MEMO

TO:	JooYeun Chang, Senior Deputy Director, Michigan Department of Health and Human Services (MDHHS)
FROM:	Sandra Gasca-Gonzalez, Vice President, Center for Systems Innovation, The Annie E. Casey Foundation
DATE:	July 13, 2020
SUBJECT:	Child Welfare Strategy Group's Review and Recommendations for CSA Oversight of Child Caring Institutions

At MDHHS' request, the Annie E. Casey Foundation's Child Welfare Strategy Group submits our findings and recommendations from a review of your agency's oversight of the safety and quality of Child Caring Institutions (CCI).[i] Our review team, comprised of national subject matter experts from child welfare, juvenile justice and residential interventions, had the privilege of interviewing a number of MDHHS staff as well as reviewing relevant documentation and publicly available data to answer a core question: How effectively does MDHHS exercise oversite for residential programs to ensure the safety and well-being of children? We believe this central question was conveyed more clearly in the words of one interview subject, who asked…

"Who is caring about these children?"

While the primary scope of our review focused on oversight and monitoring of residential programs, this could not and should not be separated from reviewing whether or not residential placements are necessary in the first place, and how one would know if youth are benefiting from or being harmed by these settings. Research studies related to the impact of institutional settings on child and youth development have found delays in cognitive skills, social-emotional development, attentional processes and mental health.[ii] The length of exposure and quality of care has been found to affect the extent of damage experienced and the potential for long-term impact. Because of the potentially toxic effect of these placements on children and youth, limiting the frequency and length of stay in residential placements is the first and most important area of oversight.

The negative impact is amplified for those children and youth with extensive trauma histories and those who identify as LGBTQ, who may even be more likely to land in residential care as the least desirable of options based on their needs. While Michigan's census of children placed in group settings is below the national average, Black youth are overrepresented in group settings relative to their representation in the general child population in Michigan.

Research is clear that placing children and youth in family settings leads to recovery from many of the developmental delays associated with residential placement, although some negative effects may be long-lasting.[iii] To complement the review conducted by Casey Foundation staff, we encourage you to explore alternatives to residential services so that more children and youth live in families. We suggest reviewing practices to ensure child welfare staff are skilled at completing behavioral health and functional assessments, working with urgency to identify family placements, determining which services children and youth need and monitoring quality of care received. Additionally, we encourage DHSS to enact provisions of the Family First Act to ensure quality of CCI care and promote development of community-based services to prevent more youth from entering foster care.

Below you will find a summary of what our team learned during this review.[iv] A summary table below includes our six recommendations, along with possible action steps and timeframes. Recommendations are followed by a narrative of themes and best practices that informed them. We include a number of best practice resources, examples and further context in endnotes and the appendices for your consideration.

Underlying the technical and often detailed recommendations provided here is a deep commitment by the review team to the belief that children deserve to be safe, grow up in families and get the help they need to heal, build lasting family relationships and reach their full potential. We believe we cannot create the brighter future we envision for **all children,** if we do not ensure **all young people** — of all races, ethnicities and socio-economic backgrounds — have the opportunity to realize their full potential. We offer these recommendations with the belief that Michigan's leaders share this commitment.

Summary of Recommendations

RECOMMENDATION	IMMEDIATE STEPS	WITHIN 6 MONTHS	WITHIN I YEAR
1. **Update coercive intervention policy and practice using national best practice guidance**	■ Immediately develop a plan that prohibits the use of all restraints, which includes but is not limited to mechanical, prone/face down and 1-person restraints ■ Phase out use of seclusion and chemical/medication restraints completely ■ As an interim measure develop strict 'guardrails' for restraints and seclusions	■ Promulgate policy to raise legal standards, licensing regulations and contractual language on coercive interventions (see Appendices A, B and C) ■ Support residential programs in culture change and practice improvements to	■ Leverage the Family First Prevention Services act to frame overarching, long-term Residential Transformation efforts that reflect best practice with residential interventions

