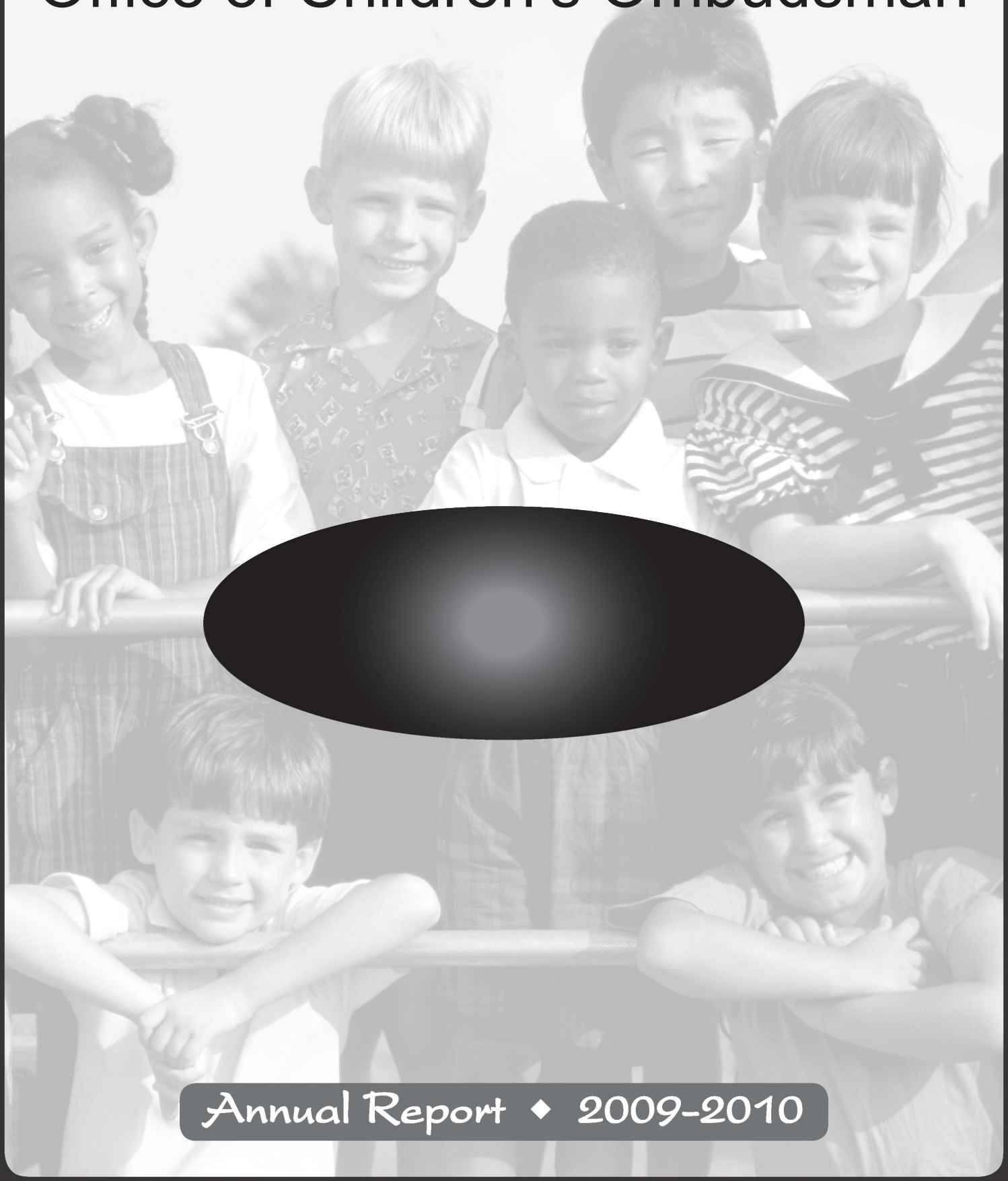
State of Michigan

Office of Children's Ombudsman



Annual Report ◆ 2009-2010

STATE OF MICHIGAN
OFFICE OF CHILDREN'S OMBUDSMAN
LANSING

RICK SNYDER
GOVERNOR

VERLIE M. RUFFIN
DIRECTOR

September 2011

The Honorable Rick Snyder, Governor
Honorable Members of the Michigan Legislature
Ms. Maura Corrigan, Director, Michigan Department of Human Services

In accordance with my statutory responsibility as the Children's Ombudsman, I respectfully submit the Fiscal Year 2010 Annual Report.

This report provides an overview of the activities of the Office of Children's Ombudsman from October 1, 2009 to September 30, 2010, and an analysis of the complaints received and investigated. In addition to the analysis are recommendations for positive change in the child welfare system to improve outcomes for children.

The Office of Children's Ombudsman appreciates the leadership and support of Governor Snyder, the Michigan Legislature, and the Department of Human Services. Thank you for the opportunity to serve the children of Michigan.

Respectfully,

Verlie M. Ruffin

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Children's Ombudsman

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Executive Summary

Mission

The mission of the OCO is to assure the safety and well-being of Michigan's children in need of protective services, foster care, adoption services, and juvenile justice and to promote public confidence in the child welfare system. This will be accomplished through independently investigating complaints, advocating for children, and recommending changes to improve law, policy, and practice for the benefit of current and future generations.

Authority

The Office of Children's Ombudsman (OCO) was established by the Michigan Legislature in 1994 to provide greater accountability and transparency to Michigan's child welfare system. Legislators were concerned that confidentiality laws governing child welfare also served to protect the system from outside scrutiny and accountability. The OCO provides citizens with the means to obtain an impartial and independent investigation of a child's case involving protective services, foster care, adoption services, or juvenile justice under the supervision of the Department of Human Services (DHS).

The Children's Ombudsman Act (1994 PA 204) authorizes the ombudsman to obtain information regarding a child's case from DHS and other agencies and service providers, including records in the possession of public and private child-placing agencies. The records of the OCO are confidential and are not subject to court subpoena or discoverable in a legal proceeding, and are exempt from disclosure under the Freedom of Information Act.

