



**Children's Services Agency  
Division of Continuous Quality Improvement**

**Child and Family Services Plan  
2015 - 2019**

**2019 Annual Progress and Services Report**

Stephanie Tubbs Jones Title IV-B Child Welfare Services  
Promoting Safe and Stable Families Program  
John H. Chafee Foster Care Program for Successful Transition to Adulthood  
Education and Training Voucher Program

**June 2018**

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The [Michigan Child and Family Services Plans and Annual Progress and Services Reports](#) can be viewed on the MDHHS website.

## GENERAL INFORMATION

The Michigan Department of Health and Human Services (MDHHS) organizational structure reflects the department's vision and priority with an emphasis on children's services, aging and adult services, service delivery/community operations, health and behavioral health services and family support, as well as population health and community services. Director Nick Lyon was appointed to lead MDHHS in 2015.

MDHHS is the state department that administers:

- Child Abuse Prevention and Treatment Act funded activities.
- Title IV-B(1) and (2) Stephanie Tubbs Jones Child Welfare Services.
- Title IV-E Child Welfare Training.
- Promoting Safe and Stable Families Program.
- Monthly Caseworker Visit Formula Grant.
- Chafee Foster Care Independence Program.
- Education and Training Voucher Program.

Child welfare services in Michigan are administered through the MDHHS Children's Services Agency. Reporting to the executive director of the Children's Services Agency are directors of:

- Division of Continuous Quality Improvement.
- Division of Child Welfare Licensing.
- Office of the Family Advocate.
- Children's Trust Fund.
- Michigan's Statewide Automated Child Welfare Information System (MiSACWIS).

The executive director of the Children's Services Agency, Dr. Herman McCall, oversees two Children's Services deputy directors. One of the deputy directors is responsible for the Office of Child Welfare Policy and Programs, the Division of Mental Health Services to Children and Families and the Office of Native American Affairs. The second oversees Business Service Center and local MDHHS directors, Children's Protective Services Centralized Intake, Juvenile Justice Programs and Child Welfare Services and Support, which provides assistance to private child-placing agencies. The Division of Continuous Quality Improvement (DCQI) is responsible for the development and administration of the Child and Family Services Plan and leading ongoing continuous quality improvement efforts.

### **MDHHS Vision**

Develop and encourage measurable health, safety and self-sufficiency outcomes that reduce and prevent risks, promote equity, foster healthy habits and transform the health and human services system to improve the lives of Michigan families.

### **Children's Services**

A priority for Michigan's health and human services programs is ensuring that children are protected, and families are supported.

## **Child Welfare Vision**

MDHHS will lead Michigan in supporting our children, youth and families to reach their full potential.

## **Child Welfare Mission**

Child welfare professionals will demonstrate an unwavering commitment to engage and collaborate with the families we serve to ensure safety, permanency and well-being through a trauma-informed approach.

## **Guiding Principles**

The vision and mission are achieved through the following guiding principles:

- Safety is the first priority of the child welfare system.
- Families, children, youth and caregivers will be treated with dignity and respect while having a voice in decisions that affect them.
- The ideal place for children is with their families; therefore, we will ensure children remain in their own homes whenever safely possible.
- When placement away from the family is necessary, children will be placed in the most family-like setting and placed with siblings whenever possible.
- The impact of traumatic stress on child and family development is recognized and used to inform intervention strategies.
- The well-being of children is recognized and promoted by building relationships, developing child competencies and strengthening formal and informal community resources.
- Permanent connections with siblings and caring and supportive adults will be preserved and encouraged.
- Children will be reunited with their families and siblings as soon as safely possible.
- Community stakeholders and tribes will be actively engaged to protect children and support families.
- Child welfare professionals will be supported through identifying and addressing secondary traumatic stress, ongoing professional development and mentoring to promote success and retention.
- Leadership will be demonstrated within all levels of the child welfare system.
- Decision-making will be outcome-based, research-driven and continuously evaluated for improvement.

Child welfare professionals will implement these guiding principles by modeling teaming, engagement, assessment and mentoring skills.

## INTRODUCTION

The 2019 Annual Progress and Services Report (APSR) represents year four of Michigan's five-year Child and Family Services Plan (CFSP) for 2015 – 2019 and demonstrates the state's advancement in aligning the CFSP/APSR with the federal Child and Family Services Review (CFSR) goals and outcomes. Aligning programmatic goals with CFSR goals ensures the state is focusing efforts on the most critical elements of safety, permanency and well-being of children and families. Alignment with CFSR goals also ensures adequate preparation for Michigan's Round 3 CFSR in 2018 by ensuring the structural and procedural foundation is in place for an accurate statewide assessment and an in-depth case review. Results of the statewide assessment and onsite review will provide a map for continued improvement.

### **Progress in 2017**

In 2017, progress continued in the development and maintenance of a responsive, effective organizational structure in the MDHHS Children's Services Agency (CSA). The continued alignment of CSA organizational structure and processes with continuous quality improvement methods is the groundwork for the targeted development of goals and strategies, assessment of progress and modifications that focus on areas needing improvement. The CSA Quality Improvement Council (QIC) oversees the collection and analysis of child welfare data and is the source for planning and design of improvement measures on the statewide level.

The rollout of the MiTEAM Fidelity Tool in 2018 provides staff the ability to assess implementation of the practice model in services to children and families statewide. The implementation of the MiTEAM model strengthened the role of community stakeholders and families in evaluating service quality. In 2017 and 2018, training and technical assistance to the field in the implementation of the enhanced MiTEAM model continued.

In 2017 and 2018, Michigan made strides in collecting, validating and analyzing data. Technical and training staff worked continuously with field staff to collect accurate data to track the effectiveness of the state's child welfare services and accurate information on foster children at any given time. The Division of Continuous Quality Improvement (DCQI) provides assistance to local offices in using data to monitor performance. Local offices and agencies are actively using the data to measure local and caseworker-level performance in key areas.

In 2018, MDHHS is pursuing plans to move toward a compliant Comprehensive Child Welfare Information System to enhance MiSACWIS. MDHHS is developing an Advanced Planning Document describing the method Michigan will use in the transition to a system that demonstrates compliance. The Advanced Planning Document will be submitted to the Children's Bureau by July 31, 2018.

MDHHS continued to address the needs of residents of the city of Flint who were exposed to contaminated drinking water.

- The state Medicaid expansion was broadened to include the screening and healthcare of

children and adults exposed to lead and other contaminants.

- Caregivers were provided with resources and information on the need to have the children in their care screened for lead and receive care to alleviate the effects if a high blood level was identified.
- Michigan used federal and state funds to alleviate the effects of exposure to contaminants on residents and providing safe drinking water and filters.
- Testing of drinking water in Genesee County over the past two years has shown the county's levels of lead are now below federal action levels. The state is ending the provision of bottled water to Flint residents in 2018.

More information on the Michigan's response to the Flint water contamination is included in Michigan's Child Welfare Disaster Plan, Attachment P.

### **Reporting on Child Welfare Outcomes**

Results in the CFSR Safety, Permanency and Well-Being outcomes from fiscal year 2017 (Oct. 1, 2016 – Sept. 30, 2017) are reported in this report and where possible, data from the first two quarters of 2018 (Oct. 1, 2017 – March 31, 2018) are included.

### **MDHHS Targeted Plans**

1. Attachment N - Foster and Adoptive Parent Diligent Recruitment Plan.
2. Attachment O - Health Care Oversight and Coordination Plan.
3. Attachment P - Child Welfare Disaster Plan.
4. Attachment Q - Staff and Provider Training Plan.

## **COLLABORATIVE DEVELOPMENT OF THE 2015 – 2019 CFSP AND 2019 APSR**

Michigan has standing committees and professional and citizen groups that inform MDHHS' five-year Child and Family Services Plan (CFSP) and Annual Progress and Services Report (APSR) and for developing services responsive to the diverse needs of the state's populations and geographical regions. Feedback from these groups on an ongoing basis provides MDHHS with vital information that spurs efforts to address issues identified. These groups include:

- Citizen Review Panel on Prevention.
- Citizen Review Panel on CPS, Foster Care and Adoption.
- State Child Death Review Team.
- The Governor's Task Force on Child Abuse and Neglect.
- Tribal-State Partnership.
- Medical Care Advisory Council.
- Michigan Youth Opportunities Initiative youth boards.
- The Michigan Office of the Children's Ombudsman.
- The Child Welfare Partnership Council.
- Prosecuting Attorney Advisory Council.

- Judicial Advisory Council.
- Foster Care and Adoption Outcomes Group.

These groups, their role in providing information and feedback for the APSR and MDHHS action steps and responses are described throughout this report and in more detail in the Agency Responsiveness to the Community section.

### **Child and Family Services Review Round 3**

In preparation for Round 3 of the Child and Family Services Review (CFSR), scheduled for Aug. 13 – 17, 2018, Michigan’s CFSR Steering Committee is providing direction and oversight while a second group, the CFSR Workgroup, is working closely with the Children’s Bureau to plan the details of the onsite review. Michigan opted to undergo a traditional CFSR with the use of the federal Onsite Review Instrument and continues to work with the Children’s Bureau on logistics for the review. The CFSR workgroup suggested qualities for a review team and developed a recruitment plan to secure a team of trained reviewers from a variety of disciplines and agencies that will serve during the onsite review and into the program improvement plan (PIP).

In 2017 and 2018, Michigan initiated a comprehensive assessment of the seven CFSR systemic factors to determine how well the state’s child welfare system responds to the needs of children and families, with the benefit of technical assistance from the Children’s Bureau. Feedback from the Children’s Bureau provided direction to improve reporting of results, and ongoing assistance will ensure the final Statewide Assessment accurately demonstrates Michigan’s strengths and areas needing improvement. Results of the Statewide Assessment will be used to target resources effectively and determine the need for stakeholder interviews during the onsite CFSR. Portions of the Statewide Assessment are included in this APSR. Michigan submitted the final Statewide Assessment on June 18, 2018.

The 2019 APSR includes details assessing the functioning of the seven CFSR systemic factors in Michigan’s child welfare system that are part of the CFSR Statewide Assessment. Data from reviews conducted by DCQI are featured as important elements in determining the strength of Michigan’s functioning in each systemic factor. Michigan will use the federal Onsite Review Instrument as part of the state’s ongoing quality assurance/continuous quality improvement process during the program improvement plan (PIP) period.