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	until these coercive interventions are eliminated altogether. ■ Immediately draft a change in policy and licensing language to prohibit restraints and seclusions ■ Require all residential programs to have an activity schedule that includes educational, arts recreation, groups and individual skill building opportunities. These should take place both in the program and with pro-social peers in the community – preferably their home communities	prevent and replace use of coercive interventions ■ Ensure every youth has an individualized, trauma-focused safety plan that identifies triggers and coping tools identified by the youth and staff and that is known by the youth and all those who interact with them ■ Support residential programs to demonstrate trauma-focused competencies for all staff and personnel	
2. **Authentically engage youth and families to advise on and co-design ongoing improvements and alternatives**	■ Engage those who have experienced CCIs, including young adults and their family members, to understand how to improve CCIs ■ Require that family members be informed every time a youth is physically restrained or secluded. ■ Establish a youth advisory group at every program ■ Establish a residential advisory group at every program, composed of community leaders/ volunteers with a focus on	■ Establish statewide youth and family advisory groups with people who have experienced CCIs ■ Include contractual requirement that all CCIs have a safety and well-being committee composed of youth, family members and staff that is responsible for developing strategies to improve safety and quality of life for all ■ Develop state protocols that promote and	■ Implement ongoing practice and policy reforms guided by recommendations from youth and family advisory groups ■ Require a robust grievance process for youth and families that informs the work of a state ombudsman or other independent entity

RECOMMENDATION	IMMEDIATE STEPS	WITHIN 6 MONTHS	WITHIN I YEAR
	bringing programs and resources and the normalization of youth in community activities	support youth spending time with their families in their homes and communities throughout the residential intervention	■ Encourage residential providers to hire family partners/advocates and youth peer mentors as program staff in their programs
3. **Improve <u>licensing, contracting, oversight and quality improvement</u>**	■ Support residential programs with new best practice requirements ■ Require quarterly monitoring of all CCIs in the licensing unit ■ Engage the National Association of Regulatory Administration (NARA) to train licensing unit managers and staff and to support development of transparent, consistent and safety-focused protocols for adverse licensing actions ■ Require through licensing regulations that CCI's submit a formal request to MDHHS prior to planning to outsource staffing and/or programming to other entities	■ Update/align Juvenile Justice and Child Welfare contracts using performance-based contracting ■ Limit the size of CCIs to no more than 16 youth ■ Require that any jurisdiction sending children from out-of-state establish a memorandum of understanding (MOU) with MDHHS requiring information sharing, visitation requirements and cross-jurisdictional communication and coordination to ensure child safety and well-being ■ Develop a staffed clinical and educational oversight team that has residential best practice experience to ensure appropriateness of	■ Work with county partners to develop community-based services to support youth of all ages, and families, in family-based care ■ Improve permanency and reduce length of stay for all youth served through extensive family finding and case planning based on the principles and practices of Extreme Recruitment[v]

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		services, guide practice improvement and work directly with youth and families to shape ongoing policy and practice	
4. **Enhance <u>data reporting and management</u>**	■ Require CCIs to notify a centralized MDHHS point of contact (POC) of all seclusions and restraints verbally within 12 hours and in writing within 24-hours. The POC should report to the Senior Deputy Director ■ Support residential programs in ensuring timely and accurate reporting ■ Assign a data analyst to produce and disseminate reports ■ Disaggregate all data reporting by race, gender and age to proactively identify and address inequitable use of coercive interventions ■ Explore establishment of a state-wide restraint reporting system that includes child welfare, mental health and juvenile justice programs	■ Initiate an active contract management approach with CCIs to leverage existing support from the Government Performance Lab ■ Produce and effectively use data from monthly reports to inform practice improvement, including residential program data as described below	■ Support legislative requirements for routine public release of data on all licensing and corrective actions taken, including all restraints and seclusions by age, race, gender and CCI
5. **Strengthen <u>organizational and finance structures</u>**	■ Reestablish the contract management function as a role distinct from licensing and deploy quality of care staff to initiate work on	■ Streamline role and performance expectations in licensing unit to facilitate consistent quarterly	■ Simplify administration of the state child-care fund so local/state partners can