Consistent with the Children's Ombudsman Act and mission of the office, the OCO performs the following duties:

- **Independently investigate and respond to citizen complaints.** The law permits the OCO to release its investigative findings and recommendations to OCO complainants, the DHS and private child-placing agencies. This year the OCO responded to 999 complaints/questions/concerns regarding 1,572 children. The OCO completed 122 investigations of 60 agencies involving 352 children from 77 of Michigan's 83 counties.

- **Promote child safety, well-being and permanency.** In cases where the OCO determines that a child may be unsafe, an administrative action may be harmful to a child, or further action is needed to ensure a child's well-being or permanency, the ombudsman may request DHS take a specific action. For example, conduct a Children's Protective Services (CPS) investigation or safety assessment of a child believed to be at risk, change the permanency plan, file a termination petition, provide services to a child, conduct a thorough home study, or consider the replacement of a child. The ombudsman may also request a licensing investigation of a child-placing agency or foster home, or may refer a criminal matter to a law enforcement agency.

- **Make recommendations to improve the child welfare system.** One of the OCO's primary roles is to identify problems and make recommendations to improve the child welfare system. Through case analysis and investigative findings, the office issued 209 recommendations this fiscal year for system-wide improvement or to address problematic decisions affecting individual children. DHS agreed to implement the majority of those recommendations.

Budget and Expenditures

The OCO is an independent state office housed administratively within the Department of Technology, Management and Budget (DTMB). The OCO was appropriated $1,387,100 for fiscal year 2010, allocated from the state general fund: Eighty percent for personnel and the remainder for facilities and support services. Staff included: the ombudsman, six investigators, one supervisor, and two administrative staff. The ombudsman maintains offices in Lansing and Detroit.

Multidisciplinary Team

The OCO has a multidisciplinary team approach to case investigations. Investigators have diverse professional and educational backgrounds with a broad range of experience in child welfare. The OCO staff receives ongoing training and routinely consults with professionals outside the office on issues related to child welfare. Each investigation is assigned to a primary investigator, who is responsible for conducting interviews, analyzing compliance, and developing preliminary findings and recommendations. Prior to completion of all investigations, investigative team members participate in the analysis of case facts, findings, and conclusions. Recommendations made in individual cases are the result of input and discussion by the OCO investigative team.

Collaboration and Outreach

Throughout the year, the OCO staff periodically consults with the DHS Office of Family Advocate (OFA) and DHS policy and administrative staff to discuss individual complaint investigations, agency policies, programs, and practice. OCO staff also regularly reviews proposed changes to DHS policies related to CPS, foster care, adoption services, and juvenile justice.

The ombudsman and investigators serve on advisory boards, workgroups, and committees including the Michigan Court Improvement Program, Foster Care Review Board, Child Support Leadership Council, Advisory Board on Overrepresentation of Children of Color in Child Welfare, Michigan Child Death Review, Bureau of Children and Adult Licensing Rules Committee, Kids Count in Michigan, and the Child Welfare Improvement Task Force, among others. OCO staff also participated in federally mandated citizen review panels including Child Death Review Advisory and Prevention.

Complaint Intake and Referral

The primary function of the OCO is to respond to complaints about children who are involved in Michigan's child welfare system.

Source of Complaints

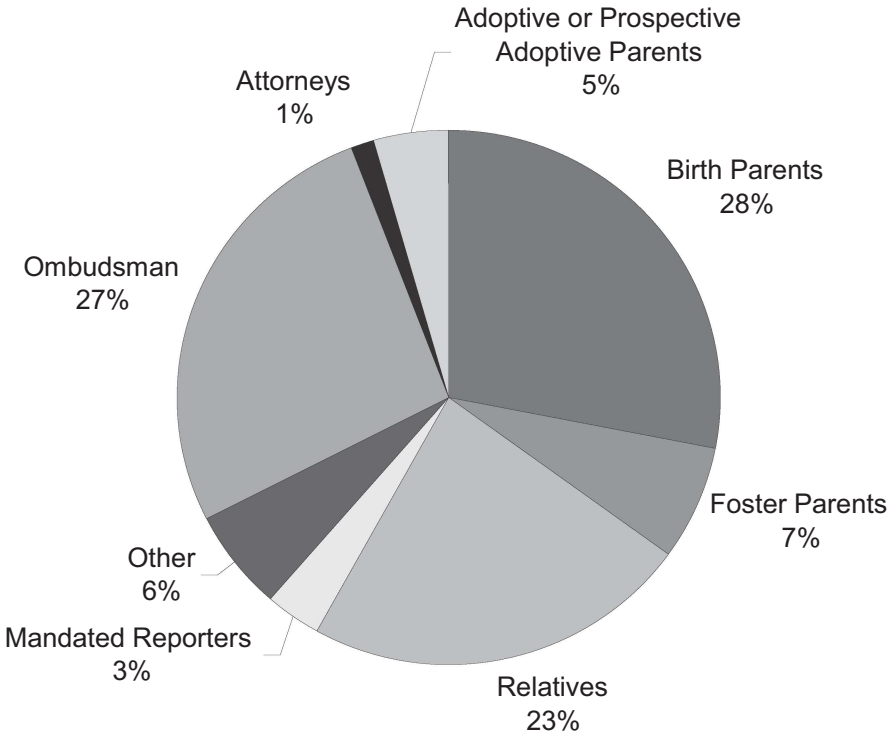
Anyone may file a complaint with the OCO. The ombudsman may also open a complaint at her discretion. Complaints can be made via telephone, mail, fax, email, or electronic complaint form accessible on the OCO website: www.michigan.gov/oco.

The identity of the complainant is kept confidential unless the complainant gives the ombudsman permission to disclose his or her identity.

In fiscal year 2010, the OCO received 999 complaints/questions/concerns concerning 1,572 children in 77 of Michigan's 83 counties. Birth parents (28%) and the ombudsman (27%)* made up the greatest share of complainants, followed by relatives of the child (23%).

*Note: Includes 239 child death alerts received by the ombudsman (see page 13).

