed from the home

### ***Wraparound***

Wraparound is a service planning and delivery approach which brings all agencies and involved with a family to one table with the family to develop a plan to meet their needs without redundancy. Each agency's involvement is well defined and everyone is kept abreast of what everyone else is doing. DHS services are then delivered through local office contracts.

- The Human Service Collaborative Body determines what population to target (differs from county to county)
  - All services delivery is driven by child/family needs
  - Provides ongoing case planning and stabilization
- Multiple fund sources make up Wraparound contracts
- Not currently a prescribed model
  - Solely community driven
  - Counties don't use standardized forms so info is difficult to track
  - Can be used in any stage of case (prevention, reunification, placement, adoption)

### **Children's Protective Services (CPS)**

Children's Protective Services (CPS) investigates allegations of non-accidental harm or threatened harm to a child's health or welfare by a parent, legal guardian, or any other person

responsible for the child's health or welfare, or a member of the clergy. CPS assesses the safety of all children in the household and initiates actions needed to protect them.

**Figure 51: CPS Caseload Trends**

	2004	2005	2006	2007	2008
Complaints received	135,775	128,854	126,690	123,149	124,716
Total Investigated	76,694	72,286	71,784	77,012	72,418
Substantiated	17,847	16,889	17,534	18,893	17,630

Five categories for disposition are determined by a combination of evidence, risk level and/or safety assessment.

**Category I:** A court petition is required because a child is unsafe or a petition is mandated in the law for another reason. The perpetrator is listed on Central Registry.

**Category II:** There is a preponderance of evidence that abuse or neglect occurred and the initial risk level is high or intensive. CPS must open a services case and the perpetrator is listed on Central Registry.

**Category III:** There is a preponderance of evidence that abuse or neglect occurred and the initial risk level is low or moderate. CPS must assist the family in voluntarily participating in community-based services. The perpetrator is not listed on Central Registry.

**Category IV:** There is not a preponderance of evidence that abuse or neglect occurred. CPS is to assist the family in accessing community-based services.

**Category V:** There is no evidence that abuse or neglect occurred (e.g., a false complaint; no basis in fact). No action beyond the investigation is required by CPS.

- Target population: Families with allegations of child abuse and/or neglect

### ***Children's Foster Care***

Children's Foster Care provides placement, supervision, and permanency planning for children who are temporary or permanent court or state wards. The department's first priority is to provide services that will keep children safe in their own homes when that is possible. When children must come into the foster care system to ensure their safety, the department works with families and community partners in a team approach to safety planning, and make every effort to keep the child with relatives or others who have existing relationships with the children, near family and schools, and together with siblings. The department makes every effort to assure that no child leaves the foster care system without a permanent attachment to a loving adult, through adoption, guardianship, or other permanent connection. Foster care services are provided through a partnership between DHS and private non-profit licensed child placing agencies.

- Fund source: Federal and State GF
- Target population: Children who have been removed from their homes because of child abuse or neglect and would continue to be at risk if not removed

### ***Reunification services***

Family Reunification Program (FRP) directly supports the DHS and purchase of services foster care programs. FRP provides an array of intensive, in-home services to enable an earlier return home for children placed in out-of-home settings.

### ***Youth in Transition (YIT)***

YIT is a funding source available to eligible foster youths or youths exiting the foster care system. These funds can be used to pay for educational needs, job training, independent living skills training, self-esteem counseling, and other supports to equip teens with the skills necessary to function as successful adults.

### ***Services for foster parents***

Local offices receive funding for recruitment and retention efforts, including recognition events.

### ***Adoption Services***

The goal of Michigan's Adoption Services Program is to find permanent adoptive placements for foster children as soon as possible following termination of parental rights. Whenever possible, these adoptive placements are with families that have existing relationships or attachments to the children, and where it is possible to keep siblings together. The DHS Adoption Program is responsible for the Central Adoption Registry, which maintains statements from birth parents consenting to or denying access to identifying information in adoption records.

Adoptions have been declining or relatively flat since reaching a high of 2,927 in FY 2001. That was the last year DHS earned Federal Adoption Incentive Funds which funded the regional Post-Adoption Service Centers to assist adoptive families

### ***Subsidized Guardianship***

Fund source: Federal and GF

Target population: Children whose parents have had their parental rights terminated due to child abuse or neglect

### ***Youth Services***

***The Runaway and Homeless Youth Services Program*** provides services to runaway and homeless youths, and when appropriate, to their families. Services are provided through contracts with private agencies.

***The Teen Parent Program*** provides comprehensive coordinated services to teen parents in 18 counties to assist in meeting the health and developmental needs of their children. Education, training, and employment services are provided to enhance teen parents' capacity to independently provide for themselves and their children.

***Educational Training Vouchers (ETVs)*** are scholarships awarded to eligible youths and youths were adopted out of the abuse/neglect/foster care system after their 16th birthday. These awards provide up to \$5,000 per year for costs related to attendance at accredited post-secondary educational programs or training.

### ***Juvenile Justice***

The Juvenile Justice program has responsibility for youths between the ages of 12 and 21 who have violated the law and are committed to DHS by the court. Based on an assessment of each youth and their need for security, they are placed in either community-based settings, a private residential facility or a DHS operated residential facility. Funding is both state and federal.

**Figure 52: Juvenile Justice Caseload Trends**

	2004	2005	2006	2007	2008
Out-of-Home	1,188	1,053	934	770	604
Relative	71	55	67	71	53
Own Home /Legal Guardian	388	343	283	302	271
Other	122	126	87	86	72
Total	1,769	1,577	1,371	1,229	1,000

***Services For Post-Adopt Children And Families To Keep Placement Intact  
Adoption Subsidy***

The Adoption Subsidy program provides financial support and/or medical subsidy to adoptive families to support the placement of children in Michigan's foster care program who have special needs. Medical subsidy assists adoptive parents covering the costs of necessary treatment for a physical, mental or emotional condition which existed (or the cause of which existed) prior to the adoption.

**Figure 53: Adoption Subsidy Caseload Trends**

	9/2004	9/2005	9/2006	2007	2008
Point in time adoption subsidy cases - total	23,984	25,029	25,840	26,652	27,021

- Fund source: programs are funded with a combination of federal and state dollars.
- Target population: Adoptive children with special needs

***Medical Subsidy***

This program is available to children for who adoption subsidies are paid. It covers costs of health-related services not available through other sources. The expenses to be covered by the medical subsidy are necessary because of an identified physical, mental, or emotional condition of the child which existed, or the cause of which existed, before the adoption petition was filed.

- Fund source: programs are funded with a combination of federal and state dollars.
- Target population: Adoptive children with special Needs

## Appendix 3: Michigan Child Welfare Demographics

**National Comparisons:** National Data Analysis System statistics indicate that, while nationally the number of substantiated victims of abuse or neglect declined by 1% between 2000 and 2006, the number of victims of neglect and abuse in Michigan rose 2 %, from 26,280 to 27,148.

Of the 5 states of similar child population to Michigan, in 2006 Michigan investigated significantly more cases, but had only about the average number of victims per 1,000 as the others. Michigan also led these states in the number of children per 1,000 in care.

**Figure 54: National Comparisons with Selected States**

	Investigations per 1,000 Child Population	Child Victims per 1,000 Child Population	Children in Care per 1,000 Child Population
Michigan	75.4	11.0	8.1
Georgia	57.9	16.2	5.4
Illinois	45.3	8.6	5.7
New Jersey	22.6	5.6	5.1
North Carolina	60.8	13.2	5.2
Ohio	41.9	15.0	6.0
National Average	49.1	11.5	7.7

**State Comparisons:** Disparities also exist within the state between overall averages and averages in the Urban 5 Counties. In all categories the Urban 5 counties have the fewest resources, the more children in care, longer length of time in care and a lower capacity of foster homes

Based on data provided by the Department of Human Services, the total number of children in foster care in Michigan as of April 2009 was 17,179, an average of 7.0 per 1,000 child population. For the Urban 5 counties, that average is 7.8 per 1,000 child population.

- The state's *mean time in placement* of children in care in April 2009 was 2.21 years. In the Urban 5 counties, the means ranged from a low of 1.7 in both Kent and Macomb Counties, to 3.11 years in Wayne County.
- State wide the percentage of children in care *less than 3 years* is 78.0%. In the Urban 5 counties that is 73.12%, as low as 66.5% in Wayne County
- State wide, fewer than 1.0% of the children in care have been in care for *more than 12 years*, while in the 5 Urban Counties, 1.6% have been in care over 12 years.

The 2008 *state allocation* of dollars for CPCP, CSPP, and SFSC was a combined \$33,801,402, an average of \$13,814 per 1,000 child population.

- In the Urban 5, that average is \$8,384.
- The average state allocation per child in care is \$1,969. In the Urban 5, the average is \$1,081.

Foster home capacity varies significantly from county to county.

- State wide there are 0.97 beds for every court ward in care. In the Urban 5 counties, that number is 0.70

State wide there are 1.46 beds for those whose living arrangement is out of home, in the Urban 5 there are 1.09 beds for those out of home.

**Figure 55: State Data**

ESTIMATED 2007 CHILD POPULATION	Under 5	Age 5-13	Age 14-17	Total
	633,017	1,208,248	605,591	2,446,856

2007 Estimates Source: US Census Data

CHILD PROTECTIVE SERVICES	# Investigations	Total Substantiations	Category I Dispositions	Category II Dispositions	Category III Dispositions	Category IV Dispositions	Category V Dispositions
Number	72,418	17,630	5,253	4,836	7,371	46,761	7,820
Per 1,000 Child Population	30	7	2	2	3	19	3

FY 2008 Data Source: DHS Administrative Data

COMMUNITY BASED AND HOME SERVICES	2008 Allocation	Average per 1,000 Child Population	Monthly Average Per Child in Care	Average per Substantiation	Average per Category III- IV	Average per Category II & III	Monthly Average per Foster Care Entry
CPCP III - IV	\$5,319,400	\$2,173.97	\$309.65	\$301.72	\$98.27	NA	\$548.28
CSPP II - III	\$15,086,700	\$6,165.75	\$878.21	\$855.74	NA	\$1,235.91	\$1,555.01
SFSC	\$13,395,300	\$5,474.49	\$779.75	\$759.80	\$247.46	\$1,097.35	\$1,380.67
Total	\$33,801,400	\$13,814.22	\$1,967.60	\$1,917.27	\$624.43	\$2,769.02	\$3,483.96

FY 2008 Allocations Source: L-07-051 & L-07-141

SUBSTANCE ABUSE SERVICES FOR CHILD WELFARE INVOLVED PERSONS	Total	Under 12	17-Dec	18-25	26+
Outpatient	2,127	29	97	681	1,320
Detox	171	0	0	56	115
Short Term Residential	264	9	9	74	172
Long Term Residential	185	7	6	36	136
Intensive Outpatient	439	0	7	111	321
Case Management	4	0	1	3	0
Total	3,190	45	120	961	2,064

4/2009 Data Source: DCH Administrative Data

FOSTER CARE FUNDING SOURCE	IV-E - 2008	*CCF - 2008	SWBC - 2008	Total
Total Expenditures	\$79,958,529	\$44,162,866	\$91,850,212	\$215,971,607
Average # Children / Month	4,082	3,012	4,258	11,352
Average Cost / Child / Month	\$1,632	\$1,222	\$1,798	\$1,585
Ave cost / Child / Day	\$54.41	\$40.69	\$59.92	\$52.85

2008 Data Source: DHS Annual Report / Annual 2008 CCF Report

\* CCF figures are for FFC only-not institutions or in home

FOSTER CARE PLACEMENTS					
Average Entries per Month	9,702	Total in Care (4/2009)	17,179	*Average Monthly # in Paid Care	11,352
Per 1,000	3.97	Per 1,000	7.02	Per 1,000	4.64

FY 2008 Data Source: DHS Administrative Data

\* 2008 Data Source: DHS Annual Report / Annual 2008 CCF Report

CAPACITY					
# FC Beds	16,613				
# Beds per Child in Care	0.97	# Beds per Child in Paid Care	1.46	AFCRR Allocation	\$1,030,000

FY 2008 Data Source: DHS Administrative / FY 2008 Allocations Source: L-07-051 & L-07-141

TIME IN CARE)									
Years	0-2.99	2-5.99	6-8.99	9-11.99	12-14.99	15-17.99	18+	Maximum	Mean
% of Children	78.0%	14.4%	4.6%	2.0%	0.8%	0.2%	0.0%	19.4849	2.219176

April 2009 Data Source: DSA Administrative Data

FOSTER CARE - SIBLING GROUP SIZE	All Court Wards		Permanent Court Wards	
	Number Groups	Number Children	Number Groups	Number Children
One	6,353	6,353	2,243	2,243
Two	2,107	4,214	540	1,080
Three	983	2,949	176	528
Four	485	1,940	66	264
Five	192	960	29	145
Six	62	372	10	60
Seven	22	154	2	14
Eight	19	152	0	0
Nine	6	54	1	9
Ten	2	20	0	0
Eleven	1	11	0	0
Total		17,179		4,343

April 2009 Data Source: DCH Administrative Data

LICENSED FOSTER HOMES	# Homes	Capacity	Children in care in Sibling Groups appropriate for homes
Family Foster Homes (1-4 Children)	6,034	14,814	14,476
Child Foster Group Homes (5-6 Children)	312	1,799	526
Sibling Groups 7+	0	0	391
Total	6,346	16,613	15,393

4/2009 Data Source: Office of Children and Adult Licensing

**Urban 5 County Comparisons:** Data on the following pages illustrate the disparities between the Urban 5 Counties and the state, as well as the disparities amongst themselves.

Census data is the most recent estimate by the Census Bureau (2007). DHS data was collected from a number of DHS reports as well as additional administrative data provided by the DHS or DCH. Specific data sources are noted with each chart. Comparisons are for either FY 2008 or for point in time in April 2009. Comparisons were made based on data per 1,000 child population, or on children in care, children in paid care, or CPS data.

Of particular note is the disparity between Wayne County and the state as a whole and other Urban 5 county. The total resources in Wayne per 1,000 child population is \$825, while as across the state those resources exceed \$1,900 per 1,000 child population.

The disparities among these counties are best summarized as follows.

**Figure 56: Urban 5 Totals**

**COMMUNITY BASED SERVICES**

County	CPCP per child in care	CSPP per child in care	SFSC per child in care	Total per child in care
State average	\$310	\$878	\$780	\$1,968
Urban 5 county average	\$130	\$621	\$330	\$1,081
Wayne County	\$53	\$466	\$306	\$825
Genesee County	\$202	\$680	\$311	\$1,193
Macomb County	\$195	\$698	\$321	\$1,214
Oakland County	\$232	859	\$374	\$1,465
Kent County	229	\$966	\$437	\$1,632

**CHILDREN IN CARE**

County	Total in Care Per 1,000 Child Population	In Paid Care Per 1,000 Child Population	Mean time in Care (Years)
State average	7.02	4.64	2.219
Urban 5 county average	7.76	5.00	NA
Wayne County	9.87	6.27	3.113
Genesee County	11.54	9.26	2.452
Oakland County	4.52	2.24	1.908
Kent County	5.79	4.76	1.711
Macomb County	6.32	3.39	1.707

**FOSTER HOME CAPACITY**

County	Beds per ALL Children In Care	Beds per Children In PAID Care
State average	0.97	1.46
Urban 5 county average	0.70	1.09
Wayne County	0.61	0.96
Genesee County	0.80	1.00
Macomb County	0.60	1.10
Kent County	1.18	1.43
Oakland County	0.70	1.50

## TOTAL URBAN 5 COUNTY DATA

ESTIMATED 2007 CHILD POPULATION	Under 5	Age 5-13	Age 14-17	Total
	333,891	638,333	316,932	1,289,156
% of State Child Population	53%	53%	52%	53%

2007 Estimates Source: US Census Data

COMMUNITY BASED AND HOME SERVICES	2008 Allocation	Average per 1,000 Child Population	Monthly Average Per Child in Care
CPCP III - IV	\$1,299,098	\$1,007.71	\$206.88
CSPP II - III	\$6,209,637	\$4,816.82	\$988.87
SFSC	\$2,300,154	\$1,784.23	\$366.30
Total	\$9,808,889	\$7,608.77	\$1,562.05
State Total	\$33,801,400	\$13,814.22	\$1,967.60

FY 2008 Allocations Source: L-07-051 & L-07-141

SUBSTANCE ABUSE SERVICES FOR CHILD WELFARE INVOLVED PERSONS	Total	Under 12	15-17	18-25	26+
Outpatient	746	25	21	203	497
Detox	40	0	2	9	29
Short Term residential	84	0	5	15	64
Long Term residential	97	0	0	16	81
Intensive Outpatient	179	0	2	46	131
Case management	186	0	0	0	186
Total	1332	25	30	289	988

Data 4/2009 Source: DCH Administrative Data

FOSTER CARE FUNDING	IV-E - 2008	*CCF - 2008	SWBC - 2008	Total
Total Expenditures	\$40,496,610	\$28,395,749	\$53,271,758	\$244,328,234
Average # Children / month	1,813	1,954	2,513	12,560
Average Cost / Child / Month	\$1,861	\$1,211	\$1,767	\$1,621
Ave Cost / Child / Day	\$62.05	\$40.37	\$58.88	\$54.04

2008 Data Source: DHS Annual Report / Annual 2008 CCF Report

\* CCF figures are for FFC only-not institutions or in home

FOSTER CARE PLACEMENTS			
Total in Care (4/2009)	10,003	*Average Monthly # in Paid Care	6,444
Per 1,000	7.76	Per 1,000	5.00
State/1,000	7.02	State/1,000	4.64

FY 2008 Data Source: DHS Administrative Data

\* 2008 Data Source: DHS Annual Report / Annual 2008 CCF Report

CAPACITY					
# FC Beds	7,037				
# Beds per Child in Care	0.70	# Beds per Child in Paid Care	1.09	AFCRR Allocation	\$239,626
State / 1,000	0.97	State / 1,000	1.46	% of State	23%

FY 2008 Data Source: DHS Administrative / FY 2008 Allocations Source: L-07-051 & L-07-141

TIME IN CARE									
Years	0-2.99	2-5.99	6-8.99	9-11.99	12-14.99	15-17.99	18+	Maximum	Mean
% of youth	73.12%	16.59%	5.73%	3.00%	1.23%	0.28%	0.06%		
State percentage	78.00%	14.39%	4.63%	1.99%	0.79%	0.16%	0.03%	19.4849	2.219176

April 2009 Data Source: DSA Administrative Data

FOSTER CARE - SIBLING GROUP SIZE	All Court Wards		Permanent Court Wards	
	Number Groups	Number Children	Number Groups	Number Children
One	3,766	3,766	1,366	1,366
Two	1,157	2,314	332	664
Three	553	1,659	108	324
Four	264	1,056	36	144
Five	125	625	20	100
Six	42	252	6	36
Seven	19	142	2	14
Eight	16	112	0	0
Nine	5	45	1	9
Ten	2	20	2	20
Eleven	1	11	1	11
Total		10,002		2,688

April 2009 Data Source: DCH Administrative Data

LICENSED FOSTER HOMES	# Homes	Capacity	Children in care in Sibling Groups appropriate for homes
Family Foster Homes (1-4 Children)	2,723	6,325	8,795
Child Foster Group Homes (5-6 Children)	74	416	877
Sibling Groups 7+	0	0	330
Total	2,797	6,741	10,002