RECOMMENDATION	IMMEDIATE STEPS	WITHIN 6 MONTHS	WITHIN I YEAR
	residential quality improvement	licensing visits and monthly data monitoring ■ Ensure staff have the required expertise to undertake fiscal and programmatic oversight ■ Repurpose and where needed increase staffing to enable more robust licensing capacity	prioritize the effectiveness of services absent local cost negotiations
6. **Update casework policy and practice according to national best practice guidance**	■ Clearly explain to CCIs what MDHHS expects them to provide--then reinforce expectations verbally and in writing ■ Require monthly in-person visits with youth from worker of record and encourage frequent virtual and phone communication ■ Clearly articulate the MDHHS management structure and protocols for internal communication so quality of care concerns are promptly presented to responsible managers ■ Develop a mechanism to share quality of care concerns with casework staff responsible for children in CCIs ■ Reinforce with CCIs that MDHHS staff are part of the youth's treatment team	■ Create protocols and train casework staff to engage in high quality visits with children in CCIs ■ Use feedback from frontline staff to improve in practice and structures for quality improvement, contract management and licensing staff	

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	and should have access to all information about the youth's care and progress in treatment		

I. Safety and Coercive Interventions in Residential Programs

Nationally, the field is moving away from coercive interventions in residential programs, including use of restraints, seclusion and mechanical and chemical/medication restraints. Instead, tight 'guardrails' are being implemented for use of these interventions. This movement is based on a growing understanding of the adverse impact of these interventions on young people,[vi] in particular, young people with trauma histories. Further, the research literature points to more effective ways to improve safety in residential interventions, such as choosing program practices and staff that use behavioral and emotional supports and that are youth-guided, family-driven, culturally and linguistically competent, trauma-informed, individualized and strengths-based. Other effective approaches include promoting youth and family engagement and emphasizing organizational change that supports partnership and skill building.

Our team interviewed staff, reviewed publicly available incident reports and reviewed your policy, licensing regulations and relevant state statutes. While data to inform our understanding program-level patterns were not available, we found significant cause for concern pertaining to the use of different types of restraints and seclusions in Michigan.

The licensing regulations, while recently updated, require revamping to meet national norms and best practices and align with research on how to improve child outcomes and well-being. MDHHS licensing language on restraints and seclusions in particular, are loosely defined and subject to broad interpretation. This creates the potential for unacceptable and avoidable levels of risk to child safety.[vii] As a result, MDHHS is limited in its authority to assure child safety through the licensure process. Fortunately, it is our understand that if licensing regulations are updated to prioritize child safety, MDHHS could have the full legal authority required for enforcement.

Additionally, our team found that MDHHS has unreliable quality-related feedback loops built into practice standards for CCI licensing, contracts and casework. Careful tracking and coordination of follow up on quality of care complaints is one strategy to intervene early, prior to serious incidents occurring related to safety or maltreatment in care. Examples of improved feedback loops in other jurisdictions include: robust grievance processes for youth and families served by residential programs; clear formal caseworker and supervisory expectations on reporting quality of care concerns; and use of an ombudsmen or Child Advocate to follow up and report on concerns from the community.

Michigan is not unique in recognizing the need to reevaluate coercive intervention policies. The National Conference of State Legislatures recently produced a brief policy scan (see Appendix A). It notes

Michigan statute includes certain requirements consistent with model legislation in other states. However, it also described gaps in crisis intervention training (e.g. Oregon) and specific prohibited practices (e.g. New Hampshire).The scan also identified some state child ombudsman/ advocate policies (e.g. Georgia, Rhode Island) that contain more robust CCI oversight requirements.

Recommendations

- Immediately develop a plan that prohibits the use of all restraints, which includes but is not limited to mechanical, prone/face down and 1-person restraints.
- Phase out use of chemical/medication restraints. Provide guidance and technical assistance to residential programs on alternatives.
- Phase out seclusion. Begin by providing more clarity and consistency of administrative rules for residential leaders and managers, including limits on duration of and conditions for seclusion. For example, if a youth is secluded for more than 15 minutes, a supervisor or clinician should talk to the youth. Provide clear guidance and technical assistance to residential programs on alternatives to seclusion. Provide specific protocols for immediate engagement of supervisors, managers and appropriate clinical staff in these decisions. Additionally, for JJ-specific CCIs, our team recommends that MDHHS engage The Center for Children's Law and Policy for support on assessing conditions of confinement based on national best practice standards (see Appendix I).[viii]
- As an interim measure develop strict 'guardrails' for restraints and seclusions until these coercive interventions are eliminated altogether.
- Immediately draft a change in policy and licensing language to prohibit restraints and seclusions.
  - Require all residential programs to have an activity schedule that includes educational, arts recreation, groups and individual skill building opportunities, both in the program and with pro-social peers in the community – preferably their home communities.
  - Require increased interaction, planning and decision-making involving program youth, families, direct care and clinical staff to improve program structure, programming, practices, and culture to alleviate the need for restraint, seclusion, and other coercive practices.
  - Require development of protocols for a range of trauma-focused individualized prevention tools (e.g., individual soothing/calming plans; sensory modulation approaches) and crisis interventions to support youth in self-calming/soothing to prevent the use of restraints.
  - Require prompt and comprehensive debriefing with staff, youth involved, families of youth involved, and youth observing a restraint and/or seclusion.
  - Develop protocols on crisis communication before use of restraints or seclusion.