## **FAMILY FIRST PREVENTION SERVICES ACT – HEALTH CARE AND COORDINATION PLAN**

Michigan is developing processes to ensure compliance with the Family First Prevention Services Act in several areas. The strategies described below were added to Attachment O: Health Care and Coordination Plan, and include developing clinical pathways to:

1. Ensure that placement of a child in any setting that is not family foster care is based on the needs of the child as identified in a child’s diagnosis by a qualified medical practitioner and documented safety needs.

2. Ensure accurate documentation and sharing of child health information with health providers and caregivers.

### **Ensuring Appropriateness of Placement in Qualified Residential Treatment**

Child welfare teams consider several factors when pursuing residential treatment for a child, including the capacity to maintain safety and benefit from treatment in the community. When a child's diagnosis includes medical/mental or behavioral health needs that cannot be safely met in the community or in a foster family home, a child may be placed in a qualified residential treatment program. Qualified residential treatment programs must:

- Include a trauma-informed treatment model designed to treat children with emotional or behavioral disorders.
- Have licensed nursing and clinical staff onsite as required by the program's treatment model.
- Facilitate outreach to family members of the child.
- Document how family members are integrated into the treatment process.
- Provide discharge planning and family-based care support for six months after discharge.

Prior to placement of a child in a qualified residential treatment facility, caseworkers must prepare a Placement Exception Request that documents supervisor and county director review and approval.

- The referring worker must provide the residential provider with all recent medical, behavioral and mental health diagnoses and reports.
- MDHHS contracts with residential providers require that a licensed clinician with a minimum of a master's level degree conduct a bio-psycho-social assessment of a child using evidence-based tools within 30 calendar days following placement.
- The bio-psycho-social assessment ensures placement is based on documented need for the treatment provided in the program and used to develop a treatment plan based on a review of past information with current assessments specific to the child's needs.

To ensure that practitioners with the appropriate knowledge, training and skills have the tools to arrive at an accurate diagnosis, all members in the child welfare systems of care must follow clinical pathways or procedures to guide decisions about treatment in residential settings. These clinical pathways are informed by the best available evidence, re-evaluated and improved regularly based on statewide outcome data and emerging scientific evidence. The process of developing clinical pathways include the following elements:

- A means to support and hold providers accountable for providing and documenting accurate and comprehensive diagnostic assessments that include diagnosis, functional capacity and recommendations based on the best available evidence.
- Specific guidelines defining the child and family characteristics that would require intervention within a residential setting.
- Capacity and accountability within the MiTEAM case management process to follow the clinical pathways for each child.

- Education of all members of the systems of care on the clinical pathways, including parents and caregivers, courts, child welfare personnel and health/mental health care providers.
- Evaluation methods to track fidelity in following the clinical pathways and outcomes for the children and families served.

MDHHS has initiatives in process to address some of these elements:

- Systems transformation project, described in the Permanency section of the APSR.
- Enhanced MiTEAM practice model training and support.
- Trauma screening, assessment and treatment protocols.

### **Ensuring Accurate Documentation and Sharing of Child Health Information**

Health providers must have a comprehensive health history of a child (the medical passport) to provide care and make an appropriate diagnosis. The medical passport must be provided to a new health provider at or before the first appointment with the child. The medical passport prints from MiSACWIS and includes the following information:

- Current primary care physician, dentist and insurance information.
- Allergies.
- Diagnosis.
- Medications.
- Health history.
- Health appointments, including behavioral health appointments in the last 18 months.
- Developmental/behavioral concerns.

During summer 2018, mandatory foster care worker training is being offered in eight sites on accessing and navigating CareConnect360, which has information on Medicaid claims from MiSACWIS. The training includes how to develop a medical passport with up-to-date and accurate information and how to enter information into MiSACWIS correctly. Beginning in June 2018, six webinars are available in the learning management system. Viewing of the webinars by caseworkers is mandatory by Dec. 31, 2018.

Additional actions MDHHS has taken or is taking to ensure compliance with the Family First Prevention Services Act are described in the following APSR sections:

- Services for Children under the Age of 5.
- John H. Chafee Foster Care Program for Successful Transition to Adulthood.
- Service Description – Title IV-B(1) and (2) Funds.

## **SAFE CARE FOR INFANTS AFFECTED BY SUBSTANCE USE**

Michigan’s policies and procedures for developing a Plan of Safe Care for infants identified as affected by substance use, required in the 2016 Comprehensive Addiction Recovery Act, include the following updates in 2017:

- Policy changes include the definition of a Plan of Safe Care to be included in an investigation involving an infant identified as being affected by substance use of their mother and/or withdrawal symptoms, or as a victim of Fetal Alcohol Spectrum Disorder.
- Michigan was one of 10 states selected to participate in the “2017 Policy Academy: Improving Outcomes for Pregnant and Postpartum Women with Opioid Use Disorders and their Infants, Families and Caregivers.” Through the Policy Academy, Michigan is developing and refining a cross-system plan to address the needs of infants affected by opioids and their caregivers.
- MDHHS added requirements in all family preservation contracts for development of a Plan of Safe Care for infants affected by substance use of their mother and/or withdrawal symptoms, or as a victim of Fetal Alcohol Spectrum Disorder.

### **CAPTA State Grant Enhancement**

Michigan was awarded additional CAPTA State Grant funds resulting from the federal Consolidated Appropriations Act of 2018, effective March 23, 2018. Beginning in 2019, the department will utilize this increased federal appropriation with a priority on addressing the development, implementation and monitoring of Plans of Safe Care for infants born and identified as being affected by substance use or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder. The department will begin the work by:

- Ensuring effective coordination of efforts for Plans of Safe Care with birthing hospitals, public health and family preservation partners and others to ensure awareness of how to develop and implement these plans and how to report to the department on their development and outcome.
- Providing statewide training and technical assistance for child welfare and public health partners on implementation and monitoring of these plans.
- Ensuring department reporting is consistent with CAPTA reporting requirements.
- Working with local partners, including law enforcement, prosecutors, child assessment centers and others to develop and maintain local child abuse and neglect investigation protocols. These protocols will address substance use investigations, system approaches designed to improve child and family outcomes and the development and reporting of Plans of Safe Care.
- Assessing service provision gaps for children and families identified by birthing hospitals, public health or child welfare and addressing needs through development of local and/or statewide services to provide Plans of Safe Care for families as needed.

## **MICHIGAN’S HUMAN TRAFFICKING LEGISLATION**

Michigan’s Safe Harbor law of 2014 was one of the key reforms in Michigan’s human trafficking legislation affirming the intent of the federal Justice for Victims of Trafficking Act and the Trafficking Victims Protection Act.

## Safe Harbor

Safe Harbor established protection for victims of human trafficking, through legislation that:

- Presumes that a minor found engaging in prostitution is a victim of human trafficking and mandates law enforcement to refer the minor victim to MDHHS for appropriate treatment.
- Established probate court jurisdiction for minor human trafficking victims who are dependent and in danger of substantial harm.
- Allows victims of human trafficking to clear their criminal record of crimes they were forced to commit by traffickers.
- Provides adult human trafficking victims safe harbor through a diversion process to avoid prostitution convictions.

Michigan continues to focus on children and youth that may have been victims of human trafficking and has policies and training that ensure that child welfare services provide safe, supportive responses to the needs of this group. Michigan will begin reporting on the number of identified victims of trafficking in its National Child Abuse and Neglect Data System (NCANDS) submission on Jan. 30, 2019 (reporting 2018 data).

## COLLABORATION WITH THE COURT SYSTEM

MDHHS collaborates extensively with courts through the State Court Administrative Office (SCAO) Court Improvement Program, including preparation for Round 3 of Michigan's CFSR in 2018. The director of SCAO's Child Welfare Services division and the director of the MDHHS Division of Continuous Quality Improvement (DCQI) were designated to co-lead the steering committee. A SCAO analyst is co-leading the state CFSR Workgroup with one of the two managers of DCQI review teams.

Through the SCAO Court Improvement Program, MDHHS works with the court system to improve court procedures and ensure all federal and state laws, statutes and rules are followed. With support and information from SCAO, MDHHS trains private agency and public caseworkers on the child welfare legal system. Local MDHHS offices actively collaborate with family courts to ensure children and families are provided services compliant with federal and state laws. Collaborative efforts in 2017 include:

### Data Projects

- MDHHS worked with SCAO to develop new court data reports for CFSR Round 3 outcome measures, including children's timely medical and dental exams, the frequency of parenting time, worker-child visits and worker-parent visits using data produced by the DCQI Data Management Unit (DMU). SCAO provides the data reports to courts quarterly to improve performance in those areas.
- Through a data-sharing agreement, the court obtains data provided by the DMU that are modified to create judicial reports on hearing timeliness and permanency. These

reports are available in SCAO's Judicial Data Warehouse.

- A Data Snapshot Report provides an overview of each county's child abuse/neglect data. This is also available to courts in SCAO's Judicial Data Warehouse.

### **Examining or Improving Hearing Quality**

- The Court Observation Project was created to assess the quality of child protection court hearings. SCAO Child Welfare Services conducted three Court Observation Projects in 2015 to 2017 based on requests from judges. The projects collect information about each hearing attendee's (e.g., jurist, parent attorneys, lawyer-guardian ad litem, caseworker and agency legal counsel) participation, demeanor and advocacy.
  - After observing multiple hearings in each locality of each hearing type, SCAO provides a report with recommendations based on the issues identified during the court observation. SCAO staff returns to the project court 10 to 12 months after the first report to conduct follow-up court observation in a feedback loop to determine if the recommendations had an impact on the quality of child protective proceedings.
- Six regional Title IV-E cross-disciplinary trainings provided an overview of federal regulations and addressed each court's needs. Invited stakeholders included court personnel, MDHHS, private agencies, attorneys and others. In 2017, the trainings were attended by 206 individuals. SCAO Child Welfare Services and the MDHHS Federal Compliance Division plan and conduct these Title IV-E trainings jointly.
- SCAO participated on a state review team during the federal Title IV-E review in 2016, including preparation calls with federal staff and coordination of case files for review.
- Meetings regularly occurred with SCAO and the MDHHS Federal Compliance and Child Welfare Funding Unit to review court orders and answer Title IV-E eligibility questions.
- MDHHS participated on a SCAO workgroup to develop draft court rules for the use of mediation in child protective proceedings.

### **Improving Timeliness of Hearings and Permanency Outcomes**

- SCAO's Court Improvement Program focused on educating parents of their rights when their children are taken into custody by developing an information brochure to be provided at the time of removal, and an in-depth information guide for use throughout proceedings. All courts received copies of the information guide and brochure and SCAO continues to provide courts with copies upon request. SCAO distributed 775 copies of each of these resources and has a wait list for 400 additional copies.
- SCAO developed training for lawyer-guardians ad litem (LGAL) to teach statutory responsibilities, the importance of advocacy in child welfare proceedings and provide information on child development. In 2017, two in-person trainings were held throughout the state, attended by 97 individuals. In 2018, two trainings will take place in addition to a five-part web-based training for attorneys including one for lawyer-guardians ad litem, "Special Considerations for LGALs."
- SCAO developed a pamphlet titled "Foster Parent Guide to Court" to assist foster caregivers to understand the court process.