Data 4/2009 Office of Children and Adult Licensing

**Figure 57: Wayne County Data**

ESTIMATED 2007 CHILD POPULATION	Under 5	Age 5-13	Age 14-17	Total
		134,879	259,149	135,307
% of Urban 5 Child Population	40%	41%	43%	41%
% of State Child Population	21%	21%	22%	22%

2007 Estimates Source: US Census Data

COMMUNITY BASED AND HOME SERVICES	2008 Allocation	Average per 1,000 Child Population	Monthly Average Per Child in Care
CPCP III - IV	\$1,299,098	\$1,007.71	\$206.88
CSPP II - III	\$6,209,637	\$4,816.82	\$988.87
SFSC	\$2,300,154	\$1,784.23	\$366.30
<b>Total</b>	<b>\$4,309,425.00</b>	<b>\$8,141.21</b>	<b>\$824.93</b>
<b>Urban Total</b>		<b>\$7,608.77</b>	<b>\$1,562.05</b>
<b>State Total</b>		<b>\$29.00</b>	<b>\$97.00</b>

FY 2008 Allocations Source: L-07-051 & L-07-141

SUBSTANCE ABUSE SERVICES FOR CHILD WELFARE INVOLVED PERSONS	Total	Under 12	17-Dec	18-25	26+
Outpatient	256	6	4	69	177
Detox	28	0	0	6	22
Short Term Residential	40	0	3	7	30
Long Term Residential	49	0	0	10	39
Intensive Outpatient	109	0	2	24	83
Case management	186	0	0	0	186
<b>Total</b>	<b>668</b>	<b>6</b>	<b>9</b>	<b>116</b>	<b>537</b>

4/2009 Data Source: DCH Administrative Data

FOSTER CARE FUNDING	IV-E	*CCF	SWBC	Total
Total Expenditures	\$17,173,003	\$16,580,811.52	\$26,502,456	\$60,256,270
Average # Children / Month	700	1,252	1,365	3,317
Average Cost / Child / Month	\$2,044	\$1,104	\$1,618	\$1,514
Ave cost / Child / Day	\$68.15	\$36.78	\$53.93	\$50.46

2008 Data Source: DHS Annual Report / Annual 2008 CCF Report

\* CCF figures are for FFC only-not institutions or in home

FOSTER CARE PLACEMENTS			
Total in Care (4/2009)	5,224	*Average Monthly # in Paid Care	3,317
Per 1,000	9.87	Per 1,000	6.27
Urban 5 / 1,000	7.76	Urban 5 / 1,000	5.00
State / 1,000	7.02	State / 1,000	4.64

FY 2008 Data Source: DHS Administrative Data

\* 2008 Data Source: DHS Annual Report / Annual 2008 CCF Report

CAPACITY	
# FC Beds	3,172

# Beds per Child in Care	0.61	# Beds per Child in Paid Care	0.96	AFCRR Allocation	\$41,998
Urban 5 /Child	0.70	Urban 5 /Child	1.09	% of Urban	17.53%
State / Child	0.97	State / Child	1.46	% of State	4.08%

FY 2008 Data Source: DHS Administrative / FY 2008 Allocations Source: L-07-051 & L-07-141

TIME IN CARE									
Years	0-2.99	2-5.99	6-8.99	9-11.99	12-14.99	15-17.99	18+	Maximum	Mean
Percentage of youth	66.50%	18.45%	7.52%	4.67%	2.20%	0.54%	0.11%	19.4849	3.113302
Urban 5 Percentage	73.12%	16.59%	5.73%	3.00%	1.23%	0.28%	0.06%	NA	NA
State Percentage	78.00%	14.39%	4.63%	1.99%	0.79%	0.16%	0.03%	19.4849	2.219176

April 2009 Data Source: DSA Administrative Data

FOSTER CARE - SIBLING GROUP SIZE	All Court Wards		Permanent Court Wards	
	Number Groups	Number Children	Number Groups	Number Children
One	2,027	2,027	774	774
Two	567	1,134	183	366
Three	274	822	47	141
Four	128	512	24	96
Five	67	335	10	50
Six	26	156	4	24
Seven	11	77	1	7
Eight	11	88	0	0
Nine	5	45	1	9
Ten	2	20	2	20
Eleven	1	11	1	11
<b>Total</b>		<b>5,227</b>		<b>1,498</b>

April 2009 Data Source: DCH Administrative Data

LICENSED FOSTER HOMES	# Homes	Capacity	Children in care in Sibling Groups appropriate for homes
Family Foster Homes (1-4 Children)	1,307	3,049	4,495
Child Foster Group Homes (5-6 Children)	22	123	491
Sibling Groups 7+	0	0	241
<b>Total</b>	<b>1,329</b>	<b>3,172</b>	<b>5,227</b>

4/2009 Data Source: Office of Children and Adult Licensing

**Figure 58: Oakland County Date**

ESTIMATED 2007 CHILD POPULATION	Under 5	Age 5-13	Age 14-17	Total
	72,588	145,586	70,778	288,952
% of Urban 5 Child Population	22%	23%	22%	22%
% of State Child Population	11%	12%	12%	12%

2007 Estimates Source: US Census Data

COMMUNITY BASED AND HOME SERVICES	2008 Allocations	Per 1,000 Child Population	Average per child in care per month
CPCP III - IV	\$302,287	\$1,046.15	\$231.64
CSPP II - III	\$1,120,667	\$3,878.38	\$858.75
SFSC	\$ 487,897	\$1,688.51	\$373.87
<b>Total</b>	<b>\$1,910,851.00</b>	<b>\$6,613.04</b>	<b>\$1,464.25</b>
<b>Urban</b>		<b>\$7,608.77</b>	<b>\$1,562.05</b>
<b>State</b>		<b>\$13,814.22</b>	<b>\$1,967.60</b>

FY 2008 Allocations Source: L-07-051 & L-07-141

SUBSTANCE ABUSE SERVICES FOR CHILD WELFARE INVOLVED PERSONS	Total	Under 12	13-15	18-25	26+
Outpatient	107	0	3	34	70
Detox	6	0	2	1	3
Short Term Residential	18	0	1	2	15
Long Term Residential	1	0	0	0	1
Intensive Outpatient	22	0	0	6	16
Case Management	0	0	0	0	0
<b>Total</b>	<b>154</b>	<b>0</b>	<b>6</b>	<b>43</b>	<b>105</b>

4/2009 Data Source: DCH Administrative Data

FOSTER CARE FUNDING	IV-E	*CCF	SWBC	Total
Total Expenditures	\$6,152,588	\$2,349,212.84	\$9,026,559	\$17,528,359
Average # Children / month	261	84	303	648
Average Cost / Child / Month	\$1,964	\$2,335	\$2,483	\$2,254
Ave Cost / Child / Day	\$65.48	\$77.84	\$82.75	\$75.14

2008 Data Source: DHS Annual Report / Annual 2008 CCF Report

\* CCF figures are for FFC only-not institutions or in home

FOSTER CARE PLACEMENTS			
Total in Care (4/2009)	1,305	*Average Monthly # in Paid Care	648
Per 1,000	4.52	Per 1,000	2.24
Urban 5 / 1,000	7.76	Urban 5 / 1,000	5.00
State / 1,000	7.02	State / 1,000	4.64

FY 2008 Data Source: DHS Administrative Data

\* 2008 Data Source: DHS Annual Report / Annual 2008 CCF Report

**CAPACITY**

# FC Beds	969				
# Beds per Child in Care	0.7	# Beds per Child in Paid Care	1.5	AFCRR Allocation	\$41,998
Urban 5 / Child	0.7	Urban 5 /Child	1.09	% of Urban	17.53%
State / Child	0.97	State/Child	1.46	% of State	4.08%

FY 2008 Data Source: DHS Administrative / FY 2008 Allocations Source: L-07-051 & L-07-141

TIME IN CARE									
	0-2.99	2-5.99	6-8.99	9-11.99	12-14.99	15-17.99	18+	Maximum	Mean
Percentage of Youth	80.69%	14.48%	3.14%	1.38%	0.31%	0.00%	0.00%	13.5918	1.90824
Urban 5 Percentage	73.12%	16.59%	5.73%	3.00%	1.23%	0.28%	0.06%	NA	NA
State Percentage	78.00%	14.39%	4.63%	1.99%	0.79%	0.16%	0.03%	19.4849	2.219176

April 2009 Data Source: DSA Administrative Data

FOSTER CARE - SIBLING GROUP SIZE	All Court Wards		Permanent Court Wards	
	Number Groups	Number Children	Number Groups	Number Children
One	456	456	158	158
Two	161	322	37	74
Three	77	231	17	51
Four	38	152	1	4
Five	17	85	2	10
Six	6	36	1	6
Seven	1	16	0	0
Eight	2	0	0	0
Nine	0	0	0	0
Ten	0	0	0	0
Eleven	0	0	0	0
Total		1,298		303

April 2009 Data Source: DCH Administrative Data

LICENSED FOSTER HOMES (point in time - 4/09)	# Homes	Capacity	Children in care in Sibling Groups appropriate for homes
Family Foster Homes (1-4 Children)	384	897	1,161
Child Foster Group Homes (5-6 Children)	13	72	121
Sibling Groups 7+	0	0	16
Total	397	969	1,298

4/2009 Data Source: Office of Children and Adult Licensing

**Figure 59: Kent County Data**

ESTIMATED 2007 CHILD POPULATION	Under 5	Age 5-13	Age 14-17	Total
	46,484	80,698	37,107	164,289
% of Urban 5	14%	13%	12%	13%
% of State Child Population	7%	7%	6%	7%

2007 Estimates Source: US Census Data

COMMUNITY BASED AND HOME SERVICES	2008 Allocations	Per 1,000 Child Population	Average per child in care per month
CPCP III - IV	\$ 217,736	\$1,325.32	\$228.95
CSPP II - III	\$ 918,596	\$5,591.34	\$965.93
SFSC	\$ 416,019	\$2,532.24	\$437.45
<b>Total</b>	<b>\$1,552,351.00</b>	<b>\$9,448.90</b>	<b>\$1,632.34</b>
Urban		\$7,608.77	\$1,562.05
State		\$13,814.22	\$1,967.60

FY 2008 Allocations Source: L-07-051 & L-07-141

SUBSTANCE ABUSE SERVICES FOR CHILD WELFARE INVOLVED PERSONS	Total	Under 12	13-17	18-25	26+
Outpatient	37	0	0	16	21
Detox	4	0	0	1	3
Short Term residential	3	0	0	0	3
Long Term residential	3	0	0	1	2
Intensive Outpatient	10	0	0	1	9
Case management	0	0	0	0	0
<b>Total</b>	<b>57</b>	<b>0</b>	<b>0</b>	<b>19</b>	<b>38</b>

4/2009 Data Source: DCH Administrative Data

FUND SOURCE	IV-E	*CCF	SWBC	Total
Total Expenditures	\$6,045,882	\$6,038,006.76	\$3,744,423	\$15,828,311
Average # Children / month	277	357	147	782
Average Cost / Child / Month	\$1,819	\$1,408	\$2,123	\$1,687
Ave Cost / Child / Day	\$60.63	\$46.94	\$70.76	\$56.22

2008 Data Source: DHS Annual Report / Annual 2008 CCF Report

\* CCF figures are for FFC only-not institutions or in home

FOSTER CARE PLACEMENTS			
Total in Care (4/2009)	951	*Average Monthly # in Paid Care	782
Per 1,000	5.79	Per 1,000	4.76
Urban 5 / 1,000	7.76	Urban 5 / 1,000	5.00
State / 1,000	7.02	State / 1,000	4.64

FY 2008 Data Source: DHS Administrative Data

\* 2008 Data Source: DHS Annual Report / Annual 2008 CCF Report

**CAPACITY**

# FC Beds	1,118				
# Beds per Child in Care	1.18	# Beds per Child in Paid Care	1.43	AFCRR Allocation	\$8,379
Urban 5/ Child	0.70	Urban 5 / Child	1.09	% of Urban	3.50%
State / Child	0.97	State / Child	1.46	% of State	0.81%

FY 2008 Data Source: DHS Administrative / FY 2008 Allocations Source: L-07-051 & L-07-141

TIME IN CARE									
Years	0-2.99	2-5.99	6-8.99	9-11.99	12-14.99	15-17.99	18+	Maximum	Mean
Percentage of youth	84.96%	12.30%	2.42%	0.32%	0.00%	0.00%	0.00%	9.2795	1.711387
Urban 5 percentage	73.12%	16.59%	5.73%	3.00%	1.23%	0.28%	0.06%	NA	NA
State percentage	78.00%	14.39%	4.63%	1.99%	0.79%	0.16%	0.03%	19.4849	2.219176

April 2009 Data Source: DSA Administrative Data

FOSTER CARE - SIBLING GROUP SIZE	All Court Wards		Permanent Court Wards	
	Number Groups	Number Children	Number Groups	Number Children
One	404	404	81	81
Two	104	208	12	24
Three	54	162	4	12
Four	25	100	0	0
Five	12	60	1	5
Six	2	12	0	0
Seven	0	0	0	0
Eight	1	8	0	0
Nine	0	0	0	0
Ten	0	0	0	0
Eleven	0	0	0	0
Total		954		122

April 2009 Data Source: DCH Administrative Data

LICENSED FOSTER HOMES (point in time - 4/09)	# Homes	Capacity	Children in care in Sibling Groups appropriate for homes
Family Foster Homes (1-4 Children)	412	1,009	874
Child Foster Group Homes (5-6 Children)	19	109	72
Sibling Groups 7+	0	0	8
Total	431	1,118	954

4/2009 Data Source: Office of Children and Adult Licensing

**Figure 60: Genesee County Data**

ESTIMATED 2007 CHILD POPULATION	Under 5	Age 5-13	Age 14-17	Total
	29,778	54,876	27,378	112,032
% of Urban 5 Child Population	9%	9%	9%	9%
% of State Child Population	5%	5%	5%	5%

2007 Estimates Source: US Census Data

COMMUNITY BASED AND HOME SERVICES	2008 Allocations	Per 1,000 Child Population	Average per child in care per month
CPCP III - IV	\$261,436	\$493.90	\$202.19
CSPP II - III	\$879,842	\$1,662.16	\$680.47
SFSC	\$ 402,231	\$759.88	\$311.08
<b>Total</b>	<b>\$1,543,509.00</b>	<b>\$2,915.94</b>	<b>\$1,193.74</b>
Urban		\$7,608.77	\$1,562.05
State		\$13,814.22	\$1,967.60

FY 2008 Allocations Source: L-07-051 & L-07-141

SUBSTANCE ABUSE SERVICES FOR CHILD WELFARE INVOLVED PERSONS	Total	Under 12	17-Dec	18-25	26+
Outpatient	211	19	11	46	135
Detox	0	0	0	0	0
Short Term residential	12	0	1	3	8
Long Term residential	43	0	0	5	38
Intensive Outpatient	29	0	0	10	19
Case management	0	0	0	0	0
<b>Total</b>	<b>295</b>	<b>19</b>	<b>12</b>	<b>64</b>	<b>200</b>

4/2009 Data Source: DCH Administrative Data

FOSTER CARE FUNDING	IV-E	*CCF	SWBC	Total
Total Expenditures	\$8,257,166	\$1,225,877	\$6,217,341	\$15,700,385
Average # Children / Month	420	98	356	874
Average Cost / Child / Month	\$1,638	\$1,046	\$1,455	\$1,497
Ave Cost / Child / Day	\$54.61	\$34.87	\$48.51	\$49.90

2008 Data Source: DHS Annual Report / Annual 2008 CCF Report

\* CCF figures are for FFC only-not institutions or in home

FOSTER CARE PLACEMENTS			
Total in Care (4/2009)	1,293	*Average Monthly # in Paid Care	1,037
Per 1,000	11.54	Per 1,000	9.26
Urban 5 / 1,000	7.76	Urban 5 / 1,000	5.00
State / 1,000	7.02	State / 1,000	4.64

FY 2008 Data Source: DHS Administrative Data

\*2008 Data Source: DHS Annual Report / Annual 2008 CCF Report

CAPACITY
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# FC Beds	1,037				
# Beds per Child in Care	0.80	# Beds per Child in Paid Care	1.00	AFCRR Allocation	\$81,813
Urban 5 / Child	0.70	Urban 5 / Child	1.09	% of Urban	34.14%
State / Child	0.97	State / Child	1.46	% of State	7.94%

FY 2008 Data Source: DHS Administrative / FY 2008 Allocations Source: L-07-051 & L-07-141

TIME IN CARE									
Years	0-2.99	2-5.99	6-8.99	9-11.99	12-14.99	15-17.99	18+	Maximum	Mean
Percentage of Youth	71.31%	20.49%	6.42%	1.70%	0.08%	0.00%	0.00%	12.8329	2.451669
Urban 5 Percentage	73.12%	16.59%	5.73%	3.00%	1.23%	0.28%	0.06%	NA	NA
State Percentage	78.00%	14.39%	4.63%	1.99%	0.79%	0.16%	0.03%	19.4849	2.219176

April 2009 Data Source: DSA Administrative Data

FOSTER CARE - SIBLING GROUP SIZE	All Court Wards		Permanent Court Wards	
	Number Groups	Number Children	Number Groups	Number Children
One	420	420	180	180
Two	151	302	49	98
Three	80	240	26	78
Four	45	180	6	24
Five	16	80	3	15
Six	7	42	1	6
Seven	3	21	1	7
Eight	1	8	0	0
Nine	0	0	0	0
Ten	0	0	0	0
Eleven	0	0	0	0
<b>Total</b>		1,293		408

April 2009 Data Source: DCH Administrative Data

LICENSED FOSTER HOMES (point in time - 4/09)	# Homes	Capacity	Children in care in Sibling Groups appropriate for homes
Family Foster Homes (1-4 Children)	310	931	1,142
Child Foster Group Homes (5-6 Children)	18	106	122
Sibling Groups 7+	0	0	29
<b>Total</b>	328	1,037	1,293

4/2009 Data Source: Office of Children and Adult Licensing

**Figure 61: Macomb County Data**

ESTIMATED 2007 CHILD POPULATION	Under 5	Age 5-13	Age 14-17	Total
		50,162	98,024	46,362
% of Urban 5 Child Population	15%	15%	15%	15%
% of State Child Population	8%	8%	8%	8%

2007 Estimates Source: US Census Data

COMMUNITY BASED AND HOME SERVICES	2008 Allocations	Per 1,000 Child Population	Average per child in care per month
CPCP III - IV	\$239,926	\$1,233.25	\$195.06
CSPP II - III	\$858,260	\$4,411.56	\$697.77
SFSC	394,567	\$2,028.12	\$320.79
<b>Total</b>	<b>\$1,492,753.00</b>	<b>\$7,672.93</b>	<b>\$1,213.62</b>
Urban		\$7,608.77	\$1,562.05
State		\$13,814.22	\$1,967.60

FY 2008 Allocations Source: L-07-051 & L-07-141

SUBSTANCE ABUSE SERVICES FOR CHILD WELFARE INVOLVED PERSONS	Total	Under 12	13-17	18-25	26+
Outpatient	135	0	3	38	94
Detox	2	0	0	1	1
Short Term residential	11	0	0	3	8
Long Term residential	1	0	0	0	1
Intensive Outpatient	9	0	0	5	4
Case management	0	0	0	0	0
<b>Total</b>	<b>158</b>	<b>0</b>	<b>3</b>	<b>47</b>	<b>108</b>