  - Require accurate and comprehensive incident reporting and program mechanisms (i.e. Quality Improvement Protocols) to ensure the use of data to inform practice improvement.
- Promulgate policy to raise the legal standards, licensing regulations and contractual language pertaining to coercive interventions—see Appendices A, B and C for detail.
- Require every CCI to have a trauma-responsive support plan[ix] that includes: evidence that staff possess skills and competencies that are trauma-focused, individualized, culturally and linguistically competent, youth-guided and strength-based; promote collaboration and empowerment with youth, ensure clear rights and expectations / responsibilities and skill building to teach youth and staff how to regulate their emotions and behavior.
- Support residential programs in the culture change and practice improvements required to prevent, reduce and replace the use of coercive interventions. Ensure that technical assistance on best practices to reduce, prevent and replace coercive interventions with family-driven, youth-guided, culturally and linguistically competent, trauma-informed, strength-based and individualized approaches is provided to residential providers.
- Leverage the Family First Prevention Services act to frame overarching long term Residential Transformation efforts. Create an urgency towards ensuring permanency, on successfully engaging and working with families, allowing residential program size of 16 beds or less, significantly shorter lengths of stay, and focus on partnerships with community providers and supports that leads to effective in-home and community work during the residential interventions and throughout aftercare.

2. Authentic Engagement of Youth and Families

Our team explored your system's structures to ensure the authentic and routine engagement of young people and their families. One of the important functions of these structures is to ensure that critical information on the experiences of youth and their families in CCIs is available to system leaders with authority to take action prior to a crisis. Our team reviewed and has provided more specific feedback on your proposed contractual changes (Appendix B), including enhanced requirements for engagement of young people and their families, consistent with the Family First Prevention Services Act.

We learned from MDHHS staff about a number of areas of youth engagement upon which to build, including routine interviews of young people during annual licensing reviews, monthly caseworker visits and existing contractual requirements that each CCI have a grievance process for young people. MDHHS staff shared that CCIs routinely serve youth from distant jurisdictions, which limits the ability of programs to serve youth in the context of their families and to engage and partner with families, as required by Family First. As context, residential best practices put a strong emphasis on residential staff continually working in the homes and communities of the youth served, with youth spending time with families as often as possible (at least weekly; ideally multiple times a week).

Our team reviewed your existing Foster Youth Bill of Rights. We believe this document, already in use, could be a central tool as you improve authentic youth voice. Similarly, MDHHS' structure for the Michigan Youth Opportunities Initiative could be deployed to ensure young people who are receiving services in CCI have an opportunity to engage with peers and build leadership and self-advocacy skills.

Finally, it will be critical as you explore technical assistance opportunities with CCIs to ensure that CCI staff are trained and supervised to engage appropriately with youth. MDHHS staff shared that a common theme from discussions with young people in CCIs is the perception that they do not have a voice and are not treated with respect. Similarly, staff shared that some CCI leaders have expressed skepticism about new contractual requirements to engage young people, based on a concern that it may be inappropriate to do so. Conversely, staff also noted at least two "bright spots"—referring to CCIs that have incorporated practices that include young people and their families in decision making. Our team would encourage MDHHS to fully leverage local best practice providers as examples as what is possible, in addition to national supports.