- The Genesee County Parent Representation Pilot Project improved legal representation of parents involved in child protective proceedings by providing a social worker to work exclusively with parents' attorneys.
- SCAO developed a permanency indicator report to track local court timeliness in child welfare hearings.
- In 2017, SCAO provided training for jurists on the new National Council of Juvenile and Family Court Judges Enhanced Resource Guidelines for Juvenile Courts.
- SCAO periodically provides training for new child welfare jurists. Training content includes basic legal, procedural and policy requirements to preside over child protective proceedings, best practice recommendations specific to court hearings and an overview of Title IV-E requirements. In 2018, SCAO provided training for 23 new jurists.
- SCAO developed a training for attorneys and caseworkers on the phases of child protection proceedings, including applicable statutes, court rules and agency policy, along with advocacy skills for reasonable efforts to preserve and reunify families. In 2017, four trainings were held throughout the state, attended by 231 individuals.

#### **Examining or Improving Compliance with the Indian Child Welfare Act (ICWA)**

- All 12 Michigan tribal courts filed for reciprocity in recognition of tribal court orders. Tribal court judgment is recognized as long as the tribe or tribal court has enacted a reciprocal ordinance, court rule, or other binding measure that obligates the tribal court to enforce state court judgments, and that ordinance, court rule, or other measure has been transmitted to SCAO.
- SCAO held 15 multi-disciplinary trainings on the Michigan Indian Family Preservation Act (MIFPA) and ICWA since 2012.
- The SCAO Tribal Court Relations Committee developed an American Indian Child Placement Evidentiary Standards document, a judicial bench card, and provided significant input into the development of SCAO Juvenile and Adoption Court forms to ensure compliance with MIFPA/ICWA.
- SCAO contracted with an Indian Law Expert from MSU College of Law to update the ICWA/MIFPA Court Resource Guide in 2016. This included relevant training for courts on the use of the Court Resource Guide.
- Judicial training was provided on the MIFPA at both the statewide judges' conference and annual referees' conference.
- SCAO collaborated with tribes for their inclusion in Michigan Supreme Court Adoption Day and Reunification Day celebrations to raise awareness of the importance of ICWA/MIFPA compliance to ensure successful outcomes for Indian children and families.
- SCAO participates on the national Children's Bureau ICWA Constituency Group to share best practices and innovative solutions to improve state compliance.
- SCAO collaborated with MDHHS Native American Affairs to initiate an ICWA Case Review Compliance Project in 2017.
- SCAO incorporated Native American Inquiry and Notice into the Court Observation Project Tool to evaluate consistency and compliance with requirement in state courts where the project has been completed.

- SCAO is collaborating with the Prosecuting Attorneys Advisory Council and the Prosecuting Attorneys Association of Michigan to create a training webinar in summer 2018 on Qualified Expert Witness Testimony for Prosecutors statewide.

### **Foster Care Review Board**

The State Court Administrative Office, Child Welfare Services division, administers the Foster Care Review Board (FCRB) program, which is comprised of citizen volunteers statewide dedicated to helping ensure that children in foster care are safe, well cared for and that they achieve timely permanency. The FCRB provides independent review of cases in the state foster care system. The board also hears appeals by foster parents who believe that children are being unnecessarily removed from their care.

The Foster Care Review Board (FCRB) reports quantitative data on the boards' activities and the data in the FCRB Annual Report. The Court Improvement Program, in which MDHHS participates in an advisory capacity, uses the data to plan training programs for judges, court personnel, child welfare staff and lawyers offered by SCAO. Data reported in the FCRB annual report includes:

- Data on FCRB performance on reviews of individual cases.
- Aggregate FCRB case-specific recommendations for safety, permanency and well-being.
- Barriers to permanency by state and county.
- Permanency outcome trends.
- State and county data on foster parent appeals of case decisions.

The FCRB annual report is distributed to all Michigan courts to share systemic issues or trends the FCRB is identifying when reviewing cases. The information is also shared with the media or legislators upon request.

In 2017, SCAO assessed which data is collected by the FCRB and how it is used. The FCRB is currently updating data reports so that the data can more directly assist with identifying program priorities and efforts. Once the new data reports are developed in 2018, FCRB program representatives who serve on various state level child welfare workgroups and committees, including the Court Improvement Program, will analyze the data and promote discussion in the workgroups about trends or issues and possible strategies.

The FCRB made significant program changes in 2017 to more directly affect decisions and permanency outcomes in the cases reviewed. The principal change was a focus on review of cases identified by the courts, child-placing agencies, and other parties that believe the progress of the case and/or well-being of the child would benefit from third party review. The program continues to review cases listed with the Michigan Adoption Resource Exchange (MARE) in which there were identified barriers in the recruitment of an adoptive family or in finalization of a planned adoption. In 2017, the FCRB conducted 419 reviews involving 789 children. Recommendations made in cases reviewed include the following:

- Thirty-six recommendations related to child safety.
- Two hundred sixty-nine recommendations related to permanency.

- Four hundred fourteen recommendations related to well-being.

The program received 157 intake calls in 2017 from foster parents inquiring about appealing removal decisions, with results as follows:

- Local review boards conducted 121 appeal hearings.
- The board supported the foster parent’s appeal of the move of the child from their home in 51 of the hearings.
- The board supported the agency’s decision to move the child in 70 of the hearings.

## COORDINATION OF CHILD WELFARE SERVICES

State-level coordination of child welfare services is accomplished through the Quality Improvement Council (QIC), which is chaired by the CSA executive director. QIC membership includes CSA executive staff, directors of Business Service Centers (BSC) and local MDHHS offices, directors of private foster care agencies, private and public child welfare program managers and leadership from the field.

The QIC structure provides a mechanism for coordination among the CSA and leaders in the field to address state-level issues. The CSA ensures that governing laws, rules and policies are followed in coordinated child welfare services and assists in securing resources. The QIC provides findings from targeted investigations based on data reports that can influence changes in policy, identify training needs and develop work groups. Strategies for improvement are developed by QIC sub-teams, which are focused on essential child welfare activities that operationalize improvement efforts in the field. Concerns from the field are funneled into the QIC or handled through existing program and operational units, depending on the issue. Issues unique to local child welfare communities are addressed by local directors, in collaboration with the BSCs, which then reports strategies and results to the QIC. This feedback loop assists MDHHS in refining implementation strategies to fit local needs. The QIC sub-teams and subcommittees include:

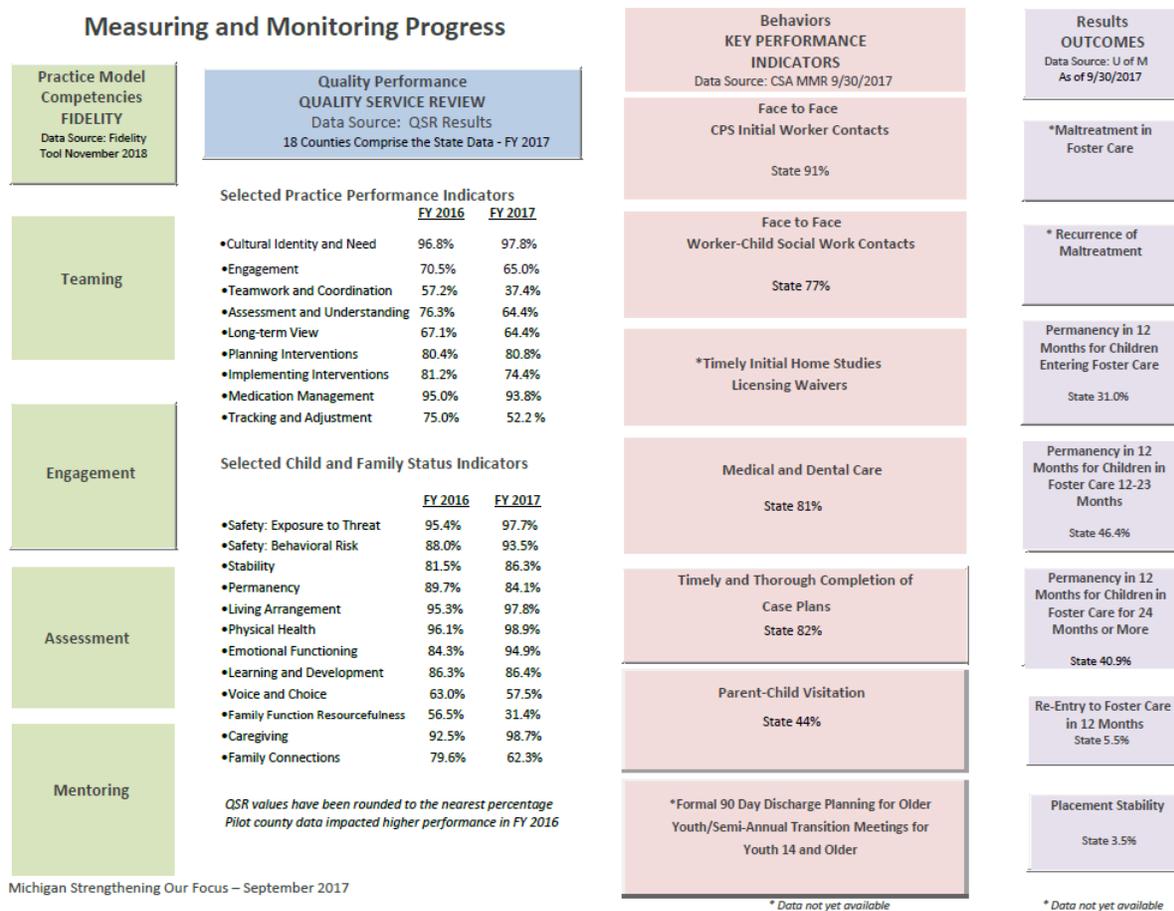
1. Permanency.
2. Safety.
3. Well-Being: a) Education/Older Youth and b) Health.
4. Placement and Foster and Adoptive Parent Recruitment and Retention.
5. Service Array and Child Welfare Workforce.
6. Training.
7. Communications.
8. Data: Children’s Cabinet.