Source of Complaints



Educating the Public

Citizens who contact the OCO have varying degrees of understanding about Michigan's child welfare system. Educating the public about how the child welfare system works is a statutory duty of the office and an essential component of system accountability. One of the functions of the intake process is to provide complainants with detailed information about laws and policies related to their specific concerns. Citizens who are informed about the relevant laws and policies that govern practice are better able to navigate the system and advocate knowledgeably and effectively for themselves and the child. Two categories of complaints/questions/concerns that focus solely on educating the public and do not result in an investigation are:

- **Inquiries:** Requests for information; general concerns about the child welfare system; or specific complaints involving areas that the ombudsman does not have jurisdiction to investigate, such as Friend of the Court, child custody matters, or educational issues. **This year, the OCO received 407 inquiries.**

- **Referrals:** Complaints that concern a child involved with CPS, foster care, adoption services, or juvenile justice, but involve actions of an agency or person the OCO is not authorized to investigate, such as the court, law enforcement, or an attorney. **The OCO referred 304 complaints to other agencies.**

Valid Complaint Criteria

The OCO uses the following criteria to evaluate valid complaints and determine whether an investigation is warranted:

- The complaint concerns a child involved with Michigan's CPS, foster care, adoption services, or juvenile justice system.

- The complaint concerns the death of a child whose family had been previously involved with the child welfare system and whose death may have resulted from abuse or neglect.

- An action or inaction by DHS or a private child-placing agency is alleged to have violated law, rule, or DHS policy.

- An alleged decision or action by DHS or a private child-placing agency was harmful to a child's safety, health or well-being.

- The complainant has exhausted other administrative remedies to resolve the complaint without success.

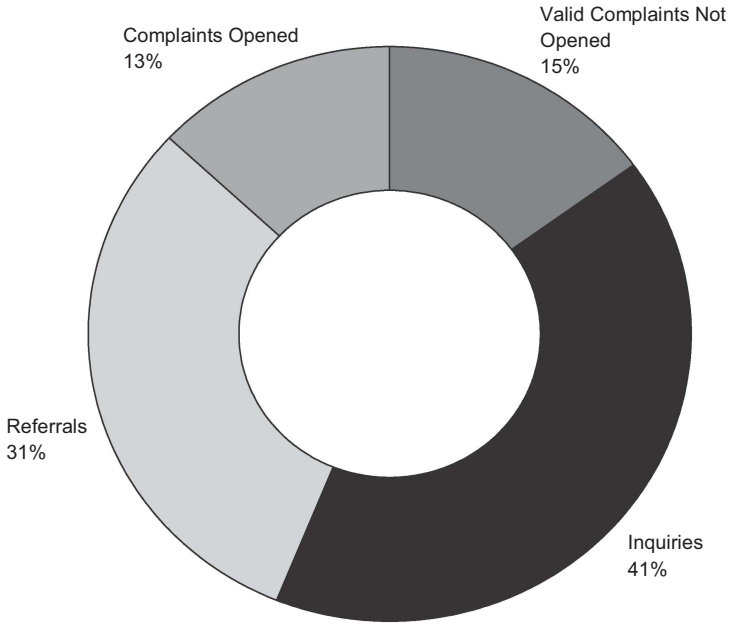
- It is likely that an investigation by the OCO will positively impact the child's situation or children in future cases.

The two categories of valid complaints are:

- **Valid Complaints Not Opened:** Complaints that may meet criteria but an investigation will not resolve the complaint issue; e.g. a complaint about CPS but a termination trial has already commenced, or a complaint from a relative concerned about not getting foster care placement but the child has already been adopted. **The OCO classified 147 complaints as valid complaints not opened.**

- **Valid Complaints Opened:** Complaints that satisfy analysis criteria resulting in the opening of a case for investigation. **This year, the OCO opened 128 complaints for investigation.** Some examples of valid complaints that were opened for investigation involve:[1]

  - Whether CPS should have removed a child from home without providing reasonable efforts.
  - A CPS determination that a parent failed to protect.
  - Placement of a child with a father who had a violent criminal history.
  - Court ordered counseling services for a temporary court ward were delayed for several weeks.
  - Parents not being provided with court ordered parenting time.
  - Whether the Indian Child Welfare Act is being followed.



[1]Each complaint has a unique set of facts and because a complaint may be similar to concerns presented here, this information is not meant as a guarantee that a case will be opened for investigation.

Administrative Response Requests

In situations where the OCO determines that immediate administrative action by the involved agency is necessary to protect a child, to alleviate a situation, or to expedite permanency, the OCO issues a Request for Administrative Response to DHS and/or a private child-placing agency. This request may be made to the agency at intake or during an investigation. In these elevated response situations, OFA will respond on behalf of the involved agencies within 10 business days. In fiscal year 2010, the OCO issued 7 administrative response requests. Following is a summary of the OCO requests and the responses by the involved agencies:

OCO Concern	DHS Response/Outcome
A child was a substantiated victim of physical abuse; the child was not receiving needed services and the guardian relative had no authority to seek medical attention for the child.	DHS determined that services were in place, but the child, age 14, refused to participate. A new referral for counseling was made and steps were taken to resolve the Medicaid issues for the child.
DHS did not consider an adoptive parent for placement of a related sibling who entered foster care.	DHS determined that parental rights to the sibling were intact and the adoptive parents were not licensed foster parents. The adoptive parents were advised to apply to adopt the sibling if parental rights were terminated.
Determine whether the children were removed from a relative, based solely upon her lack of transportation, not risk of harm.	DHS determined the children were at risk of harm due to improper supervision by the relative who had a CPS neglect history in another state that she had initially denied.
A newborn was not placed with her siblings, who had been adopted by licensed foster parents	DHS determined that the newborn's initial placement was appropriate as the goal was reunification. When the permanency goal changed, DHS decided the child should be placed with her siblings.
A father was substantiated for sexually abusing his children. CPS did not file a court petition and the father filed for full physical custody of the children and was being allowed unsupervised visits.	CPS agreed that the agency erred and a court petition should have been filed, as required by law. A petition for jurisdiction of the children was filed.
The private agency obtained a court order to remove the children from a relative circumventing an appeal of the removal to the Foster Care Review Board.	The agency determined that the relative had received the proper notification of the move and was fully informed.
The agency may not have properly assessed a foster parent with five adopted special-needs children. OCO concerns included several licensing investigations resulting in corrective action plans.	DHS determined the foster parents received numerous trainings related to caring for special-needs children, and were appropriately evaluated and assessed. The five licensing investigations resulted in two corrective action plans since 2001.