4/2009 Data Source: DCH Administrative Data

FUND SOURCE	IV-E	*CCF	SWBC	Total
Total Expenditures	\$2,867,972	\$2,201,839.63	\$7,780,980	\$12,850,791
Average # Children / month	155	163	342	660
Average Cost / Child / Month	\$1,542	\$1,126	\$1,896	\$1,623
Ave Cost / Child / Day	\$51.40	\$37.54	\$63.20	\$54.09

2008 Data Source: DHS Annual Report / Annual 2008 CCF Report

\* CCF figures are for FFC only-not institutions or in home

FOSTER CARE PLACEMENTS			
Total in Care (4/2009)	1,230	*Average Monthly # in Paid Care	660
Per 1,000 Child Population	6.32	Per 1,000 Child Population	3.39
Urban 5/ 1,000	7.76	Urban 5 /1,000	5.00
State/1,000	7.02	State/1,000	4.64

FY 2008 Data Source: DHS Administrative Data

\* 2008 Data Source: DHS Annual Report / Annual 2008 CCF Report

CAPACITY	
# FC Beds	741

# Beds per Child in Care	0.6	# Beds per Child in Paid Care	1.1	AFCRR Allocation	\$65,438
Urban 5 / Child	0.7	Urban 5 / Child	1.09	% of Urban	27.31%
State / Child	0.97	State / Child	1.46	% of State	6.35%

FY 2008 Data Source: DHS Administrative / FY 2008 Allocations Source: L-07-051 & L-07-141

TIME IN CARE									
Years	0-2.99	2-5.99	6-8.99	9-11.99	12-14.99	15-17.99	18+	Maximum	Mean
Percentage of Youth	85.93%	10.08%	2.68%	1.06%	0.24%	0.00%	0.00%	14.8082	1.706691
Urban 5 Percentage	73.12%	16.59%	5.73%	3.00%	1.23%	0.28%	0.06%	NA	NA
State Percentage	78.00%	14.39%	4.63%	1.99%	0.79%	0.16%	0.03%	19.4849	2.219176

April 2009 Data Source: DSA Administrative Data

FOSTER CARE - SIBLING GROUP SIZE	All Court Wards		Permanent Court Wards	
	Number Groups	Number Children	Number Groups	Number Children
One	459	459	173	173
Two	174	348	51	102
Three	68	204	14	42
Four	28	112	5	20
Five	13	65	4	20
Six	1	6	0	0
Seven	4	28	0	0
Eight	1	8	0	0
Nine	0	0	0	0
Ten	0	0	0	0
Eleven	0	0	0	0
<b>Total</b>		1,230		357

April 2009 Data Source: DCH Administrative Data

LICENSED FOSTER HOMES	# Homes	Capacity	Children in care in Sibling Groups appropriate for homes
Family Foster Homes (1-4 Children)	310	685	1,123
Child Foster Group Homes (5-6 Children)	10	56	71
Sibling Groups 7+	0	0	36
<b>Total</b>	320	741	1,230

4/2009 Data Source: Office of Children and Adult Licensing

**Figure 62: Data Elements Included in the Eight Data Tables DHS Provided to CWRC**

Data Table Name	TPR Data	FC R A G	FC	Sheet 3	Removals	Ongoing	Qry Fans	Qry Cans
Description of Data Table	1-TPR - Children who's parental rights have been terminated and have been in care for 365 days or more.	2-FC R A G - Children who are active FC by race age and gender.	3-FC -Link to the Load number in FC. (links to 2 and 4)	4-Sheet 3 For the active foster care children - Removal Reason for FC.	5-Removals for CPS.	6-On-going is active CPS Cases	7. Not all individuals will have data because this is a relatively new process for DHS	8. Not all individuals will have data because this is a relatively new process for DHS
Data Elements	County Of Service	Log Id	Load No	Log Id	Log Id	Log Id	Recipient Id	Recipient Id
	Load No	County No	Log Id	Removal Date	<>	Transfer To County	Log Id	Log Id
	Log Id	Trim(Both From County Name)	Child Id	Removal Reason Code	Abandonment	System Category Code	Child Characteristics	Transfer To County
	Age	Accept Date	Sib Grp Id	Description	Alcohol Abuse Of Child	Recipient Id	Communication / Interpersonal Skills	Education
	Sex	Sex			Alcohol Abuse Of Parent	Date Stored	Domestic Relations	Medical/Physical
	Race	Race Code			Caretaker's Inability To Cope Due To Illness Or Other Reasons	Swss Case State	Emotional Stability Behavior	Mental Health And Well-Being
	Days In Care	Race Description			Childs Behavior Problem	Cis Case No	Employment	
	Living Arrangement Code	Log Id			Childs Disability	Program Code	Housing	
	Federal Goal Code	Date Of Birth			Death Of Parent(S)	Close Date	Intellectual Capacity	
	Legal Status	Cis Case No			Drug Abuse Of Child	Current Risk Level Code	Literacy	
	Placement Agency	Recipient Id			Drug Abuse Of Parent	Active Until Dt	Parenting Skills	
	Placing Agency Id	Sib Grp Id			Inadequate Housing	Race Code	Physical Health Issues	
	Placing Agency Name				Incarceration Of Parent(S)	Sex	Resource Availability / Management	
	Close Date				Neglect	Abuse Neglect Code	Sexual Abuse	
	Close Code				Physical Abuse	Abuse Neglect Ind	Social Support System	
					Relinquishment	Date Of Birth	Substance Abuse	
					Sexual Abuse	Removal Reason Code		

## *Constellations of Needs Identified by Family Assessment of Needs and Strengths*

During the child protection intake and investigation process, Child Protective Services workers complete a Family Assessment of Needs and Strengths (FANS) and a Child Assessment of Needs and Strengths (CANS). Upon completion of the assessment tool, workers may enter up to three top three needs identified by the FANS into the Service Worker Support System (SWSS). In April 2009, DHS provided data to CWRC on the needs identified on the FANS for 3,955 family groups. According to the data provided, these families included 3658 from which one or more children were removed and 297 from which no child was removed.

Of the 297 families with no children removed, 285 had constellations of needs that matched needs groupings for families from whom children were removed. A complete listing of the need constellations and the number of families in each group for which each constellation was identified appears in Figure 63. The need constellations may include one, two or three needs for each family group. The listing in Figure 63 shows each constellation with the top need shown in the first position, the second need (if any) in the second position and the third need (if any) in the third position.

Further analysis of this data in conjunction with a review of qualitative data available only through a more detailed review of case records could yield information about cases in which removal might have been unnecessary had additional home and community based services been available.

Key to abbreviations in Figure 63:

ChiCh = Child Characteristics

ComIS = Communication/Interpersonal Skills

DomRel = Domestic Relations

EmoSt = Emotional Stability Behavior

Emplo = Employment

Housi = Housing

IntCa = Intellectual Capacity

Liter = Literacy

ParSk = Parenting Skills

PhyHe = Physical Health Issues

ResAv = Resource Availability Management

SexAb = Sexual Abuse

SocSu = Social Support System

SubAb = Substance Abuse

**Figure 63: Top Three Need Patterns and Matches**

Need Constellations Identified on FANS	Families with no Child(ren) Removed		Families with Child(ren) Removed		Total Families with this Need Constellation
	Number	Percent	Number	Percent	
<b>Total</b>	<b>285</b>	<b>10.22%</b>	<b>2504</b>	<b>89.78%</b>	<b>2789</b>
ParSk	23	8.07%	262	91.93%	285
ParSk, Emplo	9	8.57%	96	91.43%	105
SubAb, ParSk, EmoSt	9	5.84%	145	94.16%	154
SubAb	8	7.14%	104	92.86%	112
Emplo	7	15.22%	39	84.78%	46
ParSk, SubAb,	7	8.64%	74	91.36%	81
SexAb, ParSk, EmoSt	6	8.33%	66	91.67%	72
ParSk, EmoSt, DomRe	6	9.38%	58	90.63%	64
ParSk, EmoSt, ResAv	6	9.52%	57	90.48%	63
ParSk, EmoSt, IntCa	6	10.34%	52	89.66%	58
SubAb, Emplo	5	9.26%	49	90.74%	54
ParSk, EmoSt, SubAb	5	8.47%	54	91.53%	59
ParSk, EmoSt, Housi	5	8.93%	51	91.07%	56
ParSk, EmoSt, ComIS	5	12.50%	35	87.50%	40
Housi	4	22.22%	14	77.78%	18

SubAb, ParSk,	4	12.50%	28	87.50%	32
ParSk, EmoSt, Emplo	4	3.57%	108	96.43%	112
ParSk, SubAb, Emplo	4	8.89%	41	91.11%	45
ResAv, ParSk, EmoSt	4	12.50%	28	87.50%	32
Housi, ResAv, SubAb	4	14.81%	23	85.19%	27
ParSk, ResAv, SubAb	4	26.67%	11	73.33%	15
EmoSt	3	12.50%	21	87.50%	24
PhyHe	3	42.86%	4	57.14%	7
ParSk, EmoSt	3	3.37%	86	96.63%	89
SexAb, ParSk	3	7.50%	37	92.50%	40
ParSk, DomRe	3	7.69%	36	92.31%	39
ParSk, EmoSt, SocSu	3	6.38%	44	93.62%	47
SubAb, ParSk, Emplo	3	7.32%	38	92.68%	41
ParSk, EmoSt, PhyHe	3	13.64%	19	86.36%	22
ComIS, ParSk, EmoSt	3	15.00%	17	85.00%	20
SubAb, ParSk, ResAv	3	17.65%	14	82.35%	17
ParSk, EmoSt, ChiCh	3	60.00%	2	40.00%	5
DomRe, SubAb	2	15.38%	11	84.62%	13
EmoSt, SubAb	2	18.18%	9	81.82%	11
ParSk, IntCa	2	20.00%	8	80.00%	10
Emplo, SubAb	2	25.00%	6	75.00%	8
ResAv, Emplo	2	40.00%	3	60.00%	5
DomRe, ParSk, EmoSt	2	4.08%	47	95.92%	49
Housi, ResAv, ParSk	2	4.55%	42	95.45%	44
Housi, ParSk, ResAv	2	8.70%	21	91.30%	23
EmoSt, SubAb, ParSk	2	9.52%	19	90.48%	21
ParSk, EmoSt, Liter	2	10.53%	17	89.47%	19
Housi, SubAb, ParSk	2	12.50%	14	87.50%	16
ParSk, Housi, SocSu	2	13.33%	13	86.67%	15
ParSk, Housi, SubAb	2	13.33%	13	86.67%	15
EmoSt, ParSk, Emplo	2	14.29%	12	85.71%	14
ResAv, ParSk, Housi	2	14.29%	12	85.71%	14
DomRe, ParSk, Emplo	2	15.38%	11	84.62%	13
ParSk, DomRe, EmoSt	2	15.38%	11	84.62%	13
ParSk, SexAb, EmoSt	2	16.67%	10	83.33%	12
SubAb, EmoSt, DomRe	2	16.67%	10	83.33%	12
EmoSt, DomRe, SubAb	2	18.18%	9	81.82%	11
ParSk, Emplo, Housi	2	18.18%	9	81.82%	11
ParSk, SocSu, Emplo	2	18.18%	9	81.82%	11
SexAb, SubAb, ParSk	2	18.18%	9	81.82%	11
ParSk, Emplo, DomRe	2	28.57%	5	71.43%	7
SubAb, ResAv, ParSk	2	33.33%	4	66.67%	6
DomRe, ParSk, SocSu	2	50.00%	2	50.00%	4
DomRe, ResAv, EmoSt	2	50.00%	2	50.00%	4
SexAb, ParSk, ComIS	2	50.00%	2	50.00%	4
SubAb, DomRe, ResAv	2	66.67%	1	33.33%	3
SubAb, Housi, SocSu	2	100.00%	0	0.00%	2
SocSu	1	25.00%	3	75.00%	4
ChiCh	1	50.00%	1	50.00%	2
ParSk, Housi	1	2.38%	41	97.62%	42
ParSk, SocSu	1	4.55%	21	95.45%	22
DomRe, Emplo	1	6.25%	15	93.75%	16

SexAb, Empl	1	12.50%	7	87.50%	8
SubAb, EmoSt	1	12.50%	7	87.50%	8
EmoSt, DomRe	1	16.67%	5	83.33%	6
SubAb, PhyHe	1	20.00%	4	80.00%	5
Housi, SubAb	1	25.00%	3	75.00%	4
SocSu, Empl	1	25.00%	3	75.00%	4
SocSu, SubAb	1	25.00%	3	75.00%	4
PhyHe, Empl	1	33.33%	2	66.67%	3
SocSu, ParSk	1	33.33%	2	66.67%	3
DomRe, PhyHe	1	100.00%	0	0.00%	1
ParSk, ResAv, Housi	1	2.56%	38	97.44%	39
DomRe, SubAb, ParSk	1	4.35%	22	95.65%	23
ParSk, Empl, ResAv	1	5.26%	18	94.74%	19
SubAb, ParSk, Housi	1	5.26%	18	94.74%	19
SubAb, ParSk, SocSu	1	5.26%	18	94.74%	19
ParSk, DomRe, SubAb	1	5.56%	17	94.44%	18
SubAb, ParSk, DomRe	1	5.56%	17	94.44%	18
ParSk, Housi, DomRe	1	6.25%	15	93.75%	16
ParSk, DomRe, Empl	1	7.14%	13	92.86%	14
ParSk, SocSu, DomRe	1	7.14%	13	92.86%	14
SexAb, ParSk, Empl	1	7.14%	13	92.86%	14
ParSk, Empl, SubAb	1	7.69%	12	92.31%	13
ParSk, IntCa, Housi	1	9.09%	10	90.91%	11
EmoSt, ParSk, Housi	1	10.00%	9	90.00%	10
DomRe, ParSk, SubAb	1	11.11%	8	88.89%	9
EmoSt, ComIS, ParSk	1	12.50%	7	87.50%	8
EmoSt, Housi, ComIS	1	12.50%	7	87.50%	8
EmoSt, ResAv, SubAb	1	14.29%	6	85.71%	7
Housi, SubAb, Empl	1	16.67%	5	83.33%	6
SexAb, ParSk, IntCa	1	16.67%	5	83.33%	6
SubAb, PhyHe, Empl	1	16.67%	5	83.33%	6
Housi, ResAv, Empl	1	20.00%	4	80.00%	5
ParSk, Empl, ComIS	1	20.00%	4	80.00%	5
ParSk, SocSu, SubAb	1	20.00%	4	80.00%	5
SocSu, ParSk, EmoSt	1	20.00%	4	80.00%	5
SubAb, ParSk, IntCa	1	20.00%	4	80.00%	5
EmoSt, DomRe, Empl	1	25.00%	3	75.00%	4
EmoSt, IntCa, Housi	1	25.00%	3	75.00%	4
EmoSt, IntCa, ParSk	1	25.00%	3	75.00%	4
ParSk, ResAv, DomRe	1	25.00%	3	75.00%	4
ParSk, SocSu, PhyHe	1	25.00%	3	75.00%	4
ParSk, SocSu, SexAb	1	25.00%	3	75.00%	4
SexAb, ParSk, ChiCh	1	25.00%	3	75.00%	4
SubAb, Housi, ResAv	1	25.00%	3	75.00%	4
SubAb, ParSk, ComIS	1	25.00%	3	75.00%	4
EmoSt, ParSk, SocSu	1	33.33%	2	66.67%	3
SubAb, DomRe, EmoSt	1	33.33%	2	66.67%	3
SubAb, EmoSt, SocSu	1	33.33%	2	66.67%	3
ComIS, SexAb, ParSk	1	50.00%	1	50.00%	2
ParSk, IntCa, Empl	1	50.00%	1	50.00%	2
SocSu, ParSk, Empl	1	50.00%	1	50.00%	2
SocSu, ParSk, Housi	1	50.00%	1	50.00%	2

## ***Distribution of Sibling Groups***

Based on administrative data DHS provided to CWRC in April 2009, Figure 64 displays a frequency distribution for sibling groups by size of group for all children in the foster care system for all counties. Using the DHS administrative data from April 2009, Figure 65 shows a similar distribution for children whose parental rights are terminated and for whom a sibling group identifier was included in the data. Sibling group identifiers were not available in the data for approximately 1937 children whose parental rights have been terminated. Figure 66 aggregates data from the previous figures and compares it to DHS-provided data about the number and capacity of foster homes and group foster care homes in each county.

The information in these figures is useful for county level analysis in determining the number of foster and adoptive homes needed at each sibling group size. The data may assist as well with determining level of effort needed for recruitment of additional homes in each county.