### Local Continuous Quality Improvement Teams

County continuous quality improvement (CQI) teams guide local efforts, address barriers and ensure adherence to the MiTEAM model in case management. County CQI teams receive information including federal requirements and national trends through their respective BSCs,

through meetings with the CSA executive director and membership on state-level sub-teams. County CQI teams ensure that local CQI efforts are data-driven through analysis of local service data that measures the performance of their respective offices, showing where attention is needed. Subsequent data indicates whether improvement strategies worked. Local data is aggregated monthly to track state-level results, which drive ongoing strategizing statewide.

Analysis of data at the local, BSC and state level ensures that congruent strategies are used and improved upon in a feedback loop that drives ongoing structural changes and training efforts. In 2018, MDHHS is continuing to strengthen county-level teams through the implementation of the MiTEAM Fidelity Tool to assist local managers in monitoring caseworkers' use of the practice model. The graphic below illustrates how MiTEAM skills address activities tracked by key performance indicators leading to improvement in CFSR and QSR outcomes.



## PERFORMANCE-BASED CHILD WELFARE SERVICES

An important component of child welfare reform in Michigan, in addition to the MiTEAM practice model and a continuous quality improvement approach, is the development of performance-based child welfare services and a supportive funding model.

### **Defining Consistent Performance Measures for Child Welfare Agencies**

- In partnership with the University of Michigan Child and Adolescent Data Lab, MDHHS began reporting on federally established permanency outcomes and indicators on a monthly basis, enabling early identification of practice areas that require targeted attention to support improvement.
- County performance on key performance indicators, measurable case management activities prioritized by MDHHS, are shared monthly with public and private agencies via the Monthly Management Report. As of Feb. 28, 2018, CPS and public and private foster care staff) achieved an overall 14 percent increase in performance in key performance indicators.
- Private agency technical assistance and support ensures accountability for achievement of performance standards. As of Feb. 28, 2018, private agencies achieved an overall 11 percent increase in key performance indicators.

### **Performance-Based Funding Pilot Progress in 2017 and 2018**

#### **Kent County**

The Kent County Performance-Based Funding pilot consists of a consortium of five private child-placing agencies with the goal to achieve better outcomes for children and families through a prospective funding model. Implementation of the Kent County pilot began on Oct. 1, 2017. The Child Welfare Partnership Council, consisting of key MDHHS staff and community stakeholders, continues to guide implementation of Kent County's performance-based child welfare contracting pilot.

#### **Performance-Based Funding Pilot Progress**

MDHHS activities include:

- Providing technical assistance and support to the West Michigan Partnership for Children as initial implementation questions arose.
- Working with multiple stakeholders from within the department to identify how federal claims will be operationalized under the Kent County pilot model.
- Refining Kent County pilot cost reports and other fiscal monitoring tools and processes.
- Supporting data sharing with the West Michigan Partnership for Children through their data analytics contractor, Mindshare, including continued data-sharing agreements.
- Releasing performance reports on key performance indicators for the West Michigan Partnership for Children.
- With the West Michigan Partnership for Children, finalizing program and financial policies.

West Michigan Partnership for Children activities:

- Hired 14 staff to fulfill contract requirements.
- Implemented a new Enhanced Foster Care Model, a family-based service that provides individualized treatment for children in general foster care who present with intensive behavioral or emotional needs.

- Participated in several media events.
- Contracted with a consulting firm to lead the development of the West Michigan Partnership for Children’s strategic plan.
- Initiated a contract to obtain assistance in establishing performance-based subcontracts for service providers in fiscal year 2019.
- The partnership’s performance and quality improvement team finalized a policy handbook, which outlines protocols for continuous quality improvement and auditing.
- The partnership’s care coordination team established a tiered system of meetings to increase collaboration and attention to complex case issues. Specific teamwork allows for an increased focus on the best interest of children in foster care.
- The independent evaluator conducted site visits to gather baseline process data and completed the first annual report.

### **Planned Activities for 2019**

- MDHHS will continue implementing the private agency technical assistance and support process.
- MDHHS will continue delivering outcome data monthly to public and private agencies for ongoing assessment of progress and targeting areas needing attention.
- The independent evaluator will continue to gather and assess baseline data.
- An actuary and independent evaluator will continue to monitor the funding model.

## **PROGRAM SUPPORT**

MDHHS provides multiple types of program support to counties and local groups that operate state programs. In addition to conferences and workshops described throughout this report, MDHHS offers the following ongoing program support to field staff and service providers.

- MDHHS provides a policy mailbox for clarification and technical assistance on child welfare policy.
- The MiTEAM staff provides training and technical assistance on the enhanced MiTEAM practice model to local child welfare staff. Statewide implementation of the MiTEAM Fidelity Tool will continue through 2018 to assist local child welfare managers to monitor their staffs’ skill using the MiTEAM practice model in providing services.
- DCQI provides feedback and technical assistance on current child welfare cases through the Quality Service Review (QSR), intensive reviews of current cases in local offices and agencies through interviews with case members, local courts and community service providers. The QSR is described in detail in the Quality Assurance System section.
- DCQI staff works with local CQI teams to develop continuous quality improvement teams and provides ongoing technical assistance on using the team structure combined with state and local data to improve services. Technical assistance methods are specific to the needs of each community.
  - Local CQI teams use data from Monthly Management Reports and other sources of quantitative and qualitative information to track progress on key performance

indicators. The report provides county service data that can be drilled down to the frontline worker level to track timeliness and performance of necessary functions. Report data helps counties identify barriers that may be affecting outcomes and strategize how to replicate successful processes. The monthly report data shows whether efforts are reflected in improved scores or whether other strategies or changes are needed. Such feedback loops allow targeted and more effective progress to be achieved locally and statewide.

- The University of Michigan Child and Adolescent Data Lab provides county- and state-level CFSR safety and permanency data, updated monthly.
- Trauma-informed caregiver training is being provided in 12 counties, with plans for expansion. This training assists foster parents' understanding of the underlying issues related to children's behaviors and may increase empathy toward foster children based on improved awareness of the effects of trauma.
- The Foster Care Psychotropic Medication Oversight Unit addresses persistent challenges in achieving the engagement of children and consenting adults in psychotropic medication decisions and consent.
- Training for mandated child abuse and neglect reporters is provided by local MDHHS staff in their communities. Mandated reporter training was enhanced to include training for specific professional roles in child welfare.
- DCQI is providing training for CFSR reviewers in 2018, many of whom may remain reviewers through the program improvement plan (PIP).
- MiSACWIS project support staff are continuing the MiSACWIS Academy training. The academy includes end-user classroom workshops, webinars, web-based trainings and new worker training. MiSACWIS project staff also conducts new worker juvenile justice residential training.
- The Office of Child Welfare Policy and Programs provides materials and data to counties to assist them in completing their Adoptive and Foster Parent Recruitment and Retention plans and to track whether county goals are met.
- The Office of Workforce Development and Training (OWDT) provides Michigan tribes access to child welfare training through Title IV-E and Chafee funding. In addition, tribes have access to the learning management system to seek training schedules, track staff training, access computer-based training and register for training sessions.
- The OWDT and Native American Affairs provide ICWA/MIFPA training in Pre-Service and New Supervisor Institutes, as well as a refresher course.
- The housing specialist in the Education and Youth Services unit provides technical assistance to Homeless Youth and Runaway providers in serving young people who identify as lesbian, gay, bisexual, transgender and questioning (LGBTQ) and those identified as victims of human trafficking.
- Education planners provide resource information to public and private child welfare staff in their geographic areas and refer young people to employment and educational programs.
- MDHHS includes information about Youth in Transition and Education and Training Voucher services at each quarterly Tribal-State Partnership meeting as a standing

agenda item. Services are described, as well as how tribal youth can access them. Tribal leaders have an opportunity to ask questions and request presentations. Technical assistance is provided to individual tribes as requested.

- To support Chafee policy and procedures, child welfare specialists are trained on Youth in Transition policy in the Pre-Service Institute and Program-Specific Transfer Training. Technical assistance is provided as requested. As new issues are identified, information is shared with child welfare management and staff through communication issuances and monthly supervisory phone calls.

## MDHHS TARGETED PLANS STATUS

MDHHS has reviewed the four required targeted plans and their status is below:

- 1. Foster and Adoptive Parent Diligent Recruitment, Licensing and Retention Plan, Attachment N:** The Foster and Adoptive Parent Diligent Recruitment, Licensing and Retention Plan was assessed in 2018, and it was determined no substantive changes are necessary at this time.
- 2. Health Care Oversight and Coordination Plan, Attachment O:** The Health Care Oversight and Coordination Plan was assessed in 2018 and the following substantive changes were made to the plan:
  - MDHHS strategies to demonstrate compliance with the Family First Prevention Services Act provisions for Health Care and Coordination Plans were added.
  - Under Comprehensive Medical Examination Guidelines: A protocol was established to address vacancies when a health liaison officer is on a medical leave or working out of class.
  - Under Mental Health Care Needs: Trauma Screening Checklist Training 101 is scheduled statewide for all CPS workers, public and private foster care workers, juvenile justice specialists and their supervisors and managers. Training will help participants utilize the checklist and how to plan effectively based on the results.
  - Under Mental Health Care Needs: A trauma screening protocol and best practices guide was developed and disseminated to staff.
  - Under Psychotropic Medication Oversight Policy and Procedures: A review of professional standards of care and child welfare practices in several other states continues to inform revision to MDHHS policies and procedures.
  - Under Psychotropic Medication Oversight Policy and Procedures: The Fostering Mental Health website will be expanded to include general health information for children in foster care, health liaison officer resources, policy alerts and data.
- 3. Child Welfare Disaster Plan, Attachment P:** MDHHS county offices, BSCs and the Child Welfare Field Operations Administration reviewed Michigan's Child Welfare Disaster Plan in 2018 and determined no changes in procedure were necessary. An update on the Flint water crisis and a power outage in Washtenaw County in 2017 are included in the 2019 plan.
- 4. Staff and Provider Training Plan, Attachment Q:** The MDHHS Staff and Provider Training

Plan was reviewed in 2018 and it was determined that updates were necessary. Changes in the updated Staff and Provider Training Plan include:

- Tracking and monitoring institutional and residential training processes utilizing the new learning management system are described.
- In the Foster and Adoptive Parent Training section, more information is provided about how the Office of Workforce Development and Training is increasing opportunities for foster and adoptive parent training.
- A description of the new initial child welfare supervisor training is provided.