Investigations

The OCO completed 122 investigations this fiscal year. One investigation may involve more than one DHS county office or private child-placing agency. During this fiscal year, the OCO investigated 60 separate agencies. Because of the issues being addressed, there are two types of investigations. Investigations are categorized as preliminary or full investigations. All investigations are assigned to one primary investigator; however, a case summary is reviewed by at least two additional investigators prior to the completion of the investigation.

Preliminary Investigations

A complaint may be opened for preliminary investigation to determine whether a full investigation is warranted, or if it is determined at intake that the complainant's specific concern regarding agency actions may be resolved expediently. Preliminary investigations are usually closed within 30 days. A preliminary investigation may consist of obtaining pertinent agency or court documents, submitting questions to a caseworker via email, or conducting interviews with agency staff. A preliminary investigation is concluded as either an affirmation or administrative close. If it is determined that a more extensive investigation is warranted, the preliminary investigation will be expanded to a full investigation.

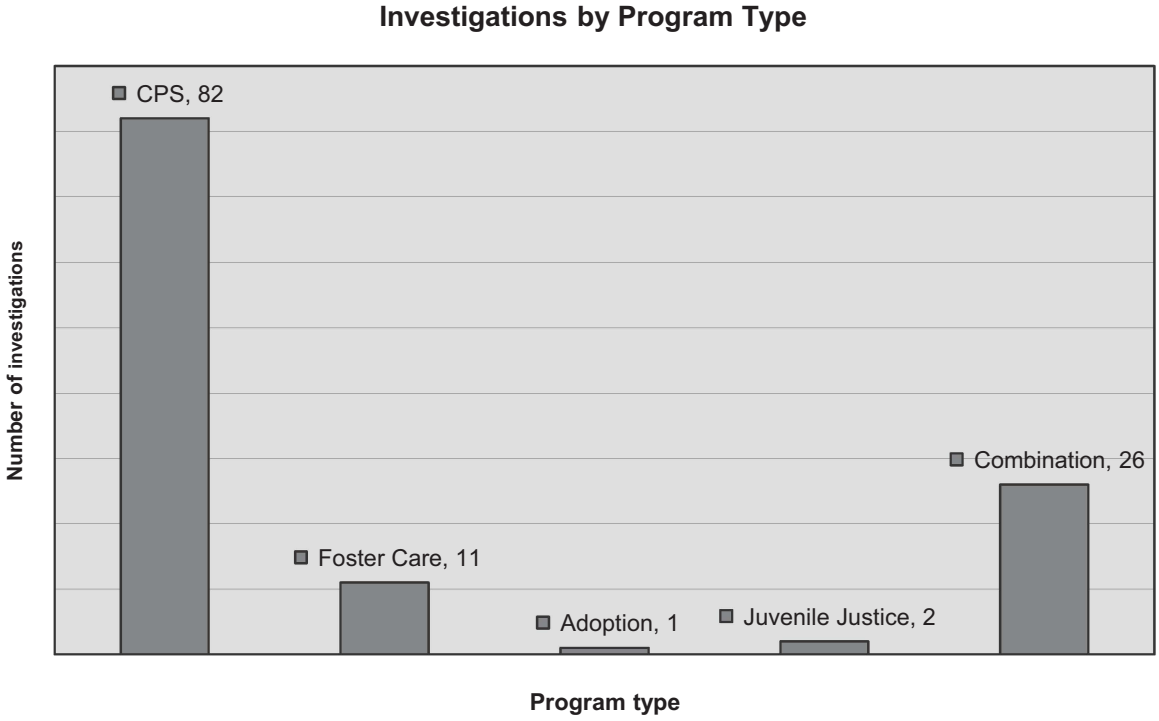
Full Investigations

A full investigation consists of requesting numerous agency records and reports, including court documents; service provider reports; and other pertinent information deemed relevant by the OCO. The assigned investigator reviews the documents and conducts interviews with agency staff and other sources as needed. The documents and other information obtained during the investigation are reviewed for compliance with DHS policy and procedure, applicable laws, and good social work practice. Full investigations are concluded as an affirmation, administrative close, or a report of findings and recommendations.

Investigation Results: Program Type

Investigations generally focus on resolving concerns identified by the complainant. However, if the OCO identified other issues, those were addressed with DHS, the Bureau of Children and Adult Licensing, the private child-placing agency, the court, or the child's attorney, as appropriate. Examples of other identified issues are those that impacted the child's well-being; such as delayed permanency, untimely service provision, lack of parenting time or sibling visits, or improper placement decisions.

Of the 122 investigations completed this fiscal year, the majority (67%) focused exclusively on CPS concerns; 21% of investigations involved more than one program area (CPS, foster care, and/or adoption services); and 9% of investigations addressed only foster care concerns.



Investigation Results: Case Closure Types

When an investigation is completed, the ombudsman notifies the complainant in writing of the outcome of the investigation and any action taken by the involved agencies to address the complaint issues. The relationship of the complainant to the child, as described in the Children's Ombudsman Act, governs the information that can legally be provided to the complainant. In addition, the OCO adheres to state and federal laws governing confidentiality; hence, there may be information that cannot legally be provided to a complainant about the results of the OCO's investigation. The Children's Ombudsman Act prohibits the OCO from releasing the results of the investigation if there is an ongoing CPS or law enforcement investigation. Once those investigations are closed, the ombudsman may release the written results.

Sixty DHS county offices and private child-placing agencies were involved in the 122 investigations completed this fiscal year (44 and 16 respectively). A total of 147 closing letters or reports were issued to the involved agencies because more than one agency was involved in several cases. (See chart on page 10).

- **26 Preliminary Investigations**

- **Full Investigation: 51 Affirmations** – The OCO determined that the agency complied with applicable laws, rules, and/or policies, and agency decisions and actions were consistent with case facts and the child's best interests.

- **Full Investigation: 40 Administrative Closings** – The OCO did not affirm the actions of the agency but concluded the investigation based on one or more of the following:

  - The agency is currently addressing the complaint.
  - The identified issues would not have altered the actions taken or the outcome of the case.
  - The issues were previously investigated and addressed in an OCO annual report.
  - An investigation by the OCO would not affect the outcome of the case.
  - Other.