**Figure 64: Distribution of Sibling Group Sizes for All Foster Children**

County	Frequencies by Sibling Group Size – All Foster Children											Total
	1	2	3	4	5	6	7	8	9	10	11	
Alcona County	5	1	0	0	0	0	0	0	0	0	0	6
Alger County	1	1	0	0	1	0	0	0	0	0	0	3
Allegan County	53	23	5	7	0	0	0	0	0	0	0	88
Alpena County	23	1	3	0	0	0	0	0	0	0	0	27
Antrim County	13	5	5	0	0	1	0	0	0	0	0	24
Arenac County	12	5	0	2	0	0	0	0	0	0	0	19
Baraga County	10	4	2	2	0	0	0	0	0	0	0	18
Barry County	14	3	5	1	1	0	0	0	0	0	0	24
Bay County	30	13	3	1	1	0	0	0	0	0	0	48
Benzie County	7	0	2	0	0	0	0	0	0	0	0	9
Berrien County	133	53	16	10	11	5	0	0	0	0	0	228
Branch County	31	18	7	4	1	0	0	0	0	0	0	61
Calhoun County	111	39	12	9	2	1	0	0	0	0	0	174
Cass County	53	15	8	4	0	0	0	0	0	0	0	80
Charlevoix County	14	8	3	3	0	0	0	0	0	0	0	28
Cheboygan County	18	7	10	4	0	0	0	0	0	0	0	39
Chippewa County	15	6	1	1	0	0	0	0	0	0	0	23
Clare County	16	4	3	0	0	0	0	0	0	0	0	23
Clinton County	57	20	13	4	1	0	0	0	0	0	0	95
Crawford County	16	4	6	2	0	1	0	0	0	0	0	29
Delta County	13	4	0	0	0	0	0	0	0	0	0	17
Dickinson County	19	6	5	2	0	0	0	0	0	0	0	32
Eaton County	37	17	6	9	0	0	0	0	0	0	0	69
Emmet County	11	3	3	1	0	0	0	0	0	0	0	18
Genesee County	420	151	80	45	16	7	3	1	0	0	0	723
Gladwin County	9	0	1	0	0	0	0	0	0	0	0	10
Gogebic County	12	11	1	0	0	0	0	0	0	0	0	24
Grand Traverse County	38	19	7	3	1	0	0	0	0	0	0	68
Gratiot County	10	4	5	6	0	0	0	0	0	0	0	25
Hillsdale County	21	9	5	5	1	0	1	0	0	0	0	42
Houghton County	5	2	0	0	0	0	0	0	0	0	0	7
Huron County	4	4	1	0	1	0	0	0	0	0	0	10
Ingham County	270	85	39	30	6	4	0	1	0	0	0	435

Ionia County	31	13	8	1	0	0	0	0	0	0	0	53
Iosco County	18	2	1	2	0	0	0	0	0	0	0	23
Iron County	12	0	0	1	0	0	0	0	0	0	0	13
Isabella County	37	16	6	1	0	0	0	0	0	0	0	60
Jackson County	97	32	17	8	5	2	0	1	0	0	0	162
Kalamazoo County	154	49	16	8	4	0	2	0	0	0	0	233
Kalkaska County	9	9	3	1	0	1	0	0	0	0	0	23
Kent County	404	104	54	25	12	2	0	1	0	0	0	602
Keweenaw County	0	0	1	0	0	0	0	0	0	0	0	1
Lake County	11	1	2	0	0	0	0	0	0	0	0	14
Lapeer County	16	6	5	0	0	0	0	0	0	0	0	27
Leelanau County	13	4	2	1	0	0	0	0	0	0	0	20
Lenawee County	51	29	10	5	2	1	0	0	0	0	0	98
Livingston County	32	10	3	5	0	0	0	0	0	0	0	50
Luce County	3	3	1	0	0	0	0	0	0	0	0	7
Mackinac County	5	3	1	0	0	0	0	0	0	0	0	9
Macomb County	459	174	68	28	13	1	4	1	0	0	0	748
Manistee County	9	2	0	0	0	0	0	0	0	0	0	11
Marquette County	29	9	3	2	0	0	0	0	0	0	0	43
Mason County	15	6	2	1	0	0	0	0	0	0	0	24
Mecosta County	14	8	7	2	0	0	0	0	0	0	0	31
Menominee County	10	2	1	1	0	0	0	0	0	0	0	14
Midland County	37	12	9	0	0	1	0	0	0	0	0	59
Missaukee County	4	3	0	1	0	0	0	0	0	0	0	8
Monroe County	51	13	5	2	1	1	0	0	1	0	0	74
Montcalm County	31	12	2	4	1	0	0	0	0	0	0	50
Montmorency County	3	0	1	0	0	0	0	0	0	0	0	4
Muskegon County	146	48	26	15	6	2	0	1	0	0	0	244
Newaygo County	22	10	5	4	2	0	0	0	0	0	0	43
Oakland County	456	161	77	38	17	6	1	2	0	0	0	758
Oceana County	7	2	2	0	0	0	0	0	0	0	0	11
Ogemaw County	16	2	1	1	0	0	0	0	0	0	0	20
Ontonagon County	4	1	0	0	0	0	0	0	0	0	0	5
Osceola County	10	6	2	1	0	0	0	0	0	0	0	19
Oscoda County	3	1	0	0	0	0	0	0	0	0	0	4
Otsego County	16	3	3	1	1	0	0	0	0	0	0	24
Ottawa County	52	27	4	2	2	0	0	0	0	0	0	87
Presque Isle County	3	1	3	0	0	0	0	0	0	0	0	7
Roscommon County	16	6	2	0	0	0	0	0	0	0	0	24
Saginaw County	103	47	20	9	6	0	0	0	0	0	0	185
Sanilac County	118	34	19	7	2	0	0	0	0	0	0	180
Schoolcraft County	63	30	18	6	3	0	0	0	0	0	0	120
Shiawassee County	13	6	2	1	1	0	0	0	0	0	0	23
St. Clair County	1	1	1	0	0	0	0	0	0	0	0	3
St. Joseph County	38	25	6	1	0	0	0	0	0	0	0	70
Tuscola County	23	12	4	3	1	0	0	0	0	0	0	43
Van Buren County	42	17	8	7	1	0	0	0	0	0	0	75
Washtenaw County	101	27	14	7	2	0	0	0	0	0	0	151
Wayne County	2,027	567	274	128	67	26	11	11	5	2	1	3,119
Wexford County	17	6	7	0	0	0	0	0	0	0	0	30
	6,353	2,107	983	485	192	62	22	19	6	2	1	10,232

**Figure 65: Distribution of Sibling Group Sizes for  
Children with Parental Rights Terminated**

County	Frequencies by Sibling Group Size - Children with Parental Rights Terminated									
	1	2	3	4	5	6	7	8	9	Total
Alcona County	1	0	0	0	0	0	0	0	0	1
Allegan County	14	5	1	1	0	0	0	0	0	21
Alpena County	5	0	0	0	0	0	0	0	0	5
Antrim County	5	1	0	0	0	1	0	0	0	7
Arenac County	2	1	0	0	0	0	0	0	0	3
Baraga County	2	0	0	0	0	0	0	0	0	2
Barry County	1	0	0	0	0	0	0	0	0	1
Bay County	12	4	1	0	0	0	0	0	0	17
Berrien County	40	12	4	2	2	0	0	0	0	60
Branch County	5	2	2	0	0	0	0	0	0	9
Calhoun County	35	12	5	2	0	1	0	0	0	55
Cass County	17	4	4	1	0	0	0	0	0	26
Charlevoix County	2	0	0	0	0	0	0	0	0	2
Cheboygan County	2	0	0	0	0	0	0	0	0	2
Chippewa County	4	0	0	0	0	0	0	0	0	4
Clare County	4	1	0	0	0	0	0	0	0	5
Clinton County	25	4	5	1	0	0	0	0	0	35
Crawford County	5	0	0	1	0	0	0	0	0	6
Delta County	5	0	0	0	0	0	0	0	0	5
Dickinson County	4	2	0	1	0	0	0	0	0	7
Eaton County	12	3	0	0	0	0	0	0	0	15
Emmet County	2	0	0	0	0	0	0	0	0	2
Genesee County	180	49	26	6	3	1	1	0	0	266
Gladwin County	2	0	0	0	0	0	0	0	0	2
Gogebic County	5	1	0	0	0	0	0	0	0	6
Grand Traverse County	8	1	1	0	0	0	0	0	0	10
Gratiot County	8	1	2	2	0	0	0	0	0	13
Hillsdale County	8	3	0	0	0	1	0	0	0	12
Houghton County	2	0	0	0	0	0	0	0	0	2
Huron County	3	1	0	0	0	0	0	0	0	4
Ingham County	83	19	3	6	0	1	0	0	0	112
Ionia County	12	2	2	0	0	0	0	0	0	16
Iosco County	7	0	0	0	0	0	0	0	0	7
Iron County	4	0	0	0	0	0	0	0	0	4
Isabella County	12	4	1	0	0	0	0	0	0	17
Jackson County	45	10	7	1	0	0	0	0	0	63
Kalamazoo County	65	12	1	0	2	0	0	0	0	80
Kalkaska County	5	2	1	0	0	0	0	0	0	8
Kent County	81	12	4	0	1	0	0	0	0	98
Lake County	2	0	0	0	0	0	0	0	0	2
Lapeer County	4	1	1	0	0	0	0	0	0	6
Leelanau County	6	0	1	0	0	0	0	0	0	7
Lenawee County	20	8	1	1	1	0	0	0	0	31
Livingston County	11	3	1	0	0	0	0	0	0	15
Luce County	1	0	0	0	0	0	0	0	0	1
Macomb County	173	51	14	5	4	0	0	0	0	247

Marquette County	9	2	1	0	0	0	0	0	0	12
Mason County	1	2	0	1	0	0	0	0	0	4
Mecosta County	5	2	0	1	0	0	0	0	0	8
Menominee County	2	0	0	0	0	0	0	0	0	2
Midland County	17	2	1	0	0	0	0	0	0	20
Missaukee County	1	0	0	0	0	0	0	0	0	1
Monroe County	26	4	2	1	0	0	0	0	0	33
Montcalm County	6	1	0	1	1	0	0	0	0	9
Montmorency County	3	0	0	0	0	0	0	0	0	3
Muskegon County	54	8	4	1	1	0	0	0	0	68
Newaygo County	9	1	1	0	0	0	0	0	0	11
Oakland County	158	37	17	1	2	1	0	0	0	216
Ogemaw County	4	2	0	0	0	0	0	0	0	6
Osceola County	1	0	0	0	0	0	0	0	0	1
Oscoda County	1	1	0	0	0	0	0	0	0	2
Otsego County	7	1	0	0	0	0	0	0	0	8
Ottawa County	15	5	0	0	0	0	0	0	0	20
Roscommon County	5	2	0	0	0	0	0	0	0	7
Saginaw County	39	15	5	3	1	0	0	0	0	63
Sanilac County	44	8	3	1	0	0	0	0	0	56
Schoolcraft County	25	6	1	0	0	0	0	0	0	32
Shiawassee County	11	3	0	0	0	0	0	0	0	14
St. Clair County	0	1	1	0	0	0	0	0	0	2
St. Joseph County	15	7	0	0	0	0	0	0	0	22
Tuscola County	8	2	0	1	0	0	0	0	0	11
Van Buren County	11	4	2	0	0	0	0	0	0	17
Washtenaw County	38	10	3	1	1	0	0	0	0	53
Wayne County	774	183	47	24	10	4	1	0	1	1,044
Wexford County	3	0	0	0	0	0	0	0	0	3
<b>Total</b>	<b>2,243</b>	<b>540</b>	<b>176</b>	<b>66</b>	<b>29</b>	<b>10</b>	<b>2</b>	<b>0</b>	<b>1</b>	<b>3,067</b>

**Figure 66: Comparison of Licensed Foster Care Capacity to Children in Care by County**

COUNTY	Child Foster Family Home (Capacity 1-4)			Child Foster Group Home (Capacity 5-6)			Number of Children in Sibling Groups of 7 - 11	All Facility Types			Capacity Deficits			
	Count	Foster Home Capacity	Number of Children In Care	Count	Group Home Capacity	Number of Children In Care		Total Count	Total Capacity	Total Children In Care	1 to 4	5 Or 6	7 to 11	
Alcona	2	7	7	0	0	0	0	2	7	7	0	0	0	0
Alger	1	2	3	0	0	5	0	1	2	8	-1	-5	0	-6
Allegan	74	180	142	10	59	0	0	84	239	142	38	59	0	97
Alpena	8	18	34	1	6	0	0	9	24	34	-16	6	0	-10
Antrim	29	75	38	1	6	6	0	30	81	44	37	0	0	37
Arenac	15	36	30	0	0	0	0	15	36	30	6	0	0	6
Baraga	8	22	32	0	0	0	0	8	22	32	-10	0	0	-10
Barry	50	129	39	5	30	5	0	55	159	44	90	25	0	115
Bay	36	79	69	1	6	5	0	37	85	74	10	1	0	11
Benzie	17	52	13	5	29	0	0	22	81	13	39	29	0	68
Berrien	148	358	327	10	56	85	0	158	414	412	31	-29	0	2
Branch	13	27	104	2	10	5	0	15	37	109	-77	5	0	-72
Calhoun	143	362	261	9	54	16	0	152	416	277	101	38	0	139
Cass	29	68	123	3	15	0	0	32	83	123	-55	15	0	-40
Charlevoix	15	38	51	7	41	0	0	22	79	51	-13	41	0	28
Cheboygan	19	49	78	3	16	0	0	22	65	78	-29	16	0	-13
Chippewa	21	56	34	0	0	0	0	21	56	34	22	0	0	22
Clare	29	77	33	2	12	0	0	31	89	33	44	12	0	56
Clinton	49	118	152	1	6	5	0	50	124	157	-34	1	0	-33
Crawford	16	43	50	0	0	6	0	16	43	56	-7	-6	0	-13
Delta	24	59	21	2	12	0	0	26	71	21	38	12	0	50
Dickinson	19	55	54	3	18	0	0	22	73	54	1	18	0	19
Eaton	101	254	125	5	27	0	0	106	281	125	129	27	0	156
Emmet	29	89	30	2	12	0	0	31	101	30	59	12	0	71
Genesee	360	931	1142	18	106	122	29	378	1037	1293	-211	-16	-29	-256
Gladwin	19	59	12	0	0	0	0	19	59	12	47	0	0	47
Gogebic	15	33	37	0	0	0	0	15	33	37	-4	0	0	-4

Grand Traverse	66	167	109	5	29	5	0	71	196	114	58	24	0	82
Gratiot	29	79	57	1	6	0	0	30	85	57	22	6	0	28
Hillsdale	27	67	74	3	18	5	7	30	85	86	-7	13	-7	-1
Houghton	14	39	9	1	6	0	0	15	45	9	30	6	0	36
Huron	11	27	15	0	0	5	0	11	27	20	12	-5	0	7
Ingham	191	455	677	6	34	54	8	197	489	739	-222	-20	-8	-250
Ionia	34	86	85	4	23	0	0	38	109	85	1	23	0	24
Iosco	13	33	33	0	0	0	0	13	33	33	0	0	0	0
Iron	7	17	16	0	0	0	0	7	17	16	1	0	0	1
Isabella	22	62	91	2	12	0	0	24	74	91	-29	12	0	-17
Jackson	98	238	244	8	46	37	8	106	284	289	-6	9	-8	-5
Kalamazoo	190	468	332	11	64	20	14	201	532	366	136	44	-14	166
Kalkaska	21	54	40	4	24	6	0	25	78	46	14	18	0	32
Kent	412	1009	874	19	109	72	8	431	1118	954	135	37	-8	164
Keweenaw			3			0	0			3	-3	0	0	-3
Lake	15	44	19	2	12	0	0	17	56	19	25	12	0	37
Lapeer	33	100	43	1	5	0	0	34	105	43	57	5	0	62
Leelanau	18	54	31	1	6	0	0	19	60	31	23	6	0	29
Lenawee	85	199	159	4	24	16	0	89	223	175	40	8	0	48
Livingston	67	169	81	3	17	0	0	70	186	81	88	17	0	105
Luce	6	21	12	1	6	0	0	7	27	12	9	6	0	15
Mackinac	5	12	14	0	0	0	0	5	12	14	-2	0	0	-2
Macomb	310	685	1123	10	56	71	36	320	741	1230	-438	-15	-36	-489
Manistee	6	12	13	1	5	0	0	7	17	13	-1	5	0	4
Marquette	43	115	64	5	28	0	0	48	143	64	51	28	0	79
Mason	18	45	37	1	5	0	0	19	50	37	8	5	0	13
Mecosta	18	57	59	2	12	0	0	20	69	59	-2	12	0	10
Menominee	7	25	21	1	6	0	0	8	31	21	4	6	0	10
Midland	64	156	88	7	40	6	0	71	196	94	68	34	0	102
Missaukee	15	44	14	3	17	0	0	18	61	14	30	17	0	47
Monroe	44	108	100	1	6	11	9	45	114	120	8	-5	-9	-6
Montcalm	41	113	77	6	36	5	0	47	149	82	36	31	0	67
Montmorency	8	24	6	0	0	0	0	8	24	6	18	0	0	18
Muskegon	179	429	380	12	70	42	8	191	499	430	49	28	-8	69
Newaygo	31	74	73	3	18	10	0	34	92	83	1	8	0	9
Oakland	384	897	1161	13	72	121	23	397	969	1305	-264	-49	-23	-336

Oceana	17	55	17	2	12	0	0	19	67	17	38	12	0	50
Ogemaw	16	42	27	0	0	0	0	16	42	27	15	0	0	15
Ontonagon	7	12	6	1	5	0	0	8	17	6	6	5	0	11
Osceola	30	92	32	6	35	0	0	36	127	32	60	35	0	95
Oscoda	3	6	5	0	0	0	0	3	6	5	1	0	0	1
Otsego	20	50	35	1	6	5	0	21	56	40	15	1	0	16
Ottawa	167	407	126	4	24	10	0	171	431	136	281	14	0	295
Presque Isle	8	25	14	1	6	0	0	9	31	14	11	6	0	17
Roscommon	11	24	34	0	0	0	0	11	24	34	-10	0	0	-10
Saginaw	154	347	293	10	55	30	0	164	402	323	54	25	0	79
Sanilac	11	25	271	2	12	10	0	13	37	281	-246	2	0	-244
Schoolcraft	2	6	201	0	0	15	0	2	6	216	-195	-15	0	-210
Shiawassee	38	110	35	6	34	5	0	44	144	40	75	29	0	104
St Clair	117	309	6	11	64	0	0	128	373	6	303	64	0	367
St Joseph	48	132	110	1	6	0	0	49	138	110	22	6	0	28
Tuscola	50	138	71	2	12	5	0	52	150	76	67	7	0	74
Van Buren	72	197	128	4	24	5	0	76	221	133	69	19	0	88
Washtenaw	105	236	225	4	24	10	0	109	260	235	11	14	0	25
Wayne	1307	3049	4495	22	123	491	241	1329	3172	5227	-1446	-368	-241	-2055
Wexford	30	92	50	4	24	0	0	34	116	50	42	24	0	66
All Counties	6034	14814	15456	312	1799	1332	391	6346	16613	17179	-642	467	-391	-566

Figure 67: EPSDT Data for FY 2008 (page 1)

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	Total	Age Groups						
		< 1	1 to 2	3 to 5	6 to 9	10 to 14	15 to 18	19 to 20
<b>1. Total Individuals Eligible for EPSDT</b>								
CN	16,306	1,207	2,399	2,657	2,780	3,420	3,669	174
MN	20	2	0	1	3	3	6	5
Total	16,326	1,209	2,399	2,658	2,783	3,423	3,675	179
<b>2a. State Periodicity Schedule</b>		5.000	4.000	3.000	2.000	4.000	4.000	2.000
<b>2b. Number of Years in Age Group</b>		1.000	2.000	3.000	4.000	5.000	4.000	2.000
<b>2c. Annualized State Periodicity Schedule</b>		5.000	2.500	1.330	1.000	0.800	1.000	1.000
<b>3a. Total Months of Eligibility</b>								
CN	179,232	7,799	27,171	30,082	31,560	38,614	41,950	2,056
MN	369	12	91	35	24	84	70	53
Total	179,601	7,811	27,262	30,117	31,584	38,698	42,020	2,109
<b>3b. Average Period of Eligibility - Total</b>								
CN	0.920	0.540	0.940	0.940	0.950	0.940	0.950	0.990
MN	1.540	0.500	0.000	2.920	0.670	2.330	0.970	0.880
Total	0.920	0.540	0.950	0.940	0.950	0.940	0.950	0.980
<b>4. Expected number of Screenings per Eligible</b>								
CN		2.700	2.350	1.250	0.950	0.750	0.950	0.980
MN		2.500	0.000	3.880	0.670	1.860	0.970	0.880
Total		2.700	2.380	1.250	0.950	0.750	0.950	0.980
<b>5. Expected Number of Screenings</b>								
CN	21,080	3,259	5,638	3,321	2,641	2,565	3,486	171
MN	27	5	0	4	2	6	6	4
Total	21,107	3,264	5,638	3,325	2,643	2,571	3,492	175
<b>6. Total Screens Received</b>								
CN	18,962	3,869	4,871	2,616	2,198	2,642	2,662	104
MN	30	7	8	2	2	4	5	2
Total	18,992	3,876	4,879	2,618	2,200	2,646	2,667	106
<b>7. Screening Ratio</b>								
CN	0.900	1.000	0.860	0.790	0.830	1.000	0.760	0.610
MN	1.000	1.000	0.000	0.520	1.000	0.720	0.860	0.460
Total	0.900	1.000	0.870	0.790	0.830	1.000	0.760	0.610

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Figure 68: EPSDT Data for FY 2008 (page 2)

Report Date: 3/25/2009  
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	Total	Age Groups						
		< 1	1 to 2	3 to 5	6 to 9	10 to 14	15 to 18	19 to 20
<b>8. Total Eligibles Who Should Receive at least One Initial or Periodic Exam</b>								
CN	15,125	1,207	2,399	2,657	2,641	2,565	3,486	171
MN	18	2	0	1	2	3	6	4
Total	15,143	1,209	2,399	2,658	2,643	2,568	3,492	175
<b>9. Total Eligibles Receiving at Least One Initial or Periodic Exam</b>								
CN	10,961	1,070	2,009	1,910	1,744	2,058	2,085	85
MN	18	2	4	1	2	3	4	2
Total	10,979	1,072	2,013	1,911	1,746	2,061	2,089	87
<b>10. Participant Ratio</b>								
CN	0.720	0.890	0.840	0.720	0.660	0.800	0.600	0.500
MN	0.990	1.000	0.000	1.000	1.000	1.000	0.690	0.450
Total	0.730	0.890	0.840	0.720	0.660	0.800	0.600	0.500
<b>12a. Total Eligibles Receiving any Dental Services</b>								
CN	8,562	4	182	1,490	1,946	2,329	2,514	97
MN	12	0	0	1	2	5	3	1
Total	8,574	4	182	1,491	1,948	2,334	2,517	98
<b>12b. Total Eligibles Receiving Preventative Dental Services</b>								
CN	8,439	4	179	1,477	1,917	2,297	2,470	95
MN	12	0	0	1	2	5	3	1
Total	8,451	4	179	1,478	1,919	2,302	2,473	96
<b>12c. Total Eligibles Receiving Dental Treatment Services</b>								
CN	3,495	0	25	390	819	958	1,258	45
MN	5	0	0	0	2	2	1	0
Total	3,500	0	25	390	821	960	1,259	45
<b>13. Total Individuals Enrolled in Managed Care</b>								
CN	8,539	640	1,585	1,764	1,751	1,771	1,012	16
MN	19	0	2	1	3	4	5	4
Total	8,558	640	1,587	1,765	1,754	1,775	1,017	20
<b>14. Total Number of Screening Blood Lead Tests</b>								
CN	2,991	39	1,583	1,369				
MN	5	0	3	2				
Total	2,996	39	1,586	1,371				

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## Appendix 4: Michigan’s Mental Health System

The Michigan Department of Community Health (MDCH) provides a variety of mental health and substance abuse services to children in the child welfare system. State policy direction for these services is provided by the Mental Health and Substance Abuse Administration within MDCH.