## SAFETY

Michigan remains focused on improving child safety, reducing the likelihood of children being abused or neglected in out-of-home care and reducing the recurrence of maltreatment. Strategies are evaluated ongoing and linked to measurable deliverables to demonstrate effectiveness. Michigan strives to ensure that placements are safe and in the best interests of the children served. Assessment of a home for placement assess child safety and risk factors and the needs of the child, as well as the capacity of the prospective caregiver. In 2017 and 2018, MDHHS continued to update child welfare policy and create effective training and tools to improve placement decisions and ensure a good fit for children with their caregivers, reduce maltreatment in care and maintain placements. Tools and policies are continuously reassessed through monitoring and reporting results in a feedback loop to ensure they address risk and safety effectively.

**Safety Outcome 1:** Children are, first and foremost, protected from abuse and neglect.

**Safety Outcome 2:** Children are safely maintained in their homes whenever possible and appropriate.

### Safety 1 and 2 Assessment of Performance

Safety achievements are tracked through the Michigan data profile provided by the Children's Bureau. Progress is also noted through QSR results, where available.

**Goal:** MDHHS will reduce maltreatment of children in foster care.

- **Objective 1:** MDHHS will decrease maltreatment of children in foster care.

**Measure:** Children's Bureau Data Profile.

**Baseline:** 13.56 rate of maltreatment in care; FY 2013.

**Benchmarks:**

**2015 – 2019:** Demonstrate improvement each year.

- **2015 Performance:** 20.42 rate of maltreatment in care; FY 2013.
  - **2016 Performance:** 16.64 rate of maltreatment in care; FY 2014.
  - **2017 Performance:** 14.68 rate of maltreatment in care; FY 2015
- **Objective 2:** MDHHS will reduce the number of children having recurrence of

maltreatment.

**Measure:** Children's Bureau Data Profile.

**Baseline:** 16 percent of children experienced recurrence of maltreatment; FY 2013.

**Benchmarks:**

**2015 – 2019:** Demonstrate improvement each year.

- **2014 Performance:** 16 percent of children experienced recurrence of maltreatment.
- **2015 Performance:** 14.9 percent of children experienced recurrence of maltreatment.
- **2016 Performance:** 13.3 percent of children experienced recurrence of maltreatment.
- **2017 Performance:** 13.6 percent of children experienced recurrence of maltreatment.

### **Safety Outcome 1 – Children are, first and foremost, protected from abuse and neglect.**

Ongoing improvements were made to child welfare programs and policies.

- A grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) funds suicide prevention training for 800 child welfare workers each year. The training modules include suicide awareness training and applied suicide intervention skills training. MDHHS staff will be trained to deliver the training in the future.
- MDHHS continues its efforts toward focusing on child and family safety through the continued training and appropriate utilization of effective safety plans. In 2017, those efforts included:
  - Continued training of Safety by Design for all new child welfare staff.
  - Ongoing Safety by Design training staff for child welfare staff.
  - Providing continuous safety planning policy and practice guidance to the field.
  - The third annual MDHHS Child Safety Conference, providing the field with training focusing on improving practices in the assessment of and responses to child welfare investigations and case management.
- MDHHS funded the 21<sup>st</sup> annual Child Abuse and Neglect conference, providing child welfare training to hundreds of child welfare practitioners.
- MDHHS completed statewide implementation of the enhanced MiTEAM practice model. MiTEAM reestablished focus on fundamental social work practice skills of working collaboratively with families. The model guides Michigan's child welfare system on case management activities to ensure that children remain safe, raised by their families whenever possible and provided support and guidance to ensure their well-being.
- The MiTEAM Fidelity Tool was piloted in three counties in 2016 and 2017. It is being rolled out for use in all 83 counties in 2018. Results from the Fidelity Tool will show local leadership where additional training and support may be needed.

### **Safety Outcome 2: Children are safely maintained in their own homes when appropriate.**

## **Item 2: Services to Families to Protect Children in their Homes**

**Family Preservation Services.** Michigan provides evidence-based family preservation services to prevent the need for placement or to allow an early return from placement. These include Families First of Michigan, the Family Reunification Program and Families Together Building Solutions. Each of Michigan's family preservation models is based on collaboration with the family to assess their strengths and needs and individualized services focused on the family's specific needs and circumstances. Michigan's family preservation services are described below:

**Families First of Michigan**, available in all 83 Michigan counties, is a home-based, intensive (up to 10 hours a week in the family home) crisis intervention model designed to keep children safe and prevent foster care placement or to provide intervention to return children to their home. Families First interventions last four weeks and can be extended for up to six weeks. Families First is available in all 83 Michigan counties. Examples of individualized intervention services the model provides include:

- Family and child needs assessment.
- Safety planning.
- Parenting skills modeling and coaching.
- Budgeting.
- Housekeeping.
- Counseling.
- Connecting families with community resources.

**Families Together Building Solutions** provides services for lower-risk families that need support. The program consists of in-home counseling utilizing a strength-based, solution-focused model. Workers spend an average of three hours in the home each week and are available to families 24 hours a day, seven days a week. Families Together Building Solutions is a 90-day program.

**Family Reunification Program** is an intensive, in-home service model that facilitates safe and stable reunification when children in out-of-home placement return to their homes. The Family Reunification Program provides weekly individual and family counseling in addition to two to four hours of in-home family support in areas identified as having placed the children at risk. The program serves families for up to four months. In 2017, the Family Reunification Program expanded services by 29 counties, now serving 73 counties.

In addition to child welfare services provided in the home by CPS staff and contracted service providers, and centrally administered family preservation services, Michigan provides funding to local communities to fund services identified as needed by that community.

- **Child Protection Community Partners** - Funding is provided to the MDHHS local offices for preventive services to children of families at low to moderate risk of child abuse or neglect. The purpose of the funding is to:
  - Reduce the number of re-referrals for substantiated abuse and/or neglect.
  - Improve the safety and well-being of children and family functioning.

- **Child Safety and Permanency Plan** - Funding is provided to 83 MDHHS local offices to contract for services to families with children at high risk of removal for abuse and/or neglect, or families with children in out-of-home placement. The purpose is to:
  - Keep children safe in their homes and prevent the unnecessary separation of families.
  - Return children in care to their families in a safe and timely manner.
  - Provide safe, permanent alternatives for children when reunification is not possible.

Some of the services funded by local funding include:

- In-home counseling.
- Parenting education.
- Parent aide services.
- Adoptive family counseling and post-adoption services.
- Wraparound coordination.
- Homemaking support.
- Flexible funds for individual needs.

### **Item 3: Risk and Safety Assessment and Management**

#### **Child Assessment of Needs and Strengths (CANS) and Family Assessment of Needs and Strengths (FANS)**

During each CPS investigation, the specialist must complete a safety assessment which must be completed in MiSACWIS as early as possible following the initial face-to-face contact. Where a preponderance of evidence of child abuse or neglect is found, a Child Assessment of Needs and Strengths (CANS) is completed by the CPS caseworker with family input. The assessment identifies areas that the family needs to focus on to reduce risk of future child abuse or neglect. A separate CANS must be completed for each child. CANS are used to:

- Develop and monitor a service agreement with the family that prioritizes the needs that contributed most to the maltreatment.
- Identify services needed for cases that are opened for service provision or closed and referred to other agencies for service provision.
- Identify gaps in resources for client services.
- Identify strengths that may aid in building a safe environment for families.

**The Family Assessment/Reassessment of Needs and Strengths (FANS), DHS-145**, is used to evaluate the presenting needs and strengths of each household with a legal right to the child(ren). CPS caseworkers engage the parents and the child(ren), if age appropriate, in discussion of the family's needs and strengths. The FANS is used for any household that has a legal right to the child(ren) in the initial services plan, due 30 days after removal from the family home and in each updated services plan, due quarterly.

#### **Other Assessment Tools**

In addition to the structured decision-making tools used in CPS investigations and foster care child and adult assessments, child welfare caseworkers may use these assessment tools:

- **Protective Factors Survey** is used by contracted providers to assess protective factors in the areas of parental resilience, social connections, concrete supports, knowledge of parenting and child development and children’s social-emotional development.
- **Trauma Screening Checklist (ages 0-5)**, developed by the Southwest Michigan Children’s Trauma Assessment Center, the checklist is administered to all children ages 0 to 5 within 30 days of referral and is a requirement for all CPS and foster care cases.
- **Safety Assessment and Plan - DHS-1232** identifies safety factors and protective strategies and documents a plan to be used if a crisis occurs. Safety is assessed each time staff visits the family and the plan is updated as often as necessary.

Safety Item 2 is measured through the results of the services outcome data showing whether children remained with their families for 12 months following the conclusion of services. Success rates for 2017 are below:

Family Preservation Service	Number of families served	Intact 12 mos. following service
Families First of Michigan	2,520	87.3%
Family Reunification Program	943	89%
Families Together Building Solutions	3,043	94%
<b>Total families served</b>	<b>6,506</b>	

### Quality Service Review Results (QSR)

Item 3 was assessed through QSR safety assessments and Quality Assurance Compliance Review data. QSR results for safety in foster care improved in 2017, in the following areas:

Performance Indicator	2015 percent acceptable	2016 percent acceptable	2017 percent acceptable
Safety – Exposure to risk	93.7%	95.4%	97.7%
Safety – Behavioral risk	88.3%	88%	93.5%

Quality Assurance Compliance Review results showed improvement in child assessments:

Question	2016	2017
Did each report show documentation of a formal or informal initial or ongoing comprehensive assessment that accurately assessed the child’s needs?	98.1%	100%

## **Maltreatment in Care**

MDHHS continues to prioritize efforts to reduce maltreatment in care (MIC) through the following activities:

The Office of Workforce Development and Training provided Safety by Design training for all new workers and CPS supervisors to improve safety assessment skills, develop effective safety plans and ensure an awareness of threatened harm. Safety by Design will continue to be offered as an in-service training across the state. MDHHS continues efforts to reduce maltreatment in care (MIC) through the following activities:

### **Training**

- **University Partnership Trainings** – Trainings offered through MDHHS’ university partnership are open for attendance by foster parents. Many of these trainings help foster parents understand child development and provide strategies for addressing trauma and challenging behaviors that may be displayed by children in care.
- **Regional Resource Teams** – Regional Resources Teams focus on recruiting, supporting and developing foster families to meet annual non-relative licensing goals, retain a higher percentage of existing foster families, prepare families for challenges associated with fostering, and develop existing foster family skills to enable them to care for children with challenging behaviors. Contracts are effective in all BSCs.
- **Training by MIC Staff** - CPS-MIC staff are engaging with private agencies, Regional Resource Teams and child caring institutions to provide training on mandated reporting, safety planning and roles and responsibilities during a CPS investigation.
- **Safety by Design** – Safety by Design is a required training for all new child welfare staff. The training is focused on assessing child safety, and effectively documenting and implementing well-structured safety plans.
- **Safety Planning Workshop** - The 2018 Foster Care/Adoption/Licensing Summit, to be held in July, will include Safety Planning as a workshop topic.
- **Certification and Complaint Training** - Licensing workers and supervisors are required to attend certification and complaint training. The curriculum focuses on thorough assessment of the applicants’ history of criminal activity, CPS involvement as a victim or perpetrator, trauma, overall social history and the ability to effectively parent children with trauma and challenging behaviors.