Recommendations

- Engage those who have experienced CCIs, including young adults and their family members, to provide input into ways to improve CCIs.
- Require that family members be informed every time a youth is physically restrained, or a seclusion takes place and involved in meetings with youth and others to identify further de-escalation and coping methods.
- Establish a youth advisory group for every program.
- Establish a residential advisory group for every program composed of community leaders/volunteers with a focus on bringing programs and resources and the normalization of youth in community activities.
- Establish statewide youth and family advisory groups with people who have experienced CCIs.
- Contractually require that all CCIs have a safety and well-being committee composed of youth and staff that is responsible for developing strategies to improve safety and quality of life for all.
- Develop state protocols that promote and support youth spending time with their families in their homes and communities throughout the residential intervention and that include communicating with family members and important fictive kin on a daily basis throughout the residential intervention. Many programs have significantly reduced the use of restraints by encouraging youth to call a family member at the earliest sign of distress.
- Implement ongoing practice and policy reforms guided by the recommendations of these advisory groups by embedding constituent voice into the program design, procurement and routine oversight of CCIs.

- Require a robust grievance process in each facility for youth and families that ensures the safety of those who raise concerns. The process should inform the work of a state ombudsman or other independent entity charged with recommending policy and practice reforms highlighted by the grievance and reporting process.
- Encourage residential providers to hire family partners/advocates and youth peer mentors as staff in their programs. Develop a robust technical assistance project to support providers in hiring, supervising and effectively using these peer staff who have lived experience of residential as a former child or family member of a child.

3. Capacity for Oversight and Quality Improvement

MDHHS licensing and contract management functions and staff roles are merged. This limits the department's effectiveness in carrying out both its regulatory responsibilities (licensing facilities) and programmatic responsibilities (meeting service needs of child welfare and juvenile justice populations). In best practice public systems, these functions are distinct from one another and well-coordinated.

Licensing provides the "floor" for assuring minimal health and safety standards are met, including annual compliance reviews, citations or sanctions for licensing violations, and investigations of complaints (see Appendix C for detailed licensing regulation feedback). Quarterly or biannual inspections are used by other jurisdictions with robust licensing programs to support greater licensing compliance and require both adequate staffing[x] and effective processes (see Appendix D).

Monitoring and enforcing licensing regulations in Michigan is even more complicated for CCIs that serve mixed populations of youth with different standards and contract expectations for each. These complexities and the high volume of issues and complaints that arise are likely the result of staff responding to emergencies rather than supporting quality services. MDHHS staff reported long standing problems with inconsistent enforcement of licensing violations. Agencies found to be in violation must complete a program improvement plan, but we found no guidance in state regulations on what the plan must include or accomplish. Additionally, there are opportunities to strengthen consistency and transparency associated with adverse licensing actions to prioritize safety. For example, some jurisdictions use a risk-based scoring approach to guide rational, consistent and transparent adverse regulatory actions (see Appendices D and E).

Even at its best, a compliance and complaint-based system has significant limitations and will not lead to significant quality improvement in areas that really matter, such as: making sure children and youth are physically and emotionally safe; engaging in developmentally appropriate activities; receiving relevant and high-quality treatment services in the appropriate type, frequency and duration; and maintaining connections with family and other social supports.

To focus time and attention on areas with potential for the greatest impact, contract management and quality improvement staff must have time and opportunity to assess, provide improvement feedback and

promote quality care in pursuit of improved child outcomes through technical assistance and other related strategies. By and large, the review team found very little indication that ongoing program improvement is occurring in a meaningful way.

Recommendations

Use national best practice guidance to update policy and practice regarding licensing, oversight and quality improvement**.**