The organization of Michigan’s public mental health service delivery system reflects the urban-rural diversity of the State. It includes 18 Prepaid Inpatient Health Plans (PIHPs). Each PIHP includes one or more Community Mental Health Service Programs (CMHSPs). When a PIHP has multiple CMHSP affiliates, one of the affiliates serves as the lead affiliate. A total of 46 CMHSPs operate in Michigan, of which:

- 6 serve a single county and act as single-county PIHPs
- 2 serve multiple counties and act as single-affiliate PIHPs
- 26 serve single counties and are part of multiple-affiliate PIHPs
- 12 serve multiple counties and are part of multiple-affiliate PIHPs

MDCH provides for statewide delivery of services through:

- Contracts with the PIHPs for Medicaid mental health specialty services and supports to children with serious emotional disturbance (SED), adults with severe mental illness (SMI) and children and adults with developmental disabilities (DD). Michigan’s definition of SED is substantially the same as the federal definition
- The services are provided under a 1915b/c capitated managed care waiver.
- The Medicaid Provider Manual details the requirements for accessing the array of Medicaid mental health specialty services for children and adults provided under this waiver. The full range of specialty services is listed below.

**Figure 69: Medicaid Mental Health Specialty Services**

Applied behavioral services	Medication review
Assertive community treatment	Nursing facility mental health monitoring
Assessments	
Case management	Occupational therapy
Child therapy	Personal care in specialized settings
Clubhouse rehabilitation programs	Physical therapy
Crisis interventions	Speech
Crisis residential services	Hearing
Family therapy	Language
Health services	Substance abuse
Home-based services	Treatment planning
Individual/group therapy	Transportation
Intensive crisis stabilization services	Partial hospitalization
Medication administration	Inpatient psychiatric hospitalization

In addition, specialty services and supports, known as B3 services, must be available and delivered when medically necessary. These services include:

Community inclusion and integration services	Family support and training, including parent-to-parent support, respite care, housing assistance, peer delivered or operated support services, prevention and consultation services and wraparound services.
Crisis response extended observation beds	

- Using a person-centered planning process and family-centered practice for children, the service providers develop individual plans of service drawing from the services listed above.
- Contracts with 46 Community Mental Health Services Programs (CMHSPs) for delivery of non-Medicaid funded services are managed as follows:
  - Funds are allocated by a formula to CMHSPs under a contract with MDCH that is managed by Mental Health Services Administration.
  - Service eligibility is limited to substance abuse children with SED, adults with SMI and children and adults with DD as defined in the Mental Health Code and who are additionally a priority for services as defined in the Mental Health Code. This contract provides the same array of services as the Medicaid funded services provided through the PIHP contracts. However, CMHSPs may establish waiting lists for the services if funds are not sufficient for full coverage of needs.
  - The providers develop individual plans for service in the same manner as for Medicaid funded services.
- Contracts through the Medicaid Health Plans for health care services which includes a small outpatient mental health benefit limited to a total of 20 visits for Medicaid beneficiaries. Children in DHS foster care have been historically excluded from the Medicaid Health Plans and remained fee for service for their health care services. This has meant they did not access the Medicaid Health Plan 20 visit out-patient benefit. In FY10, children in DHS foster care will be enrolled in the Medicaid Health Plans.
- A small fee for service mental health benefit for Medicaid beneficiaries limited to 10 visits provided by a physician or psychiatrist.

In its application for the federal Mental Health Block Grant for the period, 2009 through 2011, MDCH documents its plans for directing attention to essential mental health needs of Michigan’s children in three areas:

1. Differences in accessing the array of services available at the local level.
2. Expansion of current innovative projects.
3. Services to children in foster care.

Primary changes already in place to address these issues:

- System of Care RFP for 2008, 2009 and 2010 Mental Health Block Grant funds included emphasis on beginning or continuing working with community partners on comprehensive system of care planning for children with serious emotional disturbance. Funded projects include expansion of wraparound, infant mental health, screening of mental health needs for youth involved in the juvenile justice system, and other evidence-based practices such as Parent Management Training

- Oregon model, Multi-System Therapy, Therapeutic Foster Care and Functional Family Therapy.
- Development of a standard policy guideline to address service access and decision making which has become an attachment to the MDCH contract with PIHPs and CMHSPs.
- Development of a Technical Advisory for use through the field revising the specific access criteria for children with serious emotional disturbance. This will become an attachment to the 2010 contract with PIHPs and CMHSPS.
- CMS (was this spelled out somewhere earlier) approval of the 1915(b) waiver includes more than \$13 million in additional funding for children during the current fiscal year to be used for additional services to children with SED and DD with a specific focus on children in DHS foster care. Where will the match for the MA \$ come from?
- Additional funding has been added to the substance abuse Medicaid Waiver capitation for children and adults for increased access to services.
- The 2009 contract with PIHPs includes specific performance requirements related to the above planned increases in access to services for children.

Plans for additional changes in 2009 and beyond include:

- Implementation of funded projects listed above will increase the State's use of evidence based practices for children needing mental health services.
- Continuation and expansion of the Michigan Level of Functioning Project to assess progress for children and their families using the CAFAS to improve decisions about treatment in individual cases and to make systemic improvements in the system of care.
- Developing and providing training on an evaluation system that ensures fidelity to the Wraparound process.
- Developing an early childhood system of care for children birth through five using the Great Start Collaboratives convened by the Intermediate School Districts (ISDs).
- Increase family voice and choice in policy development, planning, training and RFP reviews to increase effectiveness in targeting programs and service delivery to consumer needs.
- Working collaboratively, MDCH and MDHS to develop new approaches to blending or braiding funding to provide intensive community based services to address gaps in mental health service available to children in foster care.

The following tables provide information about:

- PIHP and CMHSP organization and service delivery areas.
- Children served by PIHPs per year since 2001.
- Children served by each PIHP in 2007.
- Persons served by age group in each CMHSP in 2007.
- Children's services related Medicaid performance indicators.

**Figure 70: PIHP and CMHSP Organizations and Service Delivery Areas**

Prepaid Inpatient Health Plans (PIHP) and Directors	Lead Affiliate Community Mental Health Services Programs (CMHSP) Other Affiliates in each PIHP
(1) NORTH CARE Cyndi Shaffer, CEO Gail Hall, Ex. Dir. 200 West Spring Street Marquette, MI 49855 906-225-7202 24Hr# (800) 728-4929	1. Pathways CMH (Alger, Delta, Luce, Marquette) 2. Copper Country CMH (Baraga, Houghton, Keewanaw, Ontonagon) 3. Hiawatha CMH (Chippewa, Mackinac, Schoolcraft) 4. North.Pointe CMH (Menominee, Dickinson, Iron) 5. Gogebic CMH
(2) ACCESS ALLIANCE OF MICHIGAN Robert Blackford, CEO 201 Mulholland Bay City, MI 48078 989-895-2300 24Hr# (800) 448-5498	6. Bay-Arenac CMH (Bay, Arenac) 7. Huron CMH 8. Tuscola CMH 9. Montcalm CMH 10. Shiawassee CMH
(3) VENTURE BEHAVIORAL HEALTH Ervin Brinker, CEO 140 West MI Avenue Battle Creek, MI 49017 616-966-1460 24Hr# (800) 897-3035	11. Summit Pointe CMH (Calhoun) 12. Barry CMH 13. Berrien CMH 14. Pines CMH (Branch) 15. Van Buren CMH
(4) DETROIT-WAYNE CO CMH Veda Sharp, Acting Dir. 640 Temple, 8th Floor Detroit, MI 48201-2555 313-833-2500 24Hr# (866) 690-8257	16. Detroit-Wayne CMH
(5) NORTHERN AFFILIATION Dave Schneider, CEO Alexis Kaczynski, Ex. Dir. One McDonald Drive, Suite A Petoskey, MI 48602M 231-347-7890 24Hr# (800) 834-3393	17. North Country CMH (Antrim, Charlevoix, Cheboygan, Emmet, Kalkaska, Otsego) 18. Northeast CMH (Alcona, Alpena, Montmorency, Presque Isle) 19. AuSable CMH (Oscoda, Ogemaw, Iosco)
(6) THUMB ALLIANCE Michael McCartan, Ex. Dir. 1011 Military Street Port Huron, MI 48060-5416 810-985-8900 24Hr# (888) 225-4447	20. St. Clair CMH 21. Lapeer CMH 22. Sanilac CMH
(7) CMH PARTNERSHIP OF SOUTHEAST MICHIGAN Kathleen Reynolds, Ex. Dir. PO Box 915, 555 Towner Blvd Ypsilanti, MI 48197-1915 734-484-6620 24Hr# (800) 440-7548	23. Washtenaw CMH 24. Lenawee CMH 25. Livingston CMH 26. Monroe CMH
(8) OAKLAND CO CMH AUTHORITY Jeff Brown, Ex. Dir. 2011 Executive Hills Boulevard Auburn Hills, MI 48326 248-858-1210 24Hr# (800) 231-1127	27. Oakland CMH
(9) NORTHWEST CMH AFFILIATION	28. Northern Lakes CMH (Crawford, Grand Traverse, Leelanau,

Prepaid Inpatient Health Plans (PIHP) and Directors	Lead Affiliate Community Mental Health Services Programs (CMHSP) Other Affiliates in each PIHP
<p>Greg Paffhouse, CEO  105 Hall Street, Suite A  Traverse City, MI 49684  231-922-4850876-3200  24Hr# (800) 492-5742</p>	<p>Missaukee, Roscommon, Wexford)  29. West MI CMH (Lake, Mason, Oceana)</p>
<p>(10) CMH AFFILIATION OF MID-MI  Robert Sheehan, Ex. Dir.  812 East Jolly Road  Lansing, MI 48910  517-346-8200  24Hr# (517) 346-8318</p>	<p>30. CEI CMH (Clinton, Eaton, Ingham)  31. Gratiot CMH  32. Ionia CMH  33. Newaygo CMH  34. Manistee-Benzie CMH</p>
<p>(11) LIFEWAYS  Joanne Sheldon, CEO  1200 North West Avenue  Jackson, MI 49202  517-789-1200  24Hr# (517) 789-1200</p>	<p>35. Lifeways CMH (Jackson, Hillsdale)</p>
<p>(12) MACOMB CO CMH SERVICES  Donald Habkirk, Jr., Ex. Dir.  5th Fl County Bld, 10 N Main St  Mt. Clemens, MI 48043  586-469-5275  24Hr# (586) 948-0206</p>	<p>36. Macomb CMH</p>
<p>(13) CMH CENTRAL MICHIGAN  Linda Kaufman, Ex. Dir.  302 South Crapo,  Suite 100  Mt. Pleasant, MI 48858  989-773-6961  24Hr# (800) 317-0708</p>	<p>37. CMH for Central Michigan (Clare, Gladwin, Isabella, Mecosta, Midland, Osceola)</p>
<p>(14) SOUTHWEST MI URBAN &amp; RURAL CONSORTIUM  Jeff Patton, Ex. Dir.  3299 Gull Road, P.O. Box 63  Nazareth, MI 49074  616-553-8000  24Hr# (888) 373-6200</p>	<p>38. Kalamazoo CMH  39. Allegan CMH  40. Woodlands CMH (Cass)  41. St. Joseph CMH</p>
<p>(15) LAKESHORE BEHAVIORAL HEALTH  John North, Ex. Dir.  376 Apple Avenue  Muskegon, MI 49442  231-724-1104  24Hr# (231) 720-3200</p>	<p>42. Muskegon CMH  43. Ottawa CMH</p>
<p>(16) NETWORK 180  Paul Ippel, Ex. Dir.  728 Fuller, N.E.  Grand Rapids, MI 49503  616-336-3765  24Hr# (800) 749-7720</p>	<p>44. Kent CMH</p>
<p>(17) SAGINAW CO CMH AUTHORITY  Sandra Lindsey, CEO  500 Hancock  Saginaw, MI 48602  989-797-3400</p>	<p>45. Saginaw CMH</p>

Prepaid Inpatient Health Plans (PIHP) and Directors 24Hr# (800) 233-0022	Lead Affiliate Community Mental Health Services Programs (CMHSP) Other Affiliates in each PIHP
(18) GENESEE CO CMH SERVICES Danis Russell, Ex. Dir. 420 West Fifth Avenue Flint, MI 48503 810-257-3705 24Hr# (877) 346-3648	46. Genesee CMH

**Figure 71: Children Served Per Year By PIHPS**

Total Persons Served	Children with MI	%	Children with DD	%	Children with MI & DD	%	Age or Disability Not Reported	%	
1999	205,559	40,998	19.9%	4,671	2.3%	-----	-----	12,505	6.1%
2000	190,408	35,994	18.9%	5,158	2.7%	-----	-----	13,897	7.3%
2001	173,061	26,369	15.2%	4,758	2.7%	1,012	0.6%	15,021	8.7%
2002	195,552	36,732	18.8%	4,450	2.3%	926	0.5%	10,136	5.2%
2003	185,072	30,148	16.3%	4,733	2.6%	1,235	0.7%	11,217	6.1%
2004	184,708	31,300	16.9%	4,553	2.5%	1,136	0.6%	7,797	4.2%
2005	198,433	35,120	17.7%	4,821	2.4%	1,344	0.7%	5,040	2.5%
2006	205,929	36,054	17.5%	4,939	2.4%	1,593	0.8%	5,893	2.9%
2007	211,972	36,638	17.3%	5,315	2.5%	1,642	0.8%	7,740	3.7%

Data produced by: MDCH, Mental Health and Substance Abuse Services, Performance Measurement Section  
Source data: FY1999-2001 Community Mental Health Services Programs Demographic and Cost Data; FY2002-2007 Quality Improvement and Encounter Data  
File: G:\QMP\Fingertip Reports\Fingertip Report October 2007 Rev 4 8 08.xls  
Report date: 5/1/2008

**Figure 72: Children Served in 2007 by PIHP**

PIHP	Total Served	Children with Serious Emotional Disorder Served (SED)	Percentage of SED Children Served Receiving Homebased Services	Percentage of SED Children Served Receiving Wraparound Services
Access Alliance	8,720	1,530	25.23%	0.52%
CMH Affiliation of Mid-Michigan	11,979	2,552	36.91%	5.56%
CMH for Central Michigan	5,376	858	27.04%	2.21%
Detroit-Wayne	52,590	11,332	6.37%	0.40%
Genesee	10,966	1,505	13.49%	0.66%
Lakeshore Affiliation	6,755	901	10.32%	0.44%
Lifeways	7,132	1,199	10.76%	0.00%
Macomb	11,138	1,268	5.84%	2.52%
network180	9,986	1,876	8.10%	0.00%
North Care	7,067	1,171	11.61%	1.11%
North Country	8,248	1,797	11.30%	3.67%
Northern Lakes	7,152	1,447	10.71%	2.35%
Oakland	15,202	1,625	23.08%	7.38%
Saginaw	4,273	710	29.15%	2.96%
Southeast Partnership	7,916	1,143	18.20%	9.01%
Southwest Affiliation	9,972	2,313	14.48%	6.87%
Thumb Alliance	5,597	735	22.45%	0.00%
Venture	14,164	2,676	10.35%	5.31%
State Total	204,233	36,638	13.63%	2.51%

Report Produced by: MDCH, Mental Health and Substance Abuse Services, Performance measurement Section  
 Source Data: Quality Improvement and Encounter Data  
 Data Extraction Date: June 23 and 24, 2008 and march 21, 2008 (Section 404)  
 Report date: 6/24/2008

**Figure 73: Number of Persons Receiving Services from CMHSPs by County**

Number of Persons Receiving Services from CMHSPs  
by CMHSP and Age  
Persons with Mental Illness  
Fiscal Year 2007  
State of Michigan

CMHSP	Age						Unreported	Total
	0-3	4-12	13-17	18-26	27-64	65+		
Allegan	3	115	134	205	738	64	0	1,259
AuSable	2	220	251	258	940	74	0	1,745
Barry	0	92	190	283	764	74	0	1,403
Bay Arenac	10	361	374	574	2,222	172	0	3,713
Berrien	3	209	371	503	2,016	171	1	3,274
Clinton Eaton Ingham	98	466	750	790	2,823	255	0	5,182
CMH for Central Michigan	3	384	471	558	2,371	228	0	4,015
Copper	5	100	57	112	471	63	0	808
Detroit	269	3,830	7,233	5,351	26,041	1,769	1	44,494
Genesee	31	720	754	1,275	5,903	280	0	8,963
Gogebic	0	45	52	78	223	34	0	432
Gratiot	20	147	145	124	307	81	0	824
Hiawatha	6	86	115	133	518	80	0	938
Huron	1	74	74	112	421	85	1	768
Ionia	2	129	202	365	891	103	0	1,692
Kalamazoo	49	697	603	520	2,215	185	2	4,271
Lapeer	1	75	65	154	559	62	0	916
Lenewee	3	152	139	277	1,039	68	0	1,678
Lifeways	18	493	688	1,216	3,722	281	0	6,418
Livingston	2	103	115	132	513	39	0	904
Macomb	22	599	647	1,134	5,503	488	3	8,396
Manistee-Benzie	5	195	114	138	494	85	0	1,031
Monroe	1	94	138	220	794	62	1	1,310
Montcalm	11	105	120	183	453	24	0	896
Muskegon	11	277	283	526	1,889	164	0	3,150
network180	214	831	831	1,082	4,636	378	0	7,972
Newaygo	11	121	147	169	519	79	0	1,046
North Country	0	517	444	558	1,655	163	0	3,337
Northeast	4	170	189	250	1,064	155	0	1,832
Northern Lakes	20	485	447	548	2,224	244	2	3,970
Northpointe	5	115	190	234	748	118	0	1,410
Oakland	294	640	691	1,381	7,385	980	0	11,371
Ottawa	4	156	170	379	1,338	52	0	2,099
Pathways	10	130	255	407	1,120	109	0	2,031
Pines	3	231	204	271	829	71	0	1,609
Saginaw	48	250	412	435	1,888	451	1	3,485
Sanilac	7	58	63	96	425	55	0	704
Shiawassee	2	78	116	171	533	39	0	939
St. Clair	2	200	264	356	1,482	97	0	2,401
St. Joseph	30	263	194	291	947	73	0	1,798
Summit Pointe	4	487	530	640	2,449	384	0	4,494
Tuscola	1	94	109	160	494	47	0	905
Van Buren	11	123	218	244	1,007	124	0	1,727
Washtenaw	14	184	198	187	1,354	116	0	2,053
West Michigan	3	203	289	306	1,048	113	0	1,962
Woodlands	4	102	119	138	472	64	0	899
<b>Total</b>	<b>1,267</b>	<b>15,206</b>	<b>20,165</b>	<b>23,524</b>	<b>97,447</b>	<b>8,903</b>	<b>12</b>	<b>166,524</b>

This information is taken from the Quality Improvement data submitted to the DCH data warehouse.