- **Full Investigation: 30 Reports of Findings and Recommendations (F&R)** – The OCO concluded that the agency did not comply with laws, rules, and/or policies, or agency actions and decisions were not consistent with the case facts or the child's best interests. The ombudsman details case background information, specific findings (violations) and corresponding recommendations in a report to the agency, and the agency responds to the OCO in writing within 60 days.

OCO Investigation Results by Agency and Outcome

Of the 122 completed investigations, 100 (83%) involved DHS only, 17 (14%) involved both DHS and one or more private child-placing agency, and five (3%) involved only a private child-placing agency. A total of 60 separate county offices and agencies were investigated.

The following chart lists the outcome(s) by county DHS offices and private child-placing agencies for OCO investigations completed in fiscal year 2010:

Agency	Number of Investigations	Outcome			
DHS		Affirm	F&R	Administrative	Preliminary
Allegan	1	1			
Antrim	1				1
Arenac	1	1			
Berrien	2	1	1		
Branch	1			1	
Calhoun	3	1		2	
Charlevoix	1				1
Chippewa	2	2			
Clare	1	1			
Clinton	1				1
Crawford	1		1		
Delta	1	1			
Eaton	3	1			2
Emmet	1	1			
Genesee	8	2	1	3	2
Grand Traverse	3	1		1	1
Hillsdale	1	1			
Ingham	4	1	1	1	1
Iosco	3	1		2	
Isabella	1	1			
Jackson	5	2	1	1	1
Kalamazoo	2		1		1
Kent	8	1	1	2	4
Lapeer	1			1	
Livingston	2	1	1		
Luce	1				1
Macomb	6		1	4	1

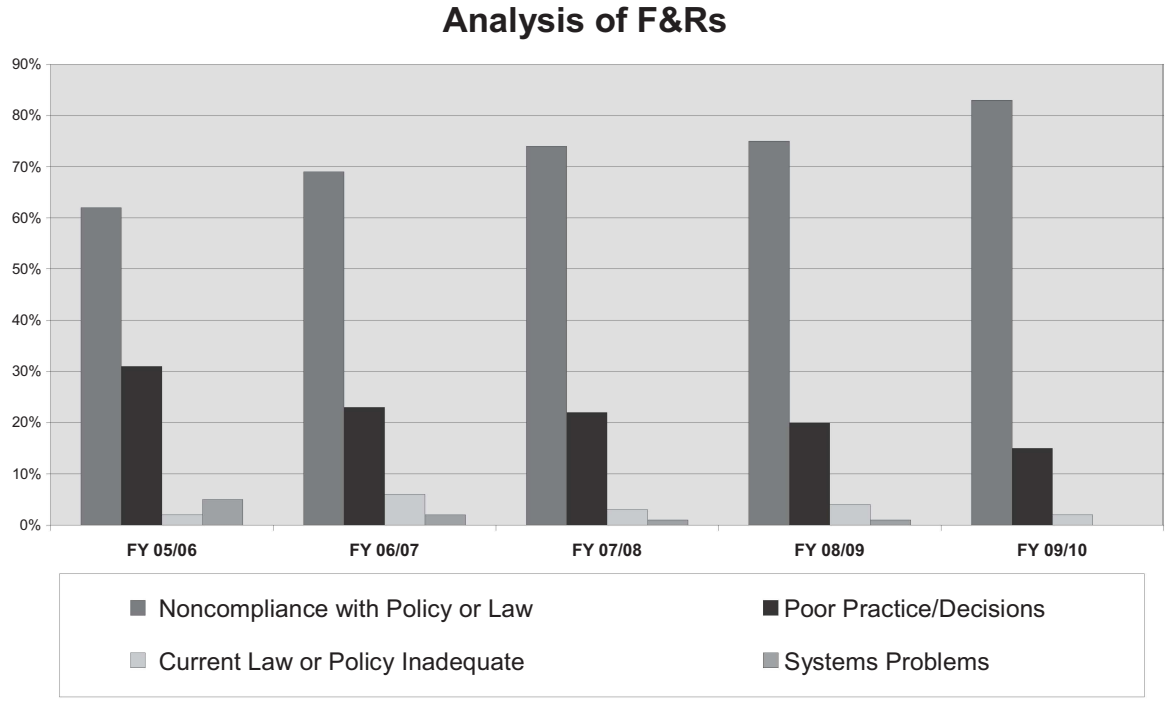
Agency	Number of Investigations	Outcome			
DHS		**Affirm**	**F&R**	**Administrative**	**Preliminary**
Marquette	1	1			
Mason	1			1	
Mecosta	1			1	
Monroe	1				1
Montcalm	1			1	
Muskegon	3	2			1
Newaygo	1			1	
Oakland	6	1	5		
Oceana	1			1	
Osceola	1		1		
Ottawa	1		1		
Saginaw	4	2	1	1	
Shiawassee	1				1
St. Clair	2		2		
St. Joseph	1		1		
Washtenaw	1	1			
Wayne	33	14	8	10	1
Private Agencies					
Alternatives for Children	1	1			
Bethany Christian Services	2				2
Catholic Charities of West Michigan	1				1
Catholic Social Services	2	1		1	
Child and Family Services of NW MI	1	1			
Children's Center	1			1	
DA Blodgett	2	1			1
Ennis Center for Children	1	1			
Evergreen Children's Services	1		1		
Lutheran Adoption Services	1			1	
Lutheran Social Services	1	1			
Methodist Children's Services	1				1
Orchards Children's Services	3	2		1	
Spaulding for Children	1	1			
Spectrum Human Services	2		1	1	
Wolverine Human Services	1			1	
Totals	**122**	**51**	**30**	**40**	**26**

Analysis of Reports of Findings and Recommendations (F&Rs)

The 30 F&Rs issued in fiscal year 2010 encompassed over 151 findings and 209 recommendations. Consistent with each year prior, the overwhelming majority, 97% of the findings were the result of noncompliance with existing law or policy or poor practice and decision-making.

Examples of prevalent findings include:

- Inaccurate completion/scoring of safety and risk assessments.
- Lack of face-to-face contact with required individuals during a CPS investigation.
- Extending beyond the 30-day time frame for completing CPS investigations.
- Lack of documentation of family history.
- Inadequate assessment of child safety.