- Support residential programs with new best practice requirements. Develop, in partnership with provider leaders, a plan to provide technical assistance to support providers in implementing new requirements into practice. The plans should address the most effective technical assistance needed pre-implementation of updated licensing and contract requirements, and throughout the first-year post implementation.
- Require quarterly, in-person monitoring of all CCIs in the licensing unit.
- Engage the National Association of Regulatory Administration (NARA) to train licensing unit managers and staff and support development of transparent, consistent and safety-focused protocols for adverse licensing actions (see Appendix F).
- Require through licensing regulations that CCIs submit a formal request to MDHHS on any future plans to outsource staffing and/or programming to other entities prior to taking that action to ensure all entities that hold liability for safety and quality of programming are in agreement with the arrangement. Monitor any outsourced programming through routine licensing reviews and contract management.
- Update/align Juvenile Justice and Child Welfare contracts using performance-based contracting.
- Limit the size of the programs to no more than 16 beds in contracts. Ensure small residential programs.
- Require that any out-of-state jurisdictions sending children for placement in a Michigan CCI notify MDHHS prior to placement and establish a memorandum of understanding (MOU) with MDHHS requiring the exchange of information, establishing visitation requirements and ensuring cross-jurisdictional communication and coordination to ensure child safety and well-being.
- Develop a staffed clinical oversight team and youth leaders to ensure appropriateness of services and guide practice improvement quality of care and treatment services within Michigan residential programs. This may include development of an internal, multi-agency team (including education, mental health, etc.) or a contracted team to ensure children and youth are screened and assessed for residential placement and more desirable family-based alternatives, and ensure the appropriate type, frequency, and duration of treatment services are provided. The team's focus could be case specific, programmatic and systemic. Responsibilities would include

consultation and support to case workers, family members and other system partners such as the courts, as well as developing processes and supports to eliminate harmful or inappropriate practices (e.g. restraint, seclusion) and facilitate improvements in the quality and effectiveness of interventions. This infrastructure could be created using internal staff or university partnerships or evolve from existing care coordination structures that may exist within health maintenance organizations, adolescent medicine or other specialized or coordinated care initiatives, health homes and others.

- Work with county partners to develop community-based services to support children, teens and families in family-based care. This would ideally mean placing youth with their own family or extended families, closer to home, and would include:
  - Prioritization of child welfare families for services from local Community Mental Health Centers. Other populations may already be prioritized (e.g. pregnant women, co-occurring disorders, and others).
  - Creating a network of peer-helpers, birth families and resource parents devoted to supporting each other to address behavior challenges and increase placement stability in family-based settings.
  - Expansion of in-home support services, such as intensive family preservation, crisis response teams and in-home behavior specialists.
- Improve permanency and reduce length of stay for all youth through extensive family finding and case planning based on the principles and practices of Extreme Recruitment.[xi]

4. Enhance Data Reporting and Management

- Require immediate reporting (verbal notification within 12 hours and written notification within 24 hours) of all uses of seclusion and restraints in CCIs to MDHHS. Consider centralizing notifications to a point of contact (POC) that reports directly to the office of the Senior Deputy Director. Holding the licensing authority when MDHHS has incomplete data for all children served in CCIs is a significant vulnerability. One state example of a simple, actionable tracking and reporting process is Oklahoma (see Appendix G).
- Support providers to ensure timely and accurate reporting. Provide technical assistance on information needed and the relevant forms or processes as well as routine on-site file checks for accuracy of reporting
- Assign a data analyst to produce and disseminate reports.
- Disaggregate all data reporting by race, gender and age to proactively identify and address inequitable use of coercive interventions (see Appendix H).

- Explore the establishment of a State-wide restraint reporting system that includes, child welfare, mental health and juvenile justice programs.
- Initiate an active contract management approach with CCIs that leverages tools from the Government Performance Lab. Active contract management (ACM) is a set of strategies developed by the Harvard Kennedy School Government Performance Lab (GPL) in partnership with government clients that apply high-frequency use of data and purposeful management of agency service provider interactions to improve outcomes from contracted services.
- Produce and use monthly reports on CCI use of restraints, seclusions and psychotropic medications along with data on police calls, AWOLS, hospitalizations and incidents of aggression or harm towards self/others/property.
- Support a legislative requirement for routine public release of data on all CCI licensing violations and corrective actions, including data on all use of restraint and seclusions youth age, race, gender and CCI facility. Incident and corrective action data could be posted in a required format on individual provider and MDHHS websites and analyzed and compiled in an annual report.[xii]