**Figure 74: Medicaid Performance Indicators 2007**

PIHP	Indicator #1a	Indicator #12a
	% children receiving pre-admission screening within 3 hours  Standard 95%	% of children readmitted to an inpatient psychiatric unit within 30 days of discharge  Standard 15% or less
	Percent	Percent
Access Alliance	99.3	17.0
CMH Affiliation of Mid-Michigan	99.5	7.5
CMH for Central Michigan	100.0	9.1
Detroit-Wayne	99.2	4.8
Genesee	99.2	19.1
Lakeshore Affiliation	99.2	4.3
Lifeways	100.0	5.4
Macomb	99.0	17.6
network180	95.7	6.1
North Care	99.2	11.1
North Country	99.2	5.9
Northern Lakes	97.0	5.2
Oakland	96.2	9.6
Saginaw	99.5	9.8
Southeast Partnership	99.7	11.2
Southwest Affiliation	100.0	7.9
Thumb Alliance	100.0	20.0
Venture	100.0	4.8
State Average	99.0	9.8

Data produced by: MDCH, Mental Health and Substance Abuse Services, Performance Measurement Section  
Source data: FY1999-FY2001 Community Mental Health Services Programs Demographic and Cost Data FY2002-FY2007  
Quality Improvement and Encounter Data  
File: G:\QMP\Fingertip Reports\Fingertip Report October 2007 Rev 4 11 08.xls  
Report date: 4/11/2008

## Appendix 5: Survey Distribution Correspondence



STATE OF MICHIGAN  
**Department  
of Human  
Services**

**Field Operations Administration  
Children's Services Administration**  
235 S. Grand Ave., Suite 1508  
P.O. Box 30037  
Lansing, MI 48909  
[www.michigan.gov/dhs](http://www.michigan.gov/dhs)

**L-09-033-CW  
Child Welfare**

# Memorandum

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To: County Directors  
District Managers  
Child Welfare Urban Field Operations Director  
Date: March 20, 2009

From: Terry A. Salacina, Acting Deputy Director, Field Operations Administration  
Kathryne A. O'Grady, Deputy Director, Children's Services Administration

Subject: Child Welfare Needs Assessment Survey  
Response Due: None

The staff of the Child Welfare Resource Center at the Michigan State University (MSU) School of Social Work is conducting a Needs Assessment of child welfare services as prescribed by the CRI lawsuit settlement agreement. As part of their information gathering, they are surveying stakeholders across the state via Survey Monkey. The survey will consist of questions regarding the availability of services in your county to meet the needs of families and children. Your responses will allow MSU to identify areas in which counties need additional child welfare services.

The Department of Human Services will also use the survey results to assist with preparation for the Child and Family Service Reviews (CFSR) and 5-Year Child and Family Services State Plan (CFSP).

We encourage you and your child welfare staff to participate in these surveys. All survey responses are anonymous and MSU will only use county information to identify distribution of services and needs across the state.

If you are a County Director or County Child Welfare Director click here:

[http://www.surveymonkey.com/s.aspx?sm=fGJkZP\\_2fHS\\_2ft2R40BNJ9fWA\\_3d\\_3d](http://www.surveymonkey.com/s.aspx?sm=fGJkZP_2fHS_2ft2R40BNJ9fWA_3d_3d)

If you are a Services Supervisor or Program Manager click here:

[http://www.surveymonkey.com/s.aspx?sm=wyv8Xe5hMusq50irGos1Tw\\_3d\\_3d](http://www.surveymonkey.com/s.aspx?sm=wyv8Xe5hMusq50irGos1Tw_3d_3d)

If you are a CPS, Foster Care, Adoption, or Permanency Worker click here:

[http://www.surveymonkey.com/s.aspx?sm=WprBgZK9\\_2bm17JT7t1EaDMg\\_3d\\_3d](http://www.surveymonkey.com/s.aspx?sm=WprBgZK9_2bm17JT7t1EaDMg_3d_3d)

Number and Status of Previous L-Letters Issued on the Same Subject: None

Contact Office: Federal Compliance Office

Telephone Number and E-mail address of Contact: Kimberly Kerns, (517) 241-6930;  
kernsk@michigan.gov

Distribution: Child Welfare Staff

Obsolete Date: April 12, 2009

*Copy of Email Notice Regarding Survey Participation sent March 17, 2008*

From: James Hennessey [mailto:hennes43@msu.edu]  
Sent: Tuesday, March 17, 2009 6:17 PM  
To: (see body of needs assessment report for description of how this email was distributed)  
Subject:  
Hello All!

The Child Welfare Resource Center at the MSU School of Social Work is conducting a Needs Assessment of child welfare services as prescribed by the CRI lawsuit settlement agreement. As part of their information gathering, we are surveying stakeholders across the state via Survey Monkey. The survey results will be used also to assist with preparation for the Child and Family Service Reviews (CFSR) and 5-Year Child and Family Services Plan (CFSP).

We encourage you and the staff in your organization to participate in these surveys. Your responses will provide information that is valuable for accurate child welfare planning. Please share the following links with your child welfare staff so they may provide valuable input regarding the array and accessibility of services to children and families. All survey responses are anonymous and information about location in the state will only be used to identify distribution of services and needs across the state.

If you are a Chief Executive Officer for your agency click here:

[http://www.surveymonkey.com/s.aspx?sm=fGJkZP\\_2fHS\\_2ft2R40BNJ9fWA\\_3d\\_3d](http://www.surveymonkey.com/s.aspx?sm=fGJkZP_2fHS_2ft2R40BNJ9fWA_3d_3d)

If you are a Services Supervisor or Program Manager click here:

[http://www.surveymonkey.com/s.aspx?sm=wv8Xe5hMusq50irGos1Tw\\_3d\\_3d](http://www.surveymonkey.com/s.aspx?sm=wv8Xe5hMusq50irGos1Tw_3d_3d)

If you are a Family Preservation, Foster Care, Licensing/Certification, Adoption, or Permanency Worker click here:

[http://www.surveymonkey.com/s.aspx?sm=WprBgzK9\\_2bm17JT7t1EaDMg\\_3d\\_3d](http://www.surveymonkey.com/s.aspx?sm=WprBgzK9_2bm17JT7t1EaDMg_3d_3d)

The surveys need to be completed by Monday, March 23, 2009. Survey access will close at 11:59 p.m. on that date.

The time you commit to provide this important information will be greatly appreciated.

Thank you.

Jim Hennessey  
Director, Child Welfare Resource Center  
MSU School of Social Work  
254 Baker Hall  
East Lansing, MI 48824  
517-353-0724

## Appendix 6: Survey Results Detail

### Supplementing Section II. Preventing Entry Into Foster Care

The survey asked CPS workers to identify services provided to children and families in their ongoing current caseloads. Their responses are summarized in the figure below:

**Figure 75: Children in CPS Caseload Receiving Preservation Services**

Source: Worker Survey, Question 25.3			
Please indicate the number of children and birth families on your ongoing CPS caseload for whom the listed services are being provided (shown in mean number of children or birth family per worker caseload).			
Number of Respondents = 77	DHS	Private	Tribes
Wraparound	1.26	4.25	2.5
Families First	2.19	5.41	7.75
Family Group Decision Making	2.05	12.20	7.75
Home Visiting	6.46	13.50	4
Parent Education	4.01	3.00	7.75
Anger Management	1.42	2.50	8
Counseling	5.19	3.77	13
Physical Health	2.4	7.06	6
Dental Health	2.88	6.70	7.75
Psychiatric	1.74	4.88	5.25
Mental Health	2.84	1.78	7.75
Substance Abuse Treatment	2.82	1.00	2.5
Financial Assistance	3.74	12.60	6
Transportation	2.31	4.83	7.75
Employment/Training	2.04	4.56	2.5
Education Services	2.82	5.28	2.5
<b>Total</b>	<b>50</b>	<b>23</b>	<b>4</b>
Mean number birth families per worker served with specific services			
Wraparound	1.15	3.50	2.50
Families First	1.45	3.50	5.25
Family Group Decision Making	1.75	4.45	5.25
Home Visiting	4.26	3.86	2.75
Parent Education	3.53	8.89	5.25
Anger Management	1.37	3.29	2.50
Counseling	3.74	2.81	2.50
Physical Health	1.43	3.29	1.00
Dental Health	1.74	2.33	5.25
Psychiatric	1.38	3.00	5.25
Mental Health	2.06	3.60	5.25
Substance Abuse Treatment	3.66	2.96	4.33
Financial Assistance	3.35	3.88	4.33

Transportation	2.57	3.50	5.25
Employment/Training	2.76	2.50	5.25
Education Services	2.13	2.35	2.50
Number of Respondents	50	23	4

A question was asked on the survey regarding the services provided to families prior to removal.

**Figure 76: Services Provided Prior to Removal of Child from the Home**

Source: Worker Survey Q22		
What services were provided prior to the removal?		
Total Respondents = 30	Total who use the service	Percent of Respondents who use the service
Mental Health	24	80.0
Families first	15	50.0
Parent Services	12	40.0
Substance Abuse	7	23.3
CPS investigation and case management	5	16.7
Financial assistance	5	16.7
Team Decision Making	3	10.0
Prevention	2	6.7
Court Services	2	6.7
Early On	2	6.7
Home Visits	2	6.7
Other	16	53.3

### Supplementing Section III. Supporting Placements and Expediting Permanency

Foster care workers were asked in the survey to identify services provided to children in their caseloads to prepare for goal change or step down in foster care. The service levels reported in the Figure below for both children and birth families is substantially higher for these cases than those reported for ongoing CPS cases where the child remains in the home.

**Figure 77: Children, Birth Families, and Kinship/Foster Families in Caseload Receiving Services Provided to Prepare for Goal Change or Step Down in Foster Care (Reunification not imminent)**

Source: Worker Survey, Question 31.1			
Services provided to prepare for permanency goal in foster care cases (Reported in terms of mean number children/ care providers per responding worker.)			
Number of Respondents = 46			
Children	DHS	Private	Tribal
In-Home Services	3.88	4.28	5.13
Parenting Education	4.83	3.88	5.13
Physical Health Services	7.94	4.60	2.67
Mental Health Services	11.39	6.08	5.13
Dental Health Services	12.58	11.90	6.00
Substance Abuse Services	2.64	3.60	5.13
Financial Assistance	5.31	4.33	4.60
Housing Assistance	5.22	4.33	6.00
Transportation Services	5.45	4.33	5.13
Employment/Training	4.87	2.50	6.00
Education	11.31	2.50	6.00
Psychiatric Services	5.60	3.60	5.13
Wraparound	4.33	5.13	6.00
Birth Families			
In-Home Services	3.69	3.29	3.88
Parenting Education	5.74	3.88	3.88
Physical Health Services	4.82	4.60	4.33
Mental Health Services	6.77	3.88	3.88
Dental Health Services	6.22	5.13	4.33
Substance Abuse Services	6.33	4.25	3.88
Financial Assistance	7.45	2.50	3.60
Housing Assistance	5.80	2.50	4.33
Transportation Services	6.92	2.50	3.88
Employment/Training	6.78	2.50	4.33
Education	5.59	2.50	4.33
Psychiatric Services	5.53	2.50	3.88
Wraparound	3.38	3.88	4.33
Kinship Care and Foster Families			
In-Home Services	2.76	2.50	2.50
Parenting Education	2.64	2.50	2.50
Physical Health Services	4.13	2.50	2.50
Mental Health Services	4.20	2.50	2.50

Dental Health Services	5.46	4.33	2.50
Substance Abuse Services	2.92	2.50	2.50
Financial Assistance	3.81	2.50	2.50
Housing Assistance	2.80	2.50	2.50
Transportation Services	3.28	2.50	2.50
Employment/Training	3.26	2.50	2.50
Education	3.47	2.50	2.50
Psychiatric Services	2.65	2.50	2.50
Wraparound	2.66	2.50	2.50

Workers were asked to identify supports they need that would assist them in the identification and recruitment of relatives or other care providers who are well matched to meet the child's needs. Responses are provided below, and indicate that additional staffing, collaboration with the family, and access to data that would help them in the process were the most frequent answers.

**Figure 78: Support Needed by Workers to Aid Them in the Identification of Relative or Other Care Providers**

Source: Worker Survey, Question 29.2		
What support would help you improve identification and selection of relatives or other care providers who are well-matched to the child's needs		
Number of Respondents = 56	Total Responding	Percent of Respondents
Staffing	14	25.0
Family collaboration	10	17.9
Access to databases or records	11	19.6
Biological Parent	6	10.7
More help from CPS	5	8.9
More Time	4	7.1
Friends	2	3.6
The Child	2	3.6
Information on Resources	3	5.4
Other	6	10.7
Don't Know/Not Applicable	7	12.5

## Supplement to Section IV. Maintaining Permanency and Stability

The survey asked permanency workers to identify the number of children and families in their caseloads receiving services to prepare children and families for their permanent placements. Responses are below.

**Figure 79: Number of Children and Families in Caseload Receiving Permanency Services**

### *Youth Transition Service Needs*

Source: Worker Survey, Question 43.1			
Services provided to prepare for permanency goal in foster care cases (Reported in terms of mean number children or permanent placements per responding worker.)			
Number of Respondents = 12			
Children	DHS	Private	Tribal
Home Visiting Programs	5.05	2.50	2.5
Parenting Education	5.05	2.50	2.5
Counseling	6.83	7.83	2.5
Psychiatric Services	5.82	4.33	2.5
Physical Health Services (other than Medical Subsidy)	5.33	4.33	2.5
Dental Health Services	8.22	4.33	2.5
Substance Abuse Services	4.78	2.50	2.5
Financial Assistance (other than Adoption Subsidy)	5.33	5.25	2.5
Housing Assistance	5.33	2.50	2.5
Wraparound	2.50	2.50	2.5
Transportation Services	5.94	2.50	2.5
Employment/Training	5.94	2.50	2.5
Education Services	6.27	4.33	2.5
Foster/Adoptive/Guardianship Families			
Home Visiting Programs	5.05	2.5	2.5
Parenting Education	3.45	2.5	2.5
Counseling	3.83	2.5	2.5
Psychiatric Services	5.60	2.5	2.5
Physical Health Services (other than Medical Subsidy)	5.33	2.5	2.5
Dental Health Services	8.22	2.5	2.5
Substance Abuse Services	5.33	2.5	2.5
Financial Assistance (other than Adoption Subsidy)	5.33	2.5	2.5
Housing Assistance	5.33	2.5	2.5
Wraparound	2.50	2.5	2.5
Transportation Services	5.94	2.5	2.5
Employment/Training	5.94	2.5	2.5
Education Services	6.27	2.5	2.5

Workers that provide youth transition services provided information in the figure below about services they provide.