### **Policy and Practice**

- **Statewide trauma screening training** started in November 2017. Use of the Trauma Screening Checklist, developed by the Children’s Trauma Assessment Center at Western Michigan University, is required for all CPS ongoing cases and all foster care cases. Guidance for resiliency-based case planning based on the results of the screening tool is also being provided.
- **Dispositional Conferences** – Case conferences must be convened for all CPS-MIC dispositions that require cross-program participation.
- **MIC Policy** – MIC policy is currently under revision.
- **Revision of assessments for relative placement** – The Initial Relative Safety Assessment

(DHS-588) and the Relative Placement Home Study (DHS-3130A) are under revision to focus more clearly on verification and resolution of safety factors. Training for staff who are assessing relatives will be provided.

- **Supportive Visitation** – Supportive visitation contracts offer coaching to biological parents during visits, which helps improve safety for children and provides strategies to reduce maltreatment during unsupervised visits.
- **Safety Planning** – Safety plans are required for:
  - Any child with history of being the aggressor in sexual acting out. The plan should be realistic and developed with the provider at the time of placement.
  - Any placement in a relative home. The plan must address parent’s access to the child(ren). Any visits supervised by the relative must have a safety plan outlined and signed by the relative.
  - Any household where a 30-day notice of a placement change has been provided. The plan must be developed and implemented during the transition to the new placement and requires more frequent contact with the provider to assess safety and risk until a replacement foster home is located.
- **Payment for Unlicensed Relative Providers** – Unlicensed, approved relative providers will be paid the same as licensed providers, thus allowing the same financial supports for children in unlicensed relative care as those in licensed provider care.

#### **Licensing and Contractual Corrective Action**

- **The Division of Child Welfare Licensing is responsible for:**
  - Assessing the safety and well-being of children placed in licensed foster homes and with unlicensed relatives as well as service provision.
  - Conducting a tour of the home where placement occurs.
  - Conducting interviews with foster parents, unlicensed relatives, children and birth parents.
  - Sending safety and service concern alerts to the child-placing agency with timeframes for resolving identified issues.
  - Documenting resolution to identified concerns in annual inspection reports.
  - Conducting annual reviews that assess a childcare organization’s compliance with Act 116, administrative licensing rules, contract provisions, MDHHS policies and federal and state laws. Violations require a corrective action plan that identifies how compliance will be achieved and maintained. Adverse license action is taken on foster homes, child-placing agencies and child caring institutions when the nature and number of violations has been determined to be willful and substantial.
  - Conducting conference calls in collaboration with the MDHHS program/policy office and child placing agencies when unlicensed relatives are recommended for denial of licensure and children continue to be placed in their homes. Technical assistance is provided to address barriers to licensure, safety planning and/or developing plans for replacement of the child.
  - Providing technical assistance and requiring addenda to initial foster parent home studies when an applicant’s criminal history, CPS history or social history is

not thoroughly assessed by the certifying agency.

### **Continuous Quality Improvement**

- **CPS-MIC management meetings** - Quarterly CPS-MIC management meetings are held with all programs involved in MIC investigations to discuss barriers, best practices and need for policy clarification/revisions.
- **CPS-MIC case reviews** - All CPS-MIC investigations where there have been three or more investigations with the same placement other than a CCI are reviewed to assess gaps in investigation or the need for other interventions to prevent repeat child abuse or neglect.
- **Quality Service Reviews** – DCQI completes QSRs, which examine implementation of the MiTEAM practice model in the child welfare community and identifies systemic strengths and opportunities that can be addressed at both the local and state levels to improve service provisions to families. This includes review of foster children who are identified as MIC cases in the random sample.
- **Quality Assurance Processes** – Completed by DCQI, these processes include reviews for compliance and quality of CPS investigations.
- **MIC Case-reading tool** – A MIC case-reading tool is currently in development for improving case practice and training opportunities at a local and statewide level.
- **CPS MIC case reviews** – DCQI reviews MIC cases for ISEP compliance reporting.
- **Monthly visit review** – Private agency analysts conduct monthly reviews of visit contacts to ensure caseworkers are visiting children each month. They identify the reasons for missed visits with the goal of reducing barriers leading to missed visits.
- **Case conferences** – CPS program office and MIC unit staff meet as needed to discuss issues that arise involving MIC cases.
- **Relative Safety Screen and Home Study Review Pilot** - The Placement sub-team is piloting a local office CQI process for reviewing the Relative Safety Screen and Relative Home Study. Results will allow local office CQI teams to develop a plan and potential solutions/strategies to ensure relative homes are visited prior to placement, ensure all central registry and criminal history clearances are completed as required and that the home study is completed within 30 days of placement.

### **Data and Reporting**

- **Monthly data analysis** - CPS-MIC analysts validate data on a monthly basis and roll up an annual report of patterns and trends for out-of-home placement investigations. These reports are provided to the field to assess trends in their areas.
- **Federal reporting** – DCQI is continuously improving reporting on MIC cases for AFCARS and NCANDS submissions to the Children’s Bureau.
- **MiSACWIS fixes** – MiSACWIS staff are working to assess requested changes and fix any existing defects related to MIC cases.

### **Workgroups**

- **MIC Quality Improvement Team**, addressing: 1) identification and resolution of data

entry issues and 2) establishment of a process to review results of monthly DCQI review of MIC cases and resolution of identified issues.

- **QIC Safety sub-team** – This group examines data of recurrence patterns and trends across the state to improve practice and recommend policy changes. The sub-team was involved in the development of the MIC case-reading tool.

## **Progress in 2017**

- MDHHS reduced the standard for foster care caseloads from 15:1 to 13:1 in 2017. The state is continuing work to reduce caseloads to meet that goal.
- The Office of Workforce Development and Training continued to provide Safety by Design training for new child welfare workers and supervisors to improve safety assessment skills, develop effective safety plans and ensure an awareness of threatened harm.
- MDHHS developed a Safety by Design 2.0 training for foster care caseworkers to assess and improve the safety of children in foster care.
- The QIC Placement and Safety sub-teams continued to lead efforts to improve placement assessment and decision-making.
- A workgroup was created consider modifications to the MDHHS threatened harm policy to assist assessment of how past and current factors contribute to child safety and child abuse/neglect.
  - Threatened harm training was offered to CPS workers on an as-needed basis, or as policy modifications occurred.
  - Threatened harm policy is under review with the goal of reducing recurrence.
- Use of the Safe and Together model for assessment and planning case response. This model is aimed at improving workers' understanding of complaints when domestic violence is a factor. The goal is to improve worker assessment of risk and to reduce recurrence of abuse/neglect in cases with domestic violence. Ongoing support includes engagement of other child welfare partners throughout the state to address domestic violence.
- CPS took the following steps to enhance mandated reporter training:
  - Maintaining and distributing an updated list of staff in each county that provide mandated reporter training.
  - Creation of an online training video to describe the responsibilities of mandated reporters, guidance for reporting abuse and neglect and resources available.
  - Revision of mandated reporter brochures for 10 types of reporters.
  - Revision of mandated reporter guide for general information regarding mandated reporting.
  - Revision of statewide training regarding mandated reporting to include various new topics.

## **Plan for Improvement - Activities for 2018 and 2019**

MDHHS will address the recurrence of maltreatment and reduction of MIC through:

- A workgroup that assesses and responds to recurrence of maltreatment on a statewide

level issued a report of findings and recommendations in 2017. The workgroup is continuing ongoing efforts in collaboration with the QIC and local safety teams.

- Data on recurrence of maltreatment is used to evaluate trends and develop pilot programs, system changes, policy development, statewide initiatives and training, the results of which demonstrate the level of effectiveness in key performance areas.
- Updates to threatened harm policy and training will enhance workers' understanding and application of this policy. The training will be provided to local MDHHS offices on request.
- Enhanced domestic violence training through the Safe and Together model will be provided to all child welfare staff statewide. Ongoing support includes engagement of other child welfare partners throughout the state.
- Local office development of CQI teams will continue. Each team will develop goals and plans specific to their county's needs. DCQI will provide ongoing support to local teams.
  - Local CQI teams are trained to use data from Monthly Management Reports and other sources to identify barriers that may affect outcomes.
- Trauma-informed screening of children in CPS and foster care continues as a case management practice.
  - Trauma-informed training for caregivers is likely to expand to additional counties. This training helps foster parents understand the underlying issues related to children's behaviors.
- Improvement of relative safety screening by frontline staff prior to out-of-home placement. Planned future initiatives include:
  - Development of podcasts and webinars to enhance training and utilization of the initial relative safety screening form.
  - Evaluating data for opportunities to prevent abuse and neglect, assess for possible maltreatment and identify areas for intervention. Efforts are focused on validating MiSACWIS foster care data. Once validation is completed, information will be shared with BSC directors to identify areas needing attention.
  - Evaluating the effectiveness of services provided to children and families to ensure appropriate focus on their needs.
  - Continued employment and expansion of family preservation and support programs to reduce risk of maltreatment and allow families to remain together, including Families First of Michigan and the Family Reunification Program.
  - Assessing investigation policies and procedures in licensed provider settings. To enhance the investigation process, MIC workers are required to coordinate pre-dispositional case conferences with their supervisors, foster care workers and licensing consultants.
  - Continuing to enhance screening and licensing procedures for relatives.
  - Continuing evaluations of and updates to the MDHHS structured decision-making tools through a contract with the National Council on Crime and Delinquency. These assessment tools provide workers with guidance for proper safety and risk assessment and provision of appropriate services.
  - MDHHS conducted a caseworker time study to evaluate the time necessary to complete caseworker responsibilities. The department will evaluate how to use

the results to support improved case practice.