5. Strengthen Organizational and Finance Structures for Oversight and Quality Improvement

- Reestablish contract management function as a role and set of responsibilities distinct from licensing. Staff could be housed in the same or separate units, but it is critical that their job functions are disentangled. Additionally, deploy quality of care staff either within a clinical oversight function or CQI to support performance improvement.
- Streamline role and performance expectations in licensing unit to facilitate consistent quarterly licensing visits and monthly data monitoring. It will not be sufficient to increase staff, but rather to redefine job functions and oversight. NARA, referenced above, may be a useful resource in formalizing and reframing these role expectations.
- Ensure that staff have the required expertise to undertake fiscal and programmatic oversite.
- Repurpose, and where needed, increase staffing in licensing to enable more robust licensing capacity as described above. Our team was unable to identify a national standard for the ratio of staff to facilities because the scope, frequency and organizational structures vary widely by jurisdiction. We provide (in Appendix D) examples from Connecticut, a system with a robust, high functioning licensing structure that was developed over a number of years following fatalities and near fatalities of youth in residential placements. Connecticut, which requires quarterly licensing visits and biannual inspections to each program, has a caseload of 10 facilities per licensing consultant. Quarterly visits require .5 to 1 workday, depending on the distance staff must travel. Regulatory consultants are involved in any residential program investigation as well as less frequent reviews of state-licensed non-residential care settings.

- Simplify administration of the state child-care fund so that local/state partners can prioritize the effectiveness of services absent local cost negotiations. Our brief review of CCI fiscal considerations found that rates in the actuarial model used to shape rates for CCIs were generally sound and on par with other systems nationally. Our team found Michigan's CCI rates to be adequate to provide quality care. Further, as MDHHS/CSA seeks to expand services, it will be important to engage effectively with county child serving agencies. We therefore recommend simplifying the childcare funds' local/state matching to use a rolling average budget total from recent years, so that county fiscal impacts are predictable and removed from consideration of child-level service planning.

6. Communication, Casework and Quality of Care Concerns

Caseworkers who visit a young person monthly, combined with family and other visitors, are important sources of information and can flag concerns about quality of care prior to them rising to the level of a fatal or near fatal incident. In our interviews with MDHHS staff a few key themes emerged. There did not appear to be a structure or process for agency staff to raise systemic, quality or culture problems with CCIs. Further, there did not appear to be a clearly defined process for responding to concerns related to quality of care that fall outside the scope of the Maltreatment in Care unit and Licensing. In short, when staff are concerned about program culture and quality, they expressed lack of clarity about what to do or who had accountability to address it. Staff have advocated and taken actions for their specific youth, but the overall culture and climate of concerns has not been systemically addressed. Staff do not believe the CCIs offer appropriate services to meet the needs of their youth.

Recommendations

- MDHHS should clearly articulate to CCIs what they expect programs to provide and then reinforce those expectations. For example, leadership should create opportunities to make declarative statements and establish impactful and transformative bottom-line expectations that may include:
  - Eliminating the use of restraints;
  - Eliminating the use of seclusion and isolation;
  - Requiring providers to use evidenced based strategies;
  - Creating a therapeutic, trauma-informed treatment environment, moving away from antiquated, punitive settings;
  - Believing in the development of youths' ability to regulate their emotions and behavior;
  - Discontinuing placements in large residential programs over 16 beds;
  - Requiring trauma assessments and safety and support plans for all youth in CCIs;

  - Placing limitations on length-of-stays in CCIs; and
  - Maintaining family and social network support at all costs.
- Require monthly visits from the worker of record with youth and encourage more frequent virtual and phone communication between monthly visits
- Clearly articulate the management structure and protocols for internal communication at MDHHS so that timely and accurate information is presented to responsible managers when there are quality of care concerns.
- Develop a mechanism to share quality of care concerns with staff whose caseloads include children in residential programs and solicit their feedback. Formalize supervisory oversight for reporting quality of care concerns in CCIs.
- Train and create protocols to support casework staff to engage in high quality visits with children in residential programs. Provide training to all staff about what needs to be reported as suspected abuse/neglect and what and how to report to licensing any concerns.
- Reinforce with CCIs that MDHHS staff are part of the youth's treatment team and should have access to all information about the youth's care and progress in treatment. Require that timely and comprehensive service planning reports on youth in CCIs be submitted to MDHHS.
- Ensure that practice and quality improvement structures, contract management structures, and licensing staff structures (described in the sections above) are informed by feedback from frontline staff (ongoing caseworker as well as incident-based and trend data regarding maltreatment in care).