**Figure 80: Services Provided to Youth in Transition**

Source: Worker Survey, Questions 52.1 and 2	
Youth Transition: What programs and services have you provided to children on your caseload in order to help them prepare to transition into adulthood? (check all that apply)	
Number of Respondents = 40	Percent of Respondents
Independent Living Skills Classes	62.5
Educational Planning	82.5
Housing Assistance	57.5
Transportation	60.0
Employment Services	60.0
Other	30.0

## Appendix 7: Focus Group Descriptions and Protocols

Figure 81: Description of Focus Groups

Focus Group	Facilitator	N	Date(s)	Description of Participants	Counties Represented	Method
Youth Focus Group and Study	Angelique Day, LLMSW and John Seita, Ed.D.	72	2006-2008	72 former foster care youth. Recruited from throughout the state of Michigan to participate in this study with 54 participating in one of 11 focus groups, and 19 respondents participating in individual, face to face or phone interviews from 2006 through 2008. All respondents were at least 18 years of age, mode was 18 years of age, median age of 21, and average age of 24. 65% were female, 35% were male. 53% were Caucasian, 39% were African American, 8% were of another race. 56% had some college education, and 44% had not completed their high school diploma.	Bay, Calhoun, Ingham, Kalamazoo, Livingston, Macomb, Oakland, Wayne, Grand Traverse, Genesee, Isabella, Kent, Marquette, Midland and Washtenaw	Appreciative inquiry and probing for focus groups and phone or face-to-face interviewing
Adoptive Parent Focus Group and Study	Gary Anderson, Ph.D. and John Mooradian, Ph.D.	21	3/07-6/07 Focus Group 4/08-6/08 Surveys	12 adoptive couples from throughout Michigan who adopted children from foster care participated in this study. Four focus groups were conducted statewide.	Ingham, Wayne, Kent and Calhoun	Appreciative Inquiry for focus groups
Wayne County DHS Focus Groups	Susan Lebold, JD, MSW	18	3/30/09 Am session Pm session	DHS caseworkers (am session): 7 DHS supervisors/managers (pm session): 11 Experience ranged from 2 to 32 years. Most caseworkers were involved with CPS and foster care, one person was a TDM facilitator, one person was an Indian Outreach Worker for Child and Family Services. Types of supervisors represented: CPS, foster care, YIT, TDM, and placement. Racial/gender make-up: 2 male, 16 female; 35% African American, 65% Caucasian	Wayne	Nominal Group Technique and Appreciative Inquiry with probing
Southeast Michigan Private Agency Focus Groups	Susan Lebold, JD, MSW	16	4/02/09 Am and Pm sessions	Am session: 7 participants included a foster care counselor, a foster care case manager, an agency director, a foster care supervisor, a Family Reunification Program (FRP) worker, a FRP team leader, and an adoption worker. Pm session: 9 participants included executive directors, foster care managers/supervisors, one chief operating officer, one family preservation director, two FRP supervisors, and a program manager. Experience ranged from 15 months to 32 years. Agencies represented included Girlstown Foundation, Starr Commonwealth, Vista Maria, Oakland County Judson Center, Oakland Family Services, Lutheran Adoption Services Racial/gender make-up: 1 male, 6 female; 50% African American, 50% Caucasian	Wayne, Oakland	Nominal Group Technique and Appreciative Inquiry with probing

Focus Group	Facilitator	N	Date(s)	Description of Participants	Counties Represented	Method
Central Michigan Private Agency Focus Groups	Holly Makimaa	11	4/3/09 Am and Pm sessions	Am session: 7 participants including foster care workers, adoption workers, a foster care therapist and a FRP worker. Pm session: 4 participants including three directors and one associate director. Experience ranged from 2 years to 30 years. Agencies represented included: Child and Family Services, Highfields, Starr Commonwealth, Judson Center, Families Forever Racial/Gender make-up: 3 males, 8 females, 1 African American, 1 Asian, 9 Caucasians	Ingham, Oakland, Jackson, Calhoun	Nominal Group Technique and Appreciative Inquiry with probing
Substance Abuse Focus Group	Lynn Hedges, MSW, and Holly Makimaa	9	3/5/09	9 professionals from the substance abuse field: 3 case managers, 3 directors of large substance abuse programs (public and private), a clinical director, a therapist and 2 program administrators. Experience ranging from 1 year to >10 years. Racial/Gender make-up: 2 males, 7 females, 2 African Americans, 7 Caucasians	Ingham, Jackson, Kent, and Ionia Counties	Appreciative Inquiry with probing
Tribal Focus Group and Conference Call	Jim Hennessey, Shelly Wood, and Carol Kraklan	9	3/31/09 and 4/16/09	Initial Focus Group: Tribal social service professionals from the Little River Band of Ottawa Indians, Ingham County Health Department - Native American Outreach, Ingham County Power of We Consortium and Michigan State University. Additional follow-up was conducted with tribal social service representatives from the Sault St. Marie Tribe of Chippewa Indians, the Saginaw Chippewa Indian Tribe, and American Indian Health and Family Services of Southeastern Michigan. Gender/Racial make-up: 9 Native Americans, 7 females and 2 males	Ingham Manistee Chippewa Isabella Wayne	Focus group with probing and follow-up conference call focus group with written questionnaire
Child Adovocacy and Assessment Center	Lynn Hedges, MSW, and Holly Makimaa	11	3/30/09 and 4/26/09	Initial focus group: directors and supervisors from CAC's in Bay, Allegan and Kent Counties. Additional follow-up was conducted with directors/coordinators from 8 other CAC's across the state (see counties represented to right). Racial/Gender make-up: 10 females, 1 male, 1 African American, 10 Caucasians	Bay, Allegan Kent, Washtenaw, Shiawassee, Ottawa, Macomb, Isabella, Calhoun, Kalamazoo Muskegon	Appreciative Inquiry with probing for focus group and focus group questionnaire for follow-up group
Birth Parent	Janet Strope, MA and Jim Hennessey	6	4/29/09	5 caucasian attendees; 5 female, 1 male	Ingham County	Appreciative Inquiry with probing
Mental Health Providers	Janet Strope, MA and Jim Hennessey	5	4/14/09	Child and family therapists from community mental health agency; 5 caucasian attendees; 4 female, 1 male	Ingham County	Appreciative inquiry with probing

## ***Focus Group Questions for Child Assessment Centers***

March 30, 2009

What is working well within child assessment centers to care for children who have been abused or who might be at risk of abuse?

What kinds of cases are you getting? What kind of cases would you like to see more of or earlier?

What suggestions do you have for the referral process?

What suggestions do you have early intervention?

How do you work with CPS, law enforcement officials and hospitals in abuse cases?

From your experience working within the child welfare realm, what do you see working well within Child Protective Services to help keep kids safe?

What are ideas you have for improvements in CPS?

Where do you see gaps in the system?

What are the most common needs you see of parents whose children are being seen for abuse?

What kinds of services are or do think would be most helpful for parents in preventing abuse?

What kinds of services are or do think would be most helpful for children in preventing abuse?

What kinds of CPS policies or practices would better help you do your job in protecting children?

How assessable are services for abused children?

Where are the gaps in these services?

What kinds of barriers do you see to assessing services for abused children (language, transportation, proper assessment, quality housing, etc.)?

What ideas do you have for solutions to service barriers?

How quickly are you able to get abused children into services?

How is interagency collaboration (between state and other agencies)?

How are CPS workers able to use the information you give them?

What ideas do you have for workers in the system to better utilize the information you give them?

What ideas do you have to help prevent child abuse from happening?

What types of educational programs do you see working?

What is your relationship with the school systems?

What role do you take in training professional about abuse prevention?

What community resources do you see supporting this goal?

What ideas do you have for collaborative partnerships to support prevention?

What do you see hindering prevention of child abuse in the child welfare system?

What ideas do you have for ending the cycles of abuse from one generation to the next?

## ***Child Advocacy and Assessment Center Focus Group Questionnaire***

April 24, 2009

The Child Welfare Resource Center at Michigan State University is preparing a comprehensive needs assessment for the State of Michigan Department of Human Services (DHS). This assessment will be used to inform changes made by the state in reforming child welfare. As invested partners in children's welfare, we would be pleased to include your input in the needs assessment. We conducted a focus group of Child Advocacy and Assessment Centers in late March, 2009, and gathered their input. However, we would like to have a broader base of centers from around the state represented in our assessment. Could you please take a few minutes to answer the following questions? We appreciate the work you do and for taking the time to help with this important child welfare reform effort. We will not list your individual names in our assessment, but we will say collectively which agencies and counties were represented in our research. Please answer the questions based on your experience at your center. Thanks for your help!

Name of Agency:

County your agency is located in:

Position at agency:

Please list and describe the 3 most effective/helpful services at your Child Advocacy and/or Child Assessment Center:

- 1.
- 2.
- 3.

Please list and describe the 3 biggest service gaps or needs at your Child Advocacy and/or Child Assessment Center:

- 1.
- 2.
- 3.

At your center, what kinds of cases are you getting? What kind of cases would you like to see more of or earlier?

What suggestions do you have for the referral process?

How are the referrals from Law Enforcement and CPS?

What suggestions do you have early intervention?

From your experience working within the child welfare realm, what do you see working well within Child Protective Services to help keep kids safe?

What are ideas you have for improvements in CPS?

At your center, what are the most common needs you see of parents whose children are being seen for abuse?

What kinds of services are or do think would be most helpful for parents in preventing abuse?

What kinds of services are or do think would be most helpful for children in preventing abuse?  
What kinds of CPS policies or practices would better help you do your job in protecting children?

How are CPS workers able to use the information you give them?  
What ideas do you have for workers in the system to better utilize the information you give them?

Please use the back of the sheet for any additional comments you would like to make about support you need to help the centers more effectively serve children, youth and their families.

## ***DHS and Private Agency Focus Groups***

(conducted multiple dates and locations)

***DHS and private agency field workers: (AM Focus Group) Juvenile Justice Workers, Prevention/Intervention Workers, Foster Care Workers, Reunification Workers, Permanency Planning Workers, Child Protective Service Workers, Foster Care Certification workers.***

The purpose of the group is to help complete an assessment of the service needs and gaps in the child welfare system. To do this, we will conduct a round robin discussion on current caseloads as workers identify available services that work well, services that should be expanded and services that are not available or not effective. During the second hour of the group, we will conduct focus group-style discussions to gather greater detail about service and strategy needs in the child welfare system.

Introduction (10 minutes)

- Introduce members of group: State name, current position, how long you have been in your current position and how long you have worked in the child welfare field
- Explain the purpose of today's discussion. Describe the opportunity the lawsuit has brought for workers to step back and imagine/discuss what's available and what's needed to effectively serve in the child welfare field – child welfare in an ideal world (outside any constraints of your current position or environment). Specifically, what is needed to meet the child welfare expectations of the settlement agreement?

Ask participants to individually write their responses to the following questions: (8 minutes)

- Based on your direct experience working in the child welfare system, cite your top three examples of:
  - Services that are working/effective at promoting child welfare ideals
  - Services that are not promoting child welfare ideals or lacking in effectiveness

Conduct a round robin discussion to collect answers from each participant. (15 minutes) Have one CWRC member record each of their answers on a flip chart (omitting duplicate answers).

Have the group rank the top 3 services that are working and top 3 service needs or gaps (5 minutes)

Conduct a focus group discussion of the top 3 services that are working (25 minutes) and then the top 3 service needs or gaps (45 minutes). Probe to gather more detail including a) a description of the services and b) the strategies that enable or prevent the services from being effective.

Questions to probe if not mentioned in the discussion:

- How are transitions from one area of the child welfare system to another? What works well? What additional support would be helpful? Where are the gaps?
- How is the communication between the various players in the child welfare system? What else is needed for enhanced and effective communication?

- What kind of collaboration is effective, inner-agency and inter-agency, in promoting child welfare ideals? What is still needed for better collaboration?
- What kind of educational and training opportunities have helped you better do your job? What kind of training opportunities do you see as needed?

Recap themes from the discussions, and do a quick round robin (10 minutes) to see if anyone has information that they were not able to share during the two hours.

Thank participants and close the group (2 minutes).

***DHS and Private Agency Managers/Supervisors/Directors/CEOs: (PM Focus Group)***

Introduction (10 minutes)

- Introduce members of group: State name, current position, how long you have been in current position and how long you have worked in the child welfare field
- Explain that earlier today we did an exercise with DHS workers to determine what's working effectively and what's most needed in the child welfare system. We will share the results of the workers with you after you complete the same exercise.
- Describe the opportunity the lawsuit has brought for supervisors/managers to step back and imagine/discuss what's available and what's needed to effectively serve in the child welfare field – child welfare in an ideal world (outside any constraints of their current positions or environment). Specifically, what is needed to meet the child welfare expectations of the settlement agreement?

Ask participants to individually write their responses to the following questions: (8 minutes)

- Based on your experience working in the child welfare system, cite your top three examples of:
- Services that are working/effective at promoting child welfare ideals
- Services that are not promoting child welfare ideals or lacking in effectiveness

Conduct a round robin discussion to collect answers from each participant. (15 minutes) Have one CWRC member record each of their answers on a flip chart (omitting duplicates).

Have the group rank the top 3 services that are working and top 3 service needs or gaps (5 minutes).

Share the results of the worker exercise. Compare and contrast the supervisor/manager list with the worker list (15 minutes). Facilitate a discussion about potential differences. Create a new list of top 3's if desired. Discuss the possible reasons workers may have had for identifying the gaps/needs they chose.

Conduct a focus group discussion of the top 3 services that are working (20 minutes) and then the top 3 service needs or gaps (35 minutes).

Probe supervisors/managers to discover:

- What supports do supervisors need that would help you deliver the highest quality services in your community?
- What enables services to work? – i.e. common threads among most effective programs

- What causes gaps in services? – i.e. common barriers/issues that keep surfacing
- The conditions within your communities that increase or reduce barriers to enhancing or providing new services.

Recap themes from the discussions, and do a quick round robin (10 minutes) to see if anyone has information that they were not able to share during the two hours.

Thank participants and close the group (2 minutes).

***Child Welfare Nominal Group Technique Hand-out for DHS and Private Agency Focus Groups***

**Child Welfare Ideals:**

- Whenever possible, family preservation and support services are provided to maintain children safely in the homes of their legal parent(s).
- When children must be removed from their homes, services and supports are provided that promote the full development and well-being of the child.
- When children must be removed from their homes, family reunification and support services are provided to the children and their legal parents to reunify them as soon as safely possible.
- When children cannot be safely reunified with their legal parents, services and supports are provided to achieve an alternate legal permanency goal for the children as expeditiously as possible.
- For all youth who are placed in foster care, services and supports are provided to them to promote their preparation for exit from the child welfare system and transition to adulthood.

Based on your experience working in the child welfare system, cite your top three examples of: Services that are working/effective at promoting child welfare ideals

- 1.
- 2.
- 3.

Services that do not promote child welfare ideals or are lacking in effectiveness

- 1.
- 2.
- 3.

## ***Substance Abuse Focus Group Protocol***

March 5, 2009

I. Welcome: Thanks, introduction/"housekeeping", refreshments, time commitment and review agenda

II. Purpose of focus group: (write on board)

During this focus group, we will be gathering information to: 1) help determine how best to safely prevent children from being taken into foster care when their families have substance abuse issues. And 2) help determine how to effectively help parents recover, stay recovered, and get their children back (if that is in the best interest of the children).

Caveat: There may be many other important issues related to this topic that we could probably talk about at length, however during this time, we will be focusing our conversation pretty narrowly on this topic so we can gain as much information as possible in a short amount of time.

III. Explanation of the focus group (group norms)

- Your Wisdom shared: We are interested in learning from your wisdom, insight and experience – being practitioners and leaders in the field
- Confidentiality: We will not be using your individual names but will be sharing what agencies/orgs participated. We will be taping this session. Does anyone have objection to that?
- What we are doing with information: The information is to be used in a comprehensive needs assessment being conducted by MSU CWRC to deliver to DHS to help them make informed decisions as they seek to reform the child welfare system. Your input is vital.
- All voices heard: It is important for this process that all voices be heard and we will be inviting all of you to speak. There are no right answers and it is important that we hear many different perspectives. You all have unique experiences, so please feel free to share opinions you may feel are different. Everyone's input is invaluable to this process. Please let one person speak at a time so we can adequately record people's comments.
- Time constraints: I want to hear from everyone. At the same time, I will keep us moving along to address the questions in a timely manner. At the end, if we have missed an important point you wanted to make there will be time to state any burning issues that were not covered.
- At the end I will summarize the themes we have covered and as I mentioned, leave time for any comments we may have missed.
- Any questions about the process?

IV. Introductions: To help us better get to know each other, please tell us

- Your name
- Where you are from
- What agency/organization you work with
- What the nature of your work is in substance abuse treatment

V. Questions

- Do summary of what has been said (use flip chart for comments)
- Do round table for ending
- Tell folks that we will email summary of findings to group

**Focus Group questions and probes:**

What is working well in your organization to help parents with substance abuse issues overcome their addictions?

What community resources outside your organization do you see helping folks recover?

What ideas do you have for collaborative partnerships are helping to foster recovery?

What is working well in your organization to help keep kids safe AND out of foster care?

Who are the key players?

What resources enable this?

What training has helped you to more effectively work with kids? What further training is needed?

What other mental health support is needed to effectively treat children and their families as a whole?

How are assessments done in your organization?

What prevention and intervention programs/services effectively support children during their parent's recovery?

What successful strategies are you using to create reunification in situations (where that would be in the best interest of the children)?

What kinds of policies and procedures support this goal?

What ideas do you have to improve integration of services for children within the system?

What kind of coordination between agencies and courts yields the best results in your experience?

What kind of effective support have you seen children receive in the schools?

What do you see is working to help engage and retain mothers and fathers in treatment?

What drug and substance-free housing options have worked for your clients?

How has access to care affected your clients?

What options do you know of for legal support to coincide with treatment?

What kind of long-term strategies do you see working?

What ideas do you have to help improve outcomes for children who are temporarily put into foster care while a parent is struggling with substance abuse?

## ***Tribal Focus Group Questions***

March 31, 2009 and April 16, 2009

- Are you aware of differences between counties with regard to the child welfare system and its interactions with Indian families? If so, explain.
- Who routinely participates in developing case plans and how do the parties participate?
- Is tribal involvement sought in child welfare cases? Is this initiated in a timely manner?
- Does the child's tribe define active efforts for the Department of Human Services?
- Are foster care placement preferences honored (unless the court or the Indian child's tribe determines there is good cause for a different order of preference)?
- Recruitment/retention efforts for Native American foster homes – are they adequate, how can they be improved?
- What do relatives need to support placements?
- What services are most helpful to families (or to foster parents) to maintain children in their homes or to reunify them with their parents?
- What do you believe can be done to increase the awareness of the Indian Outreach Services? Of the Indian Outreach Workers?
- What services do you have available that are most helpful in addressing the risks associated with abuse and neglect? Are those services available at an adequate level to meet the demand in your county? Are there services not available that would be helpful in reducing placements or promoting reunification?
- What do you believe Michigan's top priority should be to improve the child welfare system?
- Is there other information we have not covered today, that you believe would be helpful in our review of the child welfare system?

Tribal Focus Group Follow-up Questions from Conference Call on April 16, 2009

- For relatives who are providing foster care for children, what supportive help or services do they need?
- What do you believe can be done to increase the awareness of Indian Outreach Services?
- Is there a way to utilize technology to assist in training? How much could be done through webinars introduced by Native People?
- Are there DHS county offices or providers who could model best practices for others?
- What services or programs do you find to be especially effective in each of the following circumstances?
  - Preventing abuse and neglect and preserving families?
  - Moving children and families to reunification in an expeditious manner?
  - Moving to an alternate permanency solution when reunification is not possible?

- Supporting youth in transition?
- Supporting children and families after reunification, adoption, guardianship?
  
- What gaps do you think exist in services or programs in each of the following circumstances:
  - Preventing abuse and neglect and preserving families?
  
- Moving children and families to reunification in an expeditious manner?
- Moving to an alternate permanency solution when reunification is not possible?
- Supporting youth in transition?
- Supporting children and families after reunification, adoption, guardianship?

## **Youth Focus Group Questions**

2006-2008

WK Kellogg Foundation  
Focus Group Interview Protocol

Health Care Challenges for Youth Leaving the Foster Care System

I'm \_\_\_\_\_ and this is \_\_\_\_ (first names of project staff) from Michigan State University. We want to welcome you to our research discussion today. Please help yourself to snacks before we get started.

(After people get food and are settled). Again, my name is \_\_\_\_\_. Could we go around and tell us your first names? Then we will tell you what you can expect to happen today.

Some of the questions that are asked to the group may be very private in nature. We need to respect each other's right to confidentiality and need to agree that what is discussed here today stays with the group.

We plan to be done today by \_\_\_(time). We also have \$20 gift cards for each of you for considering participation in the group today.

We're going to go over the purposes for the group. Stop us anytime if you have a question while we explain things, okay? Feel free at anytime to not answer questions or to participate in this focus group.

You are invited here today because you have had previous experience as a child in the foster care system.

Let me take a moment to describe what we are going to do today. First, we will read aloud a consent form. You should be receiving two copies of the consent form; we are asking you to sign both copies of the consent form. One copy is for us, and one copy is for your records. This is to make sure each of you is okay with participating today. You will also hear about your rights and what to do if you have any questions later on.

Second, we will ask each of you to fill out a multiple choice questionnaire that gives us basic information about you. There are no right or wrong answers. We will be available to go around the room and help each of you complete the questionnaire because it is a lot of information and we want to make sure that it is clear.

Third, we are going to ask you to complete a survey for us. The survey is a Network Orientation Scale. This survey is 20 questions long and asks you to rate your opinions on a scale of one to four about a series of statements. There are no right or wrong answers to these statements.

Fourth, we will ask the whole group of you some questions. We want to hear from everyone, and want everyone to share their thoughts and ideas. It is also important to take turns talking so we can hear everyone. You don't have to answer any question you don't want to. You can just not talk, or say, "I don't want to answer that question". If you are ok answering the question, we really want to hear from you, so go ahead and tell us what you think.