### **Implementation Support**

- MDHHS will utilize the CAPTA state grant fund increase resulting from the Consolidated Appropriations Act of 2018 to enhance collaboration with health care systems on implementing infant Plans of Safe Care.
- MDHHS' Injury and Violence Prevention Unit's five-year Substance Abuse Mental Health Services Administration grant will continue through 2018 to expand suicide prevention services in Michigan.
- MDHHS' participation in the Consortium on Improved Placement Decision-Making and Capacity Building sponsored by the Annie E. Casey Foundation resulted in the following activities:
  - The Quality Improvement Council (QIC) Placement sub-team collaborated with the Office of Workforce Development and Training to develop training to improve placement outcomes, "A Guide to Critical Thinking in Child Welfare." The training supports the development of critical thinking skills for assessment.
    - "Abbreviated Licensing Training for Child Welfare Workers" provides a general overview of licensing rules for non-licensing staff. The training assists workers to improve information for relative providers about the children being placed in their homes to promote safer placements.
- Michigan was one of 10 states selected to participate in the "2017 Policy Academy: Improving Outcomes for Pregnant and Postpartum Women with Opioid Use Disorders and their Infants, Families and Caregivers." With the support of the Policy Academy, Michigan will continue to develop a cross-system plan to address the needs of infants affected by opioids and their caregivers, as well as ensure the development of Plans of Safe Care for substance-affected newborns.

### **Program Support**

- DCQI will assist local offices on the use of the MiTEAM Fidelity Tool to track use of the MiTEAM practice model.
- MDHHS will continue utilizing the QIC Placement and Safety sub-teams to strategize improved placement assessment and decision-making. Child-centered approaches are discussed and information is brought to the QIC for support and planning.
  - Information on decision-making processes utilized locally is provided to all county offices to improve outcomes by sharing successful strategies.
  - The group focused on areas of the state where recurrence rates remain high to identify potential solutions.

### **Technical Assistance and Capacity Building**

- MDHHS will continue to participate in the Consortium on Improved Placement Decision-Making and Capacity Building sponsored by the Annie E. Casey Foundation.
- Michigan will continue working with the Policy Academy to address opioid disorders and the effects on children and families.

## POPULATION AT THE GREATEST RISK OF MALTREATMENT

In 2017, the population identified at greatest risk of maltreatment were children ages 3 and younger living with their biological parents, constituting 40 percent of total child victims; this data was captured through MiSACWIS. The percentage of identified victims ages 3 and younger has been between 38 and 39 percent during the previous three reporting years. MDHHS continues to track this for consideration of services to families with young children. Factors included in identifying the population of children at the greatest risk of maltreatment include vulnerability due to their age and stressors on parents because of the children's dependent status. Five areas of policy and practice focus on this population in Michigan:

1. Multiple Complaint policy.
2. Safe Sleep policy.
3. Birth Match System.
4. Early On policy and service provision.
5. Protect MiFamily, Michigan's Title IV-E waiver project.
6. Infant Mental Health Home Visitation.
7. Plans of Safe Care.

### **Multiple Complaint Policy**

The multiple complaint policy requires that whenever MDHHS Centralized Intake receives a third complaint in a home with a child under 3 years of age, a preliminary investigation must be completed to assess the likelihood of maltreatment. This ensures that repeat abuse and neglect complaints on the youngest children are not screened out, but at a minimum, undergo investigation to determine risk to the children and their service needs.

### **Safe Sleep Policy**

The Safe Sleep policy requires that workers include in their assessments of children under 12 months regardless of investigation type the factors that place a child at risk of suffocation in his or her sleep environment.

### **Birth Match System**

This screening system identifies when a parent who previously lost rights to a child or committed an egregious act of abuse or neglect has given birth to a new baby in Michigan. The service includes automatic case assignment and requires workers to make immediate contact to assess the safety and well-being of the infant and evaluate the risk of maltreatment. Each year, this system identifies over a thousand matches, leading to investigation and in some cases, services for children who may be at high risk of maltreatment.

### **Early On**

The Child Abuse Prevention and Treatment Act (CAPTA) requires all child victims, ages birth to 36 months in substantiated cases of CPS Categories I or II to be referred to a Part C-funded early intervention service. Michigan's early intervention service, Early On, assists families with infants and toddlers that display developmental delays or have a diagnosed disability. Specific services are provided that match each child's needs.

MDHHS continues to focus on enhancing developmental information provided by CPS workers about Early On to ensure appropriate services are provided. In 2017, MDHHS referred 5,858 children to Early On. Of these:

- The number of drug-exposed infants was 2,895, 49 percent.
- The number of infants less than 1-year-old at referral was 4,806, 82 percent.

As of March 31, 2018, 3,278 children were referred for Early On services. Of these, 1,824, 56 percent, were drug-exposed at birth and 2,114, 65 percent, were less than 1-year-old at the time of referral.

### **Protect MiFamily**

In 2017, Protect MiFamily, Michigan's Title IV-E waiver project, focused on reducing the likelihood of maltreatment or repeat maltreatment. Protect MiFamily continues operation in Macomb, Muskegon and Kalamazoo counties. Results from the family satisfaction surveys continue to suggest that the families are highly satisfied with program services. A full description of ProtectMiFamily is provided later in this report.

### **Infant Mental Health Services**

Infant mental health services provide home-based parent-infant support and intervention services to families where the parent's condition and life circumstances or the characteristics of the infant threaten the parent-infant attachment and the consequent social, emotional, behavioral and cognitive development of the infant. The infant mental health specialist provides home visits to families during pregnancy, around the time of birth and during the infant's first year. Home visits occur weekly or more frequently if the family is in crisis.

### **Infant Plans of Safe Care**

In accordance with the 2016 federal Comprehensive Addiction Recovery Act, Michigan modified policies to address the needs of infants exposed to medications or substances.

### **Plan for Improvement Activities for 2018 and 2019**

In 2018, MDHHS is continuing to focus on the following projects related to the needs of infants:

- Service coordination between MDHHS staff and Early On to enhance and maintain a comprehensive early intervention system of services, referring children who are eligible for Early On services and/or meet the requirements of CAPTA.
- Training to MDHHS field staff regarding the Early On referral process as well as providing information regarding the services Early On provides.
- Ongoing resources provided to MDHHS field staff, through the Early On link of MiSACWIS, so MDHHS staff can readily access information related to the 0 to 3 aged population.
- Collaboration with Early On agency partners and remaining abreast of updated projects and policies.

## PERMANENCY

In Michigan, local courts authorize removal of children from the care of their parents and refer them to the MDHHS children's foster care program for placement, care and supervision. Foster care intervention is directed toward assisting families to rectify the conditions that brought the children into care through assessment and service provision. Foster care maintenance in Michigan is funded through a combination of Title IV-B(1), Title IV-E and state, local and donated funds.

The provision of foster care services in Michigan is a joint undertaking between the public and private sectors. As of April 5, 2018, approximately 45 percent of foster care services were contracted with private agencies. The children's foster care program is closely tied to the CPS, family preservation and adoption programs. The goal of the foster care program is to ensure the safety, permanence and well-being of children through reunification with the birth family, a permanent adoptive home, permanent placement with a suitable relative, legal guardianship or another permanent planned living arrangement. Permanency goals are developed through federal CFSR outcome standards and scores are expressed through formulae that combine percentages and national rankings.

### **Child Welfare Practice – the MiTEAM Model**

The MiTEAM model focuses child welfare services on the key skills of Teaming, Engagement, Assessment (which includes the sub-competencies: Case Planning, Case Plan Implementation and Placement Planning) and Mentoring. The unified approach of the MiTEAM model:

- Provides for consistency in practice.
- Clarifies roles and expectations for staff.
- Informs policy, training and quality assurance.
- Explains how child welfare interventions and services are delivered to families.

With the MiTEAM practice model, MDHHS implemented family team meetings, family-centered planning sessions that guide decisions concerning a child's safety, placement and permanency. Family team meetings are held at each decision point in a foster care case. Family team meetings ensure that:

- Family members are actively involved in decision-making and service participation from the time of removal through achievement of permanent homes for children.
- Family members are viewed as an important resource for ensuring safety for children.
- Family members are the first placements considered if removal is necessary.

### **Progress in 2017**

- All child welfare staff statewide completed enhanced MiTEAM training and support activities on assessment, case planning, case plan implementation, placement planning and mentoring.
- Enhanced MiTEAM activities include:

- Director and mid-manager MiTEAM practice support calls.
- Supervisor MiTEAM practice support calls.
- Supervisor led application exercises.
- MiTEAM specialist and liaison practice support training.
- MiTEAM specialist led application exercises.
- MiTEAM specialist and liaison practice support networking meetings.
- Supervisor completion of MiTEAM Fidelity worksheets for each of their staff and a fidelity tally worksheet for their unit
- MiTEAM specialists modeled, coached, trained, observed, documented and provided feedback to staff on the MiTEAM competencies and related skills in 2017. They provided individual assistance to caseworkers on practice behaviors and skills. They were also active participants in teaming for local CQI planning.
- The MiTEAM Fidelity Tool is an assessment instrument for measuring the extent to which the MiTEAM skills are practiced in case management as designed. MiTEAM pilot counties (Kent, Lenawee and Mecosta-Osceola) continued to test and use the automated web application of the MiTEAM Fidelity Tool in 2017.
- A Trauma Screening Contract was awarded to the Children’s Trauma Assessment Center at Western Michigan University to implement trauma screening training statewide for all youth on an open CPS or foster care case.
- Trauma Screening training and follow up sessions began in November 2017 to remove barriers in locations where the screening tool was already implemented.

### **Progress in 2018**

- Eleven train-the-trainer MiTEAM Fidelity local office expert (LOE) sessions were held across the state from January through March.
- MiTEAM Fidelity LOEs trained their supervisors within one month of their train-the-trainer sessions from February through April.
- Child welfare public and private agencies are implementing full use of the MiTEAM Fidelity Tool with one Fidelity Tool completed per worker per quarter.
- The MiTEAM Fidelity Tool is scheduled for statewide implementation in all counties and agencies by July 2018.
- MiTEAM specialists served as MiTEAM Fidelity LOEs in 2018. They trained supervisors on the MiTEAM Fidelity Tool review process and assisted local offices in resolving any issues with the automated web application.
- To date in 2018, Trauma Screening Training and follow up meetings to review barriers have been held in Wayne County and in BSCs 3 and 4.

### **Systems Transformation on Reducing Residential Placements**

MDHHS convened a workgroup consisting of representatives from child welfare, community mental health, courts and residential treatment providers in March 2016 to analyze Michigan’s continuum of mental health and behavioral health services. In 2017 and 2018, the group is working to ensure that Michigan provides interventions that will ensure youth are able to maintain long-term success. The group will shift focus to outcomes beyond a specific

intervention episode and ensure practices address long-term outcomes for youth, such as length of time to permanency and placement stability.

Residential programs will provide treatment and support services to youth and their families with these goals. Providers and MDHHS are working collaboratively to establish community resources, screening and assessment standards and intervention goals and expectations that will meet the needs of Michigan's youth. New contracts for Mental Health Behavior Stabilization are being established with a projected implementation in fiscal year 2019.