Child Death Case Investigations

Specific criteria are used to determine whether the OCO will open a child death case for investigation. The main focus of an OCO investigation is to determine whether previous interventions by DHS and/or a private child-placing agency were handled in accordance with policy and law. The OCO also determines whether a correlation exists between previous DHS involvement with the family and the circumstances that led to the child's death.

The OCO and the DHS Office of Family Advocate entered into an agreement in 2008 that resulted in DHS sending an electronic "Child Death Alert" to the OCO when DHS becomes aware that a child has died. An OCO investigation may be conducted when at least one of the following criteria is met:

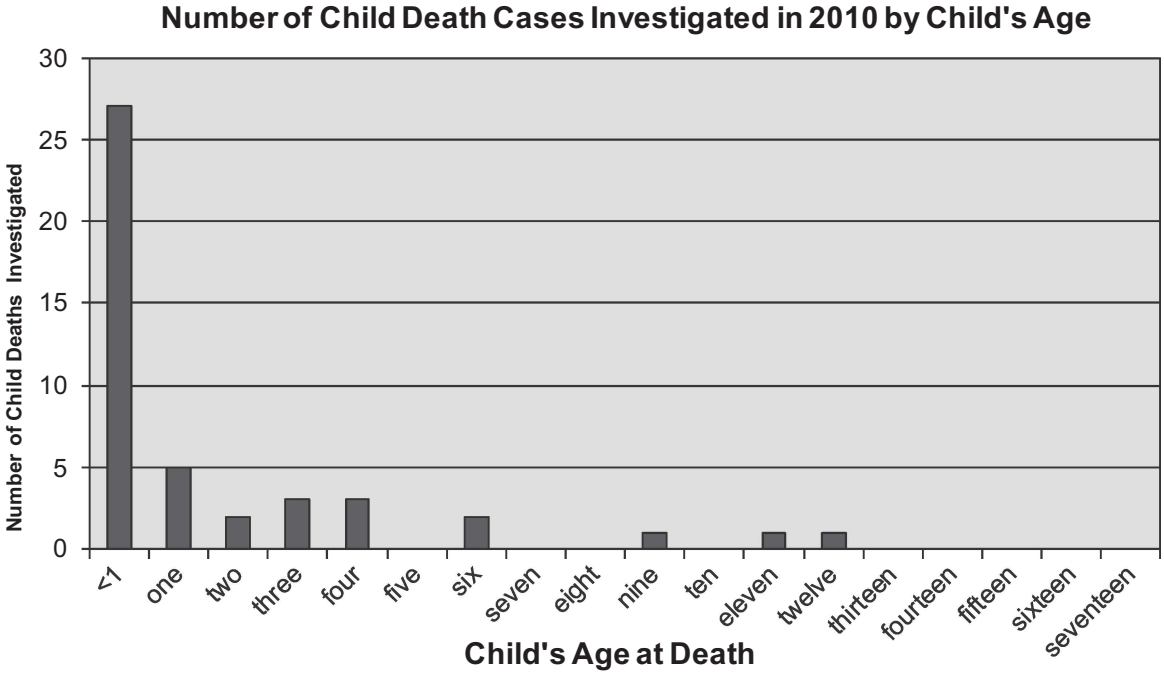
- A child died during an active CPS investigation or open services case, or there was an assigned or rejected CPS complaint within the previous 24 months.
- A child died while in foster care, unless the death resulted from natural causes and there were no prior CPS or licensing complaints concerning the foster home.
- A child was returned home from foster care and there is an active foster care case.
- The foster care case involving the deceased child or sibling was closed within the previous 24 months.
- Media interest.
- Legislator request.
- Ombudsman discretion.

In fiscal year 2010, the OCO received 239 child death alerts from DHS resulting in the opening of 37 child death case investigations. The number of child death cases opened each fiscal year is dependent upon information in the child death alert or separate information obtained from DHS as it compares to the OCO's criteria. Many children die as a result of an accident, medical condition or for other reasons that do not meet the OCO criteria.

Child Death Investigation Analysis

Statistical information regarding the 41 completed child death investigations indicates:

- Sixty percent of the child deaths involved a child under the age of one year.
- Eight children died in parental care during an active investigation or an open CPS services case.
- In seven cases the child's previous medical condition was identified as a factor.
- Six children died as a result of severe physical abuse.
- Four children died while in foster care; however, only one death occurred in a licensed foster home and the cause of death was from a previous medical condition.
- In over 34 percent of the investigations, the child's sleep environment was identified as a factor associated with the child's death.



Child Death Case Investigation Results by Agency and Outcome

The 41 completed child death investigations involved 16 DHS county offices and 2 private child-placing agencies. A total of 47 closing letters or reports were issued to the involved agencies. The three investigations involving the private agencies also involved one or more DHS county offices.

Agency	Number of Investigations	Outcome		
DHS		**Affirm**	**F&R**	**Administrative Closings**
Berrien	1	1		
Chippewa	1	1		
Clare	1	1		
Genesee	2	1	1	
Jackson	2	1	1	
Kalamazoo	1		1	
Kent	4	1	1	2
Lapeer	1			1
Livingston	2	1	1	
Macomb	2			2
Muskegon	1	1		
Oakland	2		2	
Ottawa	1		1	
Saginaw	1		1	
St. Clair	1		1	
Wayne	21	10	5	6
Private Agencies				
Ennis Center for Children	1	1		
Orchards Children's Center	2	1		1
Totals	**41**	**20**	**15**	**12**

OCO FY 2010 Annual Report Recommendations and DHS Responses

DHS policy and procedure adequately outline the steps caseworkers must follow when handling a case and also sufficiently guides caseworkers toward making decisions based on child safety, best interest and permanency. However, the OCO has noted areas of concern that repeatedly arise during case investigations and at other times when contacting individuals concerned about case handling. These concerns were highlighted in previous annual reports and are repeated in the recommendations below because of their continued importance to children and families.

Supervisory Oversight

OCO Recommendation 1:

The OCO recommends that DHS determine what additional enhancements may be necessary in order to improve supervisory oversight of caseworkers.