Conclusion

The work in front of MDHHS will require a transformation of the residential system across the state. Provided in Appendix J is a recommended framework for MDHHS to consider as a guide for your residential transformation work. The memo references a number of resources and documents, included in the attached appendices, where your team can find additional detail and guidance supporting the recommendations. Finally, we want to express our gratitude to the MDHHS team, especially Stacie Bladen and Patricia Neitman, for providing the needed documentation and participating in interviews so that we could learn more about your system and develop sound recommendations.

List of Appendices[xiii]

- **Appendix A: National Council of State Legislatures Policy Scan**
- **Appendix B1 & B2: BBI Summary and Recommendations for Review of MI QRTP RFCAN Master Template**

- **Appendix C1, C2, C3 & C4: BBI Summary and Recommendations from Review of MI DCWL Documents**
- **Appendix D1 & D2: Documentation from Connecticut's Regulatory Approach & Structures**
- **Appendix E: Florida Child Care Adverse Sanctions Matrix**
- **Appendix F: National Association of Regulatory Administration White Paper**
- **Appendix G1 & G2: Oklahoma DHS Data Reporting and Monitoring tools**
- **Appendix H: The Annie E. Casey Foundation Racial Equity and Inclusion Action Guide**
- **Appendix I: The Annie E. Casey Foundation Juvenile Detention Facilities Standards and Self-Assessment**
- **Appendix J: BBI Recommended Framework for Residential Transformation**

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[i] We use the terminology Child Caring Institution (CCI) because it reflects a licensing category in the state of Michigan regulations. When considering best practice terminology and framework, we would advise that Michigan use the terminology Residential Program or Residential Intervention.

[ii] See series of research articles collected in the Lancet Commission in the Institutionalization and De-institutionalization of Children, June 23, 2020.

[iii] van IJzendoorn MH, Bakermans-Kranenburg MJ, Duschinsky R et al. Institutionalization and deinstitutionalization of children 1: A systematic and integrative review of evidence regarding effects on development. Lancet Psychiatry. 2020; (published online June 23.) https://doi.org/10.1016/S2215-0366(19)30399-2

[iv] It is important to note the limitations of this analysis. First, quantitative data on use of restraints and incident frequency were not available to the team for review. Second, we did not evaluate the practices of individual staff, units or child caring agencies, but rather the capacity of the state's Children's Services Administration to provide effective oversight. Undoubtedly there are many examples of exceptional performance within these offices and our team was impressed by your visionary staff who are tirelessly leading reform. Third, due to the current public health crisis, information that would be best conveyed through face-to-face conversations and focus groups was gathered via email, phone calls and video conferences.

[v] Extreme Recruitment is a program of the Foster and Adoptive Care Coalition. Learn more at https://www foster-adopt org/recruitment-programs/#extreme

[vi] Blau, G M , Caldwell, B & Lieberman, R E (Eds) *Residential Interventions for Children, Adolescents, and Families: A Best Practice Guide (P 110-125)* Routledge, Taylor & Francis Group New York.

[vii] Blau, G M , Caldwell, B & Lieberman, R E (Eds) *Residential Interventions for Children, Adolescents, and Families: A Best Practice Guide (P 110-125)* Routledge, Taylor & Francis Group New York.

[viii] The self-assessment tool referenced has been adapted for utilization in a range of JJ facilities beyond detention We would recommend using the modified standards available from the Center for Children's Law and Policy.

[x] As a comparison, Connecticut, which requires quarterly licensing visits and biannual inspections to each program, has a caseload of 10 facilities per licensing consultant Quarterly visits require 5 to 1 work day, depending on the distance staff must travel Additionally regulatory consultants are involved in any investigation in a program that pertain to licensing regulations.

[xi] Extreme Recruitment a program of the Foster and Adoptive Care Coalition. Learn more at https://www foster-adopt org/recruitment-programs/#extreme

[xii] New Hampshire provides an example of agency that provides an annual report on use of restraint and seclusion to their legislature. The policy requires that such reports be based on "periodic, regular review of such records and shall include the number and location of reported incidents and the status of any outstanding investigations."

[xiii] In addition to the attached appendices, Casey will provide Michigan MDHHS with a number of residential best practice materials including two BBI books and articles on successful restraint/seclusion prevention initiatives.