The questions will be about your experiences with the foster care system and other services. We are curious about things that helped, things that didn't help. We will also be asking you about your health and mental health status. We will tape record your answers, but won't tell anyone who you are. When we are almost done, we will take a few minutes to check to see if we understand what you've told us. We will summarize what we have heard and ask you to correct anything or add anything we missed. When you leave, we have information for you on resources available to foster care alumni.

We will be talking to other groups of people like this one. Then we will put some of your ideas, and the ideas from people in other groups into a report. The report will go to people who work in agencies that serve foster care youth. So some of what you say today will be read by people who make decisions about foster care services and programs. That's one reason why your ideas are so important! Do you have any questions about what to expect today?

Transition to Q 1: Okay, we are ready to begin. Here is the first question.

What are your experiences with the foster care system?

Probes:

- How long ago did you age out of the system?
- How long were you in the foster care system?
- Was there anything good about foster care? What were services that were helpful?
- What services were not helpful?
- If someone was getting ready to transition out of the foster care system, what advice would you give that person?

Transition to Q 2: We are interested in learning more about you. Many people who age out of the foster care system are living with physical or mental health problem like arthritis, heart disease, depression, dental problems, diabetes or other health related problems.

Question 2: For those of you who have a health problem, are there ways in which it impacts your activities on a daily basis?

Probes:

- How might it affect things that you need to do every day to take care of yourself? (activities of daily living, community living)
- How does it impact you in finding and keeping work?
- If you are in school, how does it impact your performance in school?
- What kinds of treatment was needed? Obtained? Missing?

Question 3 What are some of your experiences with finding and using physical and mental health care services? We are interested in access and barriers to finding and using health care services.

Probes:

- What are some of your experiences with receiving health care services?
- Do you have health insurance? From where?
- What makes a service helpful? (use an example from the group's discussion)
- What makes a service not so helpful? (Service named by participant)
- Could you afford to pay health care providers?

We are nearly done with our discussion today. We will ask one more question, after that, we will take a few moments to talk about our notes and check in with you. We will find out if we understand what you are telling us. Finally, we will ask you an “other” type of question, for example, what else would you like us to know?

Question 4 is about your ideas about services. We will ask you about your ideas about keeping good services the same, making some services better, and coming up with ideas for new services that would help a person and their family live the best possible life most of the time.

Imagine that you were put in charge helping people like you and your family. You are making the rules. Think about how services should work and which services might go together.

Question 4: Why kinds of uncertainty have you experienced when trying to find and use health care services?

Probes:

- Did you know how to find a doctor/dentist/MH professional?
- How did you find a provider?
- Were you ever embarrassed to seek services?
- Did anyone help you find services?
- Did you feel any stigma about finding services?

Question 5: If you could talk to people making the rules, what would you say to them?

Probes:

- What would help encourage you to take advantage of preventive services?
- What would help you to live a healthier lifestyle?
- How would your recommendations make things better?

Transition: Now we are ready for the last question. It's the “other” question.

Question 6: What else would you like us to know?

Probes:

- What else may we not have asked about that you think is important?
- What would you like us to add?
- Any other questions or comments?

We really want to thank you for sharing your time and thoughts with us today! It's been a great help and we learned a lot. Also, we have given you our contact information if you have questions for us later. Thanks again!

## ***Adoptive Parent Focus Group Protocol***

Topic: Impact of Adoption on the Relationship of Parenting Partners

We know that there are many rewards to adopting a child from the child welfare system. Just as there are rewards, studies tell us that there are also challenges to the relationships between spouses/partners who are adoptive parents. This focus group would like to look at the rewards and the challenges to the relationship of parenting partners who are raising children from the child welfare system.

Tell me a story about a time (or times) when adoption strengthened your relationship with your spouse/partner.

- Describe how you and your spouse/partner worked especially well together.
- What did you do? What was your role in achieving this?
- How did you feel during this experience?

What kinds of things have you done to connect, grow together, or remain close as a couple since you adopted? Where did you learn how to do these things?

What, if anything, surprised you about the way adopting your child impacted your marriage/relationship?

Describe an incident when you felt your relationship was challenged by the adoption of a child from the child welfare system.

- In what ways was your relationship challenged?
- How did you feel during this experience?
- Who helped you get through this experience?

Think about your marriage/relationship before you adopted your child. Describe an incident where you felt especially close to your spouse/partner.

- How did you feel during this experience?
- If there was a challenge you faced together, what did you do to overcome it?
- Who helped you overcome it?

If you had three wishes for improving your relationship with your spouse/partner since adopting, what would they be? If the person's partner is not there, may want to follow up with these questions:

- How do you think your partner's wishes would be the same?
- How do you think they would be different?

Topic: Preparing for Adoption as a Couple

The process of adopting children from the child welfare system can be challenging for families. There are many things to learn and many processes to go through. Sometimes couples don't think about how the adoption can impact their relationship before they adopt.

- What if couples were given an opportunity to really learn how to prepare for the impact that adoption would have on their relationship?
- What would be the 3 most important things for them to learn?
- How would they learn those things?
- What would make it difficult for them to learn what they need to know?
- What would make it easier for them to learn?

Topic Area: Impact of Professionals on the Family's Adoption Experience

We know that families have all kinds of experiences when they go through the adoption process and when seeking services after adoption. Some experiences are positive and some are challenging. Adoption workers and other community helpers such as mental health professionals, ministers, physicians, and others can be one resource to help adoptive families understand what they need to know about the impact of adoption on the relationships between parents.

What is the most important thing that professionals taught you about the impact of adoption on your relationship?

What did you have to learn on your own?

Describe a situation where a professional helper really assisted you in preparing for or handling an adoption challenge as a couple.

What do you wish adoption professionals would have told you in advance of your adoption regarding how it would affect your marriage/relationship?

What is the most important thing that you learned in your adoption home-study and/or pre-service training that helped you understand how your marriage/relationship would be affected by adoption?

Describe what you think adoption professionals and others need to know in order to support relationships between spouses/partners in adoptive families?

## ***Birth Parent Focus Group Protocol***

Lansing, April 28, 2009

Introductions – Please fill out the focus group participant information sheet.

Purpose:

- Conducting child welfare needs assessment for Michigan Department of Human Services.
- Interested in experiences you have had with DHS and other public and private family and children's services agencies.
- Looking for information about needs that parents have in providing for the safety and well-being of children and how well current programs and services meet those needs.
- Interested in parent's perspectives about the needs of their children and how well current programs and services meet those needs.

We are not asking you to share any information that would cause you discomfort. We will not use your names.

First, I would like to have each of you share briefly the services provided by or through the Department of Human Services that you know about. Please remember that we are not asking for specific information about you or your family.

Now, I would like you to talk about the children's services or programs you know about that are effective in helping children and families. We would like to get your thoughts about what makes those services or programs effective.

In working to improve child welfare services in Michigan, the Department of Human Services wants to accomplish several things:

- Increase the ability to keep children and families together in their own homes rather than placing children in foster care
- For children who are placed in care, move the children back home as rapidly as possible considering the needs of the child and family.
- When children are returned home, provide increased support to provide more stability for families who may still be dealing with some difficult challenges.

I would like to talk with you about each of these areas separately.

- Keeping children in their own homes.
- Returning children home.
- Support after children return home.

Probe: help parents need, help children need, engagement, respite, mental health services, physical health services, dental care, flexible services and flexible funds for non-service related needs (housing, jobs, transportation, etc.)

Thank you for your time and participation in this discussion

## ***Community Mental Health Focus Group Protocol***

Lansing, April 14, 2009

### Introductions

#### Purpose:

- Conducting child welfare needs assessment for Michigan Department of Human Services (DHS).
- Interested in experiences you have had as a community mental health therapist.
- Looking for information about the mental health needs of children and families in the child welfare system.

In working to improve child welfare services in Michigan, the Department of Human Services wants to accomplish several things:

- Increase the ability to keep children and families together in their own homes rather than placing children in foster care
- For children who are placed in care, move the children back home as rapidly as possible considering the needs of the child and family.
- When children are returned home, provide increased support to provide more stability for families who may still be dealing with some difficult challenges.

#### Focus group questions (Probe if necessary):

1. What services do you provide to children in the child welfare system?
2. What services do you feel are working well within community mental health to help support birth, foster care and adoptive families?
3. What ideas for improvements do you have for community mental health services to help support birth, foster and adoptive families?
4. How is the relationship between DHS and Community Mental Health (CMH)?
5. How is the relationship between the courts and CMH?
6. How are mental health assessments done? Do you see any need for improvements?
7. What is the average amount of time for treatment for children at community mental health?
8. What kinds of needs do you see children facing in the education system?
9. What kinds of mental health needs do you see in:
  - a) Foster children

- b) Birth parents
- c) Adoptive children

10. What kind of support is needed for foster and adoptive parents caring for children with mental health needs?

11. What barriers to or gaps in mental health services do you typically see?

12. What kind of mental health services would be most useful in supporting reunification?

Thank you for your time and participation in this discussion

## **Appendix 8: Focus Group Systemic Needs Responses**

The following detailed focus group responses are provided to supplement the systemic needs chart (Figure 5) in the body of the report. It is organized according to general topic area of administrative or systemic needs expressed by focus group participants.

### ***Training Needs***

- Caseworkers report a need for more training on the resources available to clients. (Central Michigan Private Agency Focus Group).
- Child Advocacy and Assessment Center (CAC) directors suggest that Child Protective Services (CPS) workers receive more training in the legal aspect of physical and sexual abuse cases. Workers' testimony in court and actions on cases can dramatically affect outcomes for children and families (negatively or positively). Family court is not the same as criminal court and, CPS workers need better education on the legal side of the issues because their involvement can make or break a criminal court case. Thirty to forty percent of abuse cases are expected to end up in criminal court. (Child Advocacy and Assessment Center Focus Group).
- Some DHS workers would like to see private agency foster care workers better trained for court cases. (Kent County DHS Focus Group).
- CAC focus group members recommend more training for mandated abuse reporters to help promote early intervention for physical and sexual abuse cases. CAC directors say that it is difficult to get medical providers to attend the mandated reporter trainings, and that health professionals need to be held accountable to help solve the problem. (Child Advocacy and Assessment Center Focus Group).
- Kent County DHS representatives report a need for faster and more frequent training for new DHS workers. Existing workers say they are overwhelmed with caseloads that new workers cannot help with until they are trained.

### ***Cultural Competence Needs***

- According to DHS workers, oftentimes, not until a team-decision making (TDM) meeting occurs, does the Native American outreach representative get the chance to work with a family. Outreach representatives would like the chance to be involved in cases sooner. (Wayne County DHS and Tribal Focus Group).
- Kent County DHS workers report a need to address the foreign-language barriers in some grassroots child welfare services.
- Some tribal focus group members report a lack of culturally-sensitive prevention programs and cultural insensitivity on the part of some non-tribal providers.

### ***Collaboration Needs***

- Private agencies see a lack of coordination among overlapping services provided by the Michigan Department of Education (MDE), DHS, the courts and the Michigan Department of Community Health (MDCH). They would like to see coordination of funding at the state level among these programs. Private agency directors shared a belief that these organizations don't seem to know what their colleagues are doing well enough

to effectively cross over and help child welfare clients. If there were more collaboration, there could be more prevention of people entering the system and/or more effective intervention. Agency representatives report seeing “turf issues” among these programs. (Central Michigan Private Agency Focus Group).

- Some CAC’s would like to see more abuse cases come to the centers through CPS, not just the law enforcement branch. They prefer that CPS to do the initial intake so they can get involved earlier in the case. (Child Advocacy and Assessment Center Focus Group).
- Tribal groups report that they desire for collaboration and partnership with them to be grounded in a full understanding and recognition of the government to government relationship between Tribes and the State.
- Multiple focus groups expressed feeling tension in the collaboration between private agencies/entities and DHS and that this interferes with effective child welfare work. (Kent County DHS, Southeast and Central Michigan Private Agency, Substance Abuse, Child Assessment and Advocacy Centers and Tribal Focus Groups).
  - Private agencies reported a desire to feel more trusted by DHS.
  - Agencies would like to be partners and respected for their knowledge and expertise. (Central and Southeast Michigan Private Agency Focus Groups).
- Nearly all focus groups advocated for a decrease in staff turnover at both private agencies and DHS to create more continuity of care for children/families. Less staff turnover would mean less work for existing employees because they would not have to re-educate new workers continually on the policies and practices. (Substance Abuse, Child Advocacy and Assessment Center, Kent County DHS, Central and Southeast Michigan Private Agency Focus Groups).

### ***Funding and Resource Needs***

- Several focus groups reported a need for greater funding for private agency prevention services. (Central Michigan Private Agency Focus Group, Substance Abuse and Child Advocacy and Assessment Center Focus Groups).
- Kent County DHS workers report a need for child safety to always drive decisions rather than federal funding when caring for children and families.
- Child welfare workers would like to see clients receive individualized care rather than the cookie-cutter approach to care that is sometimes offered due to limitations in funding and resources. (Kent County DHS and Central Michigan Private Agency Focus Groups).
- Several focus groups say that front-loading preventive services is crucial in child welfare and needs to be funded. (Southeast Michigan Private Agency and Child Assessment and Advocacy Centers Focus Group).
- Southeast and Central Michigan Private Agency focus groups say that they would like to see communication about policy changes from DHS in a more timely, clear and consistent manner.
- Private agency representatives would like to see the competitive bid process changed to allow for more consideration of an agency’s experience and expertise. Agency employees report a belief that the competitive bid process for child welfare services creates problems for families who have to switch services when a service provider changes. Agencies say that the lowest bidder usually wins even if an agency has provided services for 10 years. (Central Michigan Private Agency Focus Group).

- DHS workers report a need for the State Emergency Relief (SER) process to improve. Workers suggest a debit card system to get money in clients' hands quickly. (Wayne County DHS Focus Group).
- DHS workers state a desire for consistent and effective long-term programs. They report seeing too many pilot programs and not knowing what works and what is going to stay around. Workers say they are hesitant to embrace new programs because of so many past changes. (Wayne and Kent County DHS Focus Groups).
- Multiple focus groups advocate for a solution to the long-waiting lists for services. None of the workers want to see children being removed from their homes because services are not available. (Kent and Wayne County DHS, Substance Abuse, Youth, Southeast Michigan and Central Michigan Private Agency Focus Groups).
- Tribal focus group members recommended that the Indian Child Welfare Act (ICWA) requirements be embedded in all DHS policies. Tribal members believe that codifying ICWA in Michigan law will demonstrate the State's commitment to the principles and requirements of ICWA and to the sovereignty of the tribes.
- Tribal members say that consideration should be given to establishing ICWA specialists at the county or area level who would provide DHS direct services to children who are enrolled members of tribes. It would be easier, more reliable and more effective to train a small group of DHS personnel to work with these children and families than to attempt to develop expertise within the hundreds of child welfare personnel who may have involvement with tribal children and ICWA only occasionally.
- Tribal focus group members desire for collaboration and partnership with them to be grounded in a full understanding and recognition of the government to government relationship between Tribes and the State. Development of effective collaboration is dependent on willingness to honor tribal authority and sovereignty and on understanding of the processes and needs of tribal government. Michigan tribes have three branches of government just as the state does. They use executive, legislative and judicial decision making processes that are quite similar to those of the state and federal government. This means that sufficient lead time needs to be allowed for planning, preparation of materials and decision making for many child welfare issues related to program and system development.

### ***Information System Needs***

#### **SWSS:**

- Private agencies would like access to the information on SWSS regarding payments, background checks, etc. They say it would help the effectiveness of the child welfare process. Access would help foster care and adoption workers do their job more quickly and efficiently. (Central Michigan Private Agency Focus Group).
  - DHS employees say that the SWSS system needs to be more user-friendly and better designed to be helpful to DHS workers and supervisors. DHS employees state a belief that SWSS is currently designed to count numbers for federal reporting purposes. Workers recommend that system be updated so that reports can be informative as to what is really going on with a family. This would help workers better determine families' service needs. (Wayne and Kent County DHS Focus Groups).

- There is a belief that the number of tribal members receiving child welfare services is under-reported. Tribal focus group members say that SWSS does not currently include CPS and foster care data from tribal information systems. This needs to be addressed in order provide complete and accurate information about child welfare services for tribal members.
- Tribal focus group members say that consideration should be given to cross-checking SWSS data with Census data where possible. Comparing information in these databases might help identify potential improvements for information/data collection in both. Accurate data is important for several reasons:
  - Provides information needed to sustain existing programs and services.
  - Provides information essential to drawing formula grant funds and competing for special grants and foundation funds.
  - Provides valuable information about the benefits and effectiveness of services.
  - Can be used to document compliance with ICWA requirements.
  - Provides information about how to direct services to specific sub-groups, such as identifying youth aging out of care and determining the appropriate mix of services that need to be available to serve them.
- Private agency caseworkers report a need to reach/communicate with Financial Independent Specialists (FIS) with greater ease. (Central Michigan Private Agency Focus Group).

### ***Collaboration Needs***

- The CWITF and other similar workgroups report that the available service array is highly determinate on the county director. This results in different services and different treatment in each location which leads to inequity for children and families. Wealthier counties get better or more diverse services. Urban counties may have a greater array of services but limited availability. Rural counties may have limited array but more flexibility. Innovation is not necessarily encouraged, shared or adopted across counties.
- Wayne County DHS employees recommend that there be a centralized resource directory online.
- Tribal members would like to see centralized services (and information) to eliminate having to seek out resources from several different agencies.
- Private agency workers report a need for greater and faster collaboration between agencies, doctors, courts and DHS on Release of Information procedures. (Central Michigan Private Agency and Substance Abuse Focus Groups).

### ***Court and Legal Process Needs***

Court appointed special advocates (CASAs) and guardians *ad litem* (GALs) are appointed by judges to represent children's best interests in child abuse and neglect cases. CASAs are trained volunteers; GALs may be attorneys or trained volunteers, but in Michigan they are attorneys only, and are commonly referred to as LGALs. Focus group respondents had the following comments about the legal system, LGALs and volunteers:

- Private Agency caseworkers state a desire for CASA workers to be more helpful to their cases. Currently, caseworkers say that CASA workers only add to their workload. (Central Michigan Private Agency Focus Group).

- Private agency caseworkers report a need for better LGAL involvement. Youth are supposed to see their LGALs once a quarter, and caseworkers say that that is not always happening. Caseworkers report a belief that LGALs have an overload of cases and would like to see them be able to be more involved with youth (Central Michigan Private Agency Focus Group).
- Caseworkers would like judges and referees to be able to expedite adoption subsidies. Workers report a belief that judges and referees don't seem to know enough about how the adoption process works. (Central Michigan Private Agency Focus Group).
- Private agency directors and caseworkers would like to see judges (the courts) and DHS on the same page regarding expectations for child welfare cases. They would also like to see similar expectations, policies, rules and procedures between DHS and the courts county to county. Workers need the requirements to be more uniform all the way around to work more efficiently with children. (Central Michigan Private Agency Focus Group).
- Private agency supervisors and directors report a need for better communication between DHS and the court system.
- Private agency workers would like to see foster care review boards serve more effectively. Caseworkers report a belief that the process doesn't change what happens in court and that it only adds to their workload. (Central Michigan Private Agency Focus Group).