Rationale: In the OCO annual reports for fiscal years 2005 and 2006, supervisory oversight was listed as a "prevalent finding" because this was repeatedly found as a concern during case investigations. In the FY 2007 annual report, the OCO requested that DHS identify strategies to ensure "timely and effective oversight" by supervision. DHS subsequently instituted specialized training for supervisors in its children's protective services, foster care and adoption services programs. DHS also improved training for children's protective services workers and supervisors to ensure thorough investigations.

However, OCO case investigations continue to find caseworker noncompliance with DHS policies and subsequent supervisory approval of caseworkers' reports. Areas of noncompliance involve:

- Interviews with required contacts/household members during CPS investigations not being conducted.
- Reaching incorrect dispositions based upon the evidence documented in the file.
- Inaccurate completion of Safety and Risk Assessments and Reassessments.
- Extending beyond the 30-day time frame for completing CPS investigations.
- Deficiencies in verifying the safety and well-being of children during CPS investigations.
- Deficiencies in making required face-to-face contacts in CPS and foster care cases.

DHS Response to Recommendation 1:

The CPS Program Office, Foster Care Program Office, and Child Welfare Field Operations developed a program improvement plan for the Child and Family Services Review that will improve supervisory oversight of caseworkers.

For CPS, the plan includes case consultation between worker and supervisor prior to case disposition and for every ongoing CPS case at least monthly. In addition, there will be a requirement for supervisors to accompany the worker on a family home visit to assess the worker's proficiency in assessing child safety and engaging families. For Foster Care, the plan includes developing a supervisor shadowing pilot in multiple counties which will require supervisors to accompany casework staff on home visits at least one time quarterly for the purpose of assessing the worker's safety assessment and engagement skills as well as developing a supervision tool to increase quality supervision. Child Welfare Field Operations will develop a means of tracking the above requirements for both programs and will implement this by the end of FY2011.

DHS has begun a Data Driven Decision Making initiative to provide central administration and local office management and staff with reports necessary to increase positive outcomes for children and families served in child protective services, foster care, licensing, adoption and juvenile justice programs. One of the key areas identified across programs includes visitation standards. The visitation standard report outlines for each case the required visits with children and families and whether they are being completed.

Additionally, the Child Welfare Training Institute has initiated a curriculum review team consisting of DHS staff, private agency staff, and external stakeholders. The goal is to review the existing supervisory training curriculum and make recommendations that strengthen supervisory oversight and improve supervisory case work practice. Moreover, the Child Welfare Training Institute has begun developing video and webinar-based training addressing clinical and case supervision for supervisory staff. These sessions are skill-based development trainings which assist supervisors to better communicate with their case workers on difficult or complex case issues. A separate set of video training will be developed that use home-visiting scenarios to increase the skill level of both workers and supervisors. The video will be incorporated into classroom-based training for supervisors as appropriate.

Regarding caseworker noncompliance with policy, L-10-138-CW, a DHS communication to child welfare field staff, was issued in November 2010 introducing a new policy review and certification process which all children's services supervisors must follow. All children's services supervisors must certify that they have reviewed newly released policy manual material or interim bulletins with their staff and provide certification of this in JJOLT as a means of tracking compliance. It is anticipated this will assist in increasing caseworker compliance with policy.

Parenting Time

OCO Recommendation 2:
(This is the same recommendation published in the FY 2001 OCO Annual Report with minor modifications).

The OCO recommends that DHS and private child-placing agencies comply with the laws and policies pertaining to parenting time in foster care cases with a goal of reunification.

Pertinent Statutes:

- If a juvenile is removed from his or her home, the court shall permit the juvenile's parent to have frequent parenting time with the juvenile. However, if parenting time, even if supervised, may be harmful to the juvenile, the court shall order the child to have a psychological evaluation or counseling or both, to determine the appropriateness and the conditions of parenting time. The court may suspend parenting time while the psychological evaluation or counseling is conducted.[2]

- Unless parenting time, even if supervised, would be harmful to the child as determined by the court under section 13a of this chapter or otherwise, a schedule for regular and frequent parenting time between the child and his or her parent shall be implemented and shall not be less than once every 7 days.[3]

- The supervising agency shall require that its worker make monthly visits to the home or facility in which each child is placed. The supervising agency shall also require its worker to monitor and assess in-home visits required under this subsection, the supervising agency shall institute a flexible schedule to provide a number of hours outside the traditional workday to accommodate the schedules of the individuals involved.[4]

Pertinent DHS Policies:

- Supervising agencies must use parenting time to maintain and strengthen the relationship between parent and child. By facilitating weekly parent/child parenting time, agency staff can positively influence the length of time children stay in the foster care system and the time required to achieve permanence. Foster care workers must engage the family in establishing/scheduling parenting time.[5]

- The frequency of parenting time prior to the dispositional hearing is an important indicator of how quickly children can be reunited with their families, when this is the plan. Therefore, the more frequent the parenting time the more likely the child will return home.[6]

- The supervising agency must institute a flexible schedule to provide a number of hours outside the traditional workday to accommodate the schedules of the

[2]MCL 712A.13a(11)
[3]MCL 712A.18f(3)(e)
[4]MCL 722.954b(3)
[5]DHS policy FOM 722-6
[6]Ibid.

individuals involved. Barriers to parenting time are to be identified and where possible, resolved.[7]

- Parenting time is to occur in a child and family friendly setting conducive to normal interaction between the child and parent.[8]

Rationale: It is well documented that the quality and frequency of parenting time correlates significantly with the success or failure of a family reunification plan. However, the OCO continues to see a lack of compliance with the above-noted laws and policies designed to facilitate successful parenting time and thus successful reunification plans. In many instances, the OCO finds that foster care agencies provide the minimum amount of parenting time required by law (generally one hour, once per week) rather than developing parenting time plans that meet the unique needs of each case. Court orders often give agencies the discretion to increase parenting time. In addition, supervised parenting time often occurs at the agency in surroundings that may not be conducive to normal interactions between parents and children. Since parenting time is a measured component of a parent's case service plan and progress is reported to the court at each review hearing, the agency should make every effort to enhance the quality, duration and frequency of parenting time. Unless these efforts are made, parenting time cannot be used to accurately gauge the potential success of reunification or accomplish the stated goals of maintaining and strengthening the parent-child relationship.