## **Permanency 1 – Assessment of Performance**

Permanency 1 achievements are tracked through the Michigan data profile provided by the Children's Bureau.

**Goal:** MDHHS will increase permanency and stability for children in foster care.

- **Objective 1:** MDHHS will increase the percentage of children discharged to permanency within 12 months of entering care.  
**Measure:** AFCARS data profile  
**Baseline:** 34.6 percent; FY 2012  
**Benchmarks:**  
**2015-2019:** Demonstrate improvement each year.
  - **2015 Performance:** 34.5 percent
  - **2016 Performance:** 31.1 percent
  - **2017 Performance:** 32.3 percent
  - **2018 Performance (as of March 2018 – U-M Data Lab):** 29.9 percent
- **Objective 2:** MDHHS will increase the percentage of children in care for 12 to 23 months discharged from foster care to permanency within 12 months.  
**Measure:** AFCARS data profile (2015)  
**Baseline:** 50.6 percent, risk standardized performance  
**Benchmarks:**  
**2015-2019:** Achieve the national standard of 43.7 percent or more.
  - **2015 Performance:** 49.3 percent
  - **2016 Performance:** 50.3 percent
  - **2017 Performance:** 48.1 percent
  - **2018 Performance (as of March 2018 – U-M Data Lab):** 46.6 percent
- **Objective 3:** MDHHS will increase the percentage of children in care for 24 months or more discharged to permanency within 12 months.  
**Measure:** AFCARS data profile  
**Baseline:** 32.8 percent, FY 2014  
**Benchmarks:**  
**2015-2019:** Achieve the national standard of 30.3 percent or more.
  - **2015 Performance:** 35.8 percent
  - **2016 Performance:** 41.3 percent

- **2017 Performance:** 36.6 percent
  - **2018 Performance (as of March 2018 – U-M Data Lab):** 40.2 percent
- **Objective 4:** MDHHS will decrease the percentage of children who re-enter foster care within 12 months of discharge to relative care or guardianship.  
**Measure:** AFCARS data profile (2015)  
**Baseline:** 3.4 percent, risk standardized performance  
**Benchmarks:**  
**2015-2019:** Achieve the national standard of 8.3 percent or less.
    - **2015 Performance:** 3.7 percent, FY 2012
    - **2016 Performance:** 4.3 percent
    - **2017 Performance:** 3.9 percent
    - **2018 Performance (as of March 2018 – U-M Data Lab):** 4.9 percent
  - **Objective 5:** MDHHS will decrease the rate of placement moves per 1000 days of foster care.  
**Measure:** AFCARS data profile (2015)  
**Baseline:** 3.45 percent; FY 2014  
**Benchmarks:**  
**2015-2019:** Achieve the national standard of 4.12 moves or less.
    - **2015 Performance:** 3.58 moves; FY 15b/16a
    - **2016 Performance:** 3.51 moves
    - **2017 Performance:** 3.64 moves
    - **2018 Performance (as of March 2018 – U-M Data Lab):** 3.5 moves

### Plan for Improvement - Activities for 2018 and 2019

- Statewide implementation of the MiTEAM Fidelity Tool will be completed in 2018.
- Michigan will incorporate training in the use of the MiTEAM Fidelity Tool into the New Supervisor Institute.
- Implementation of five contracted Regional Resource Teams to provide consistent regional foster parent training, assistance with local recruitment and retention, foster parent navigator services and caregiver training opportunities.
- The QIC Permanency sub-team is working to increase the percentage of children discharged from foster care to permanency within 12 months through targeted case review in the use of structured decision-making tools and improving the foster care worker-to-worker transfer process.

### Implementation Support

Collaboration with the courts, universities, private providers and child welfare advocates is essential to reduce the number of children awaiting reunification, adoption, guardianship or permanent placement. The following action steps strengthen MDHHS' permanency outcomes:

- A change was made in the contract between MDHHS and Community Mental Health (CMH) service providers related to the county of financial responsibility for mental and

behavioral health services for children in foster care. The change enables a child to be served by the CMH located in the county where the child is placed, regardless of whether the child came from another county or the child's parents reside in another county or court of jurisdiction. Delaying service provision to negotiate payment for services with other counties was a longstanding barrier to providing timely services to children placed in foster care. This change eliminates that barrier.

- The SCAO Court Improvement Program works collaboratively with MDHHS to provide county-specific placement data to courts and assists judges to pinpoint challenging areas to improve performance.
- The QIC Placement sub-team focuses on placement of children in unlicensed placements, foster parent licensing, relative licensing and placement exceptions.
- Adoption resource consultants provide services to children statewide who have been waiting over a year for adoption without an identified adoptive family.
- The Adoption Oversight Committee provides policy recommendations to improve permanency through adoption.
- Foster care and adoption navigators provide support and assistance to families pursuing foster home licensure or adoption of children from Michigan's child welfare system.
- Permanency resource monitors assist with timely progress toward permanency goals. Permanency resource monitors provide assistance to first line staff and supervisors to assess the need for residential treatment and provide facility recommendations based on the needs of the child. This process provides support through the treatment process to expedite less restrictive placements with community treatment.
- The Michigan Adoption Resource Exchange (MARE) continues to produce recruitment brochures and newsletters, maintain an informational website and host "meet and greet" events.
  - The exchange maintains the Michigan Heart Gallery, a traveling exhibit introducing children available for adoption.
  - The Match Support Program is a statewide service for families who have been matched with a child from the website and are moving forward with adoption. The Match Support Program provides up to 90 days of information and referral services to families.

## **Program Support**

- DCQI will provide technical assistance to local counties and agencies on how to use management reports and other data to track case management activities.
- DCQI staff will assist counties to develop and implement county CQI plans.
- DCQI staff will assist county CQI teams to implement the MiTEAM Fidelity Tool to track the use of the MiTEAM practice model in case management.
- MiTEAM analysts provide technical assistance to local counties and agencies on continuous development of practice skills at all levels.
- MDHHS is developing training and enhanced MiTEAM materials to address the use of family team meetings for the engagement of parents, caregivers and other case members in the development of parenting time plans.

- In the QSR, DCQI provides feedback to caseworkers and supervisors on current case practice in local offices and agencies.
- DCQI provides QSR data in the form of county and annual reports that can be used to identify areas for local and statewide improvement efforts.

### **Technical Assistance and Capacity Building**

- MDHHS participates in the Consortium on Improved Placement Decision-Making and Capacity Building sponsored by the Annie E. Casey Foundation.
- MDHHS participated in Permanency Roundtable training sponsored by the Annie E. Casey Foundation.

### **Permanency 2**

Michigan demonstrated strength in visiting parents and keeping children connected to their community in 2017. Results from 2017 cases reviewed in the Quality Assurance Compliance Review (QACR) include the following:

- In 100 percent of cases, mother/child contacts were of sufficient frequency to promote the parent/child relationship. This is a notable increase from 2016, when this was true in only 93 percent of cases. Visits with mothers continue to be of greater frequency than visits with fathers.
- Father/child contacts were of sufficient frequency to promote the parent/child relationship in 94 percent of cases. This is an increase from 2016, when 81 percent of cases showed sufficient father/child contacts.
- In 94 percent of cases, documentation showed concerted efforts were made to maintain the child's connections with his or her extended family/community/faith/school/friends. This is an increase from 2016, when 80.8 percent of cases showed efforts to maintain these connections.
- In 83 percent of cases, siblings who were placed apart had sufficient visits with each other. This is an increase from 2016, when this occurred only 62.9 percent of the time.

### **Progress in 2017 and 2018**

- Policy on family team meeting types and timeframes provides guidance to ensure that children and families have an active voice in case planning.
- The MiTEAM manual was updated to provide guidance for family team formation, functioning and coordination. Regularly scheduled and intervention-based family team meetings ensure that the family, caseworker and other team members are actively implementing, reviewing and revising case plans to address barriers to permanency.
- Enhanced MiTEAM training and support efforts was completed statewide to enhance practice skills at all levels.
- Permanency Forums were held in Wayne County.
- Development of the automated MiTEAM Fidelity Tool continued, which assists supervisors in capturing and providing feedback on caseworker competency.

- The highlight of the Permanency sub-team’s work was the successful rollout of the statewide Connect, Strengthen and Achieve Summits, focusing on social work contact policy and documentation in MiSACWIS, as well as effective case planning and best practices. Over 400 staff attended the events. Those in attendance were satisfied with the material presented at the summits and provided positive feedback overall.
- The Visits sub-team was developed as a subset of the QIC Permanency sub-team, tasked with improving foster care social work contact performance statewide, including worker-child, worker-parent, parent-child and worker-supervisor contacts. This team is tasked with improving overall performance and there is a strong emphasis on quality and purpose of the visits.
- MDHHS is working with congregate care providers to reduce length of stay and return children to a less restrictive, more family-like setting at the soonest point possible, while ensuring that a high level of mental and behavioral health interventions are available to the child and family.

## **Permanency 2 – Assessment of Performance**

Permanency 2 achievements are tracked through the Quality Assurance Compliance Review (QACR) and the Quality Service Review (QSR), which are detailed in the Quality Assurance section of this report.

**Goal:** MDHHS will maintain and preserve family relationships and the child’s connections.

- **Objective 1:** Children will have visits of sufficient frequency with their mother and father to promote their relationships.

**Measure:** Quality Assurance Compliance Review (QACR)

**Baseline:** 77 percent of children in care had visits with their parents of sufficient frequency to promote parent-child relationships, 2014.

**Benchmarks:**

**2015-2019:** Demonstrate improvement each year.

- **2015 Performance:** 65.5 percent of children in care had visits with their parents of sufficient frequency to promote their relationships.
- **2016 Performance:** 76 percent of children in care had visits with their parents of sufficient frequency to promote their relationships.
- **2017 Performance:** 97 percent of children in care had visits with their parents of sufficient frequency to promote their relationships.

- **Objective 2:** MDHHS will track and report the number of children in foster care who are placed with relatives.

**Measure:** Data Warehouse Monthly Fact Sheet.

**Benchmarks:**

**2015-2019:** Demonstrate improvement each year.

- **2015 Performance:** 34 percent of children were placed with relatives in their initial placement.
- **2016 Performance:** 36 percent of children were placed with relatives in their initial placement.

- **2017 Performance:** 56 percent of children were placed with relatives in their initial placement.
- **Objective 3:** Children in foster care will have visits of sufficient frequency with siblings to maintain and promote sibling relationships.
  - Measure:** QACR