2001 DHS Response:

Agree. It is imperative that supervising agencies have flexible parenting time to accommodate individual schedules. It is also important that the environment in which parenting time occurs allows for normal, quality interaction between the child(ren) and the parent(s). However, the court oversees parenting time and often sets the parameters for parenting time, over which DHS/private agencies have no control. DHS supports increased training for agency staff on the value of parenting time, especially during the immediate period following the initial removal from the home.

DHS Response to Recommendation 2:

Foster Care policy continues to require parenting be offered at least weekly and that scheduling be done with primary consideration for the parents' time commitments. The supervising agency must institute a flexible schedule to provide a number of hours outside of the traditional workday to accommodate the schedules of the individuals involved. Barriers to parenting time are to be identified and where possible, resolved.

The current Data Driven Decision Making Initiative will provide reports to local office management and staff to measure the average frequency of parenting time. As indicated in the 2001 response, there are instances where parameters for parenting time are set by the court which the agency has no control.

[7]Ibid.
[8]Ibid.

Foster Care Program Office, in collaboration with Child Welfare Field Operations and the State Court Administrative Office, developed a program improvement plan for the Child Welfare Services Review in an effort to increase the frequency and quality of parenting time. The plan includes convening a committee to identify and problem solve barriers to parenting time as well as additional training and court oversight during review hearings. Michigan will also be implementing a case practice model (MiTEAM) which focuses on concurrent permanency planning and family engagement. One of the main tenants of this model is increased frequency of parenting time according to the child's age and developmental needs.

Statutory Recommendation

Children with Mental Health Concerns and Parental Rights

OCO Recommendation 3:
(This is the same recommendation published in the FY 2002 OCO Annual Report with minor modifications)

The OCO recommends a law be enacted to prevent parents from having to relinquish custody and plead guilty to neglect of their child solely to obtain residential mental health services deemed necessary for their child's serious mental health illness or emotional disorder.

The OCO further recommends that an interagency task force be established to review current child mental health care programs and funding sources, identify gaps in the system, and develop a comprehensive mental health care system that will meet the needs of all children in Michigan.

Rationale: The OCO has received a number of complaints from biological and adoptive parents who are unable to obtain intensive, specialized mental health services for a seriously mentally ill or emotionally disturbed child. Private insurance plans typically limit mental health services to a prescribed number of outpatient visits and, in emergencies, a certain number of inpatient hospital days. A child with a serious mental illness can quickly exceed these limits, and may even require intensive long-term treatment or residential placement, which can place a serious financial burden on the family. In the most extreme cases reported to the OCO, the parent has agreed to plead to a neglect charge under the Child Protection Law, the court adjudicates the parents as neglectful and takes jurisdiction of the child, who now qualifies to receive publicly funded mental health services.

The OCO finds it unreasonable that a parent must be adjudicated as neglectful and be placed on the Central Registry in order to obtain mental health services for a seriously mentally ill or emotionally disturbed child. One alternative is to enact a statute that allows the court to adjudicate a child in need of services, take physical custody of the child only with the consent of the parent, and order the necessary specialized services for the child.

However, enacting a statute alone will not address the underlying issues contributing to the shortcomings of the child mental health system. Therefore, an interagency task force should be established to review the current mental health care system, identify problems, and implement a comprehensive plan that would allow: 1) early identification of mental health needs, and adequate treatment services and supports for both children and their families; 2) adequate access to a wide array of mental health services, including intensive outpatient and residential treatment for all children, regardless of family income and health care coverage; and 3) combined funding from various state agencies to pay for services, allowing access to mental health services for all children.

2002 DHS Response:

Agree. The DHS agrees with the intent of this recommendation. The lack of mental health services to children and their parents has been an important issue to CPS for years. CPS has consistently been put in the position of having to file neglect/ dependency petitions on parents who have not been able to obtain mental health services to help them manage their child at home or to manage their child upon discharge from a mental health facility. The DHS asserts that this is an issue that requires both legislation and collaboration with the Department of Community Health (DCH). As such, the Children's Action Network (cabinet level, multi-departmental executive team) under the leadership of the DHS will be apprised of this issue to ensure executive attention to issues that affect children. The DHS will initiate direct contact with DCH to begin working toward the development of an action plan to address this situation, to the extent possible, with or without legislation.

DHS Response to Recommendation 3:

The Department of Community Health/Department of Human Services Children's Leadership Team has been meeting since March 2009. Among others, team members include the directors of the Children's Services Administration, Child Welfare Bureau, Child Welfare Field Operations, the DHS manager of the Health, Education and Youth Unit, the DCH directors of Mental Health and Substance Abuse Administration, Mental Health Services to Children and Families, Children's Home and Community Based Waivers Mental Health Services to Children and Families, and the "Serious Emotional Disturbance Waiver" Specialist. The team's focus is meeting the mental health services needs of children in the child welfare system. The team is responsible for identifying cost-effective opportunities to increase access to needed mental health services for children in the child welfare system that are eligible for mental health services.

One of the first products of this collaboration is the implementation of the "Serious Emotional Disturbance Waiver" (SEDW) pilot for children in foster care. The SEDW enables Medicaid to fund necessary home and community-based services for children with serious emotional disturbance who meet the criteria for admission to a state inpatient psychiatric hospital and who are at risk of hospitalization without waiver services. The Community Mental Health Services Program is responsible for assessment of potential waiver candidates and DHS provides the match to draw down Medicaid to serve 266 children in the pilot counties. Currently, the counties in the SEDW pilot are: Genesee, Ingham, Kalamazoo, Kent, Macomb, Oakland, Saginaw and Wayne.

To date, over 214 foster children have been served by the SEDW. DHS also directed additional funding that enabled the Community Mental Health Service Programs to serve children not rising to the level of SEDW services but at risk of disruption from their current foster care placement or stepping down from a residential treatment center. To date, twenty-eight children have been served by the additional funding.

The Department of Community Health used block grant funds to staff a community mental health services program position in the DHS offices participating in the SEDW pilot. This county level collaboration has improved communication between systems and improved practice.

Discussions continue at the state level to expand current services to more counties. Additional funding must be identified to continue these efforts and to expand to other populations, including CPS, adoption subsidy and the developmentally disabled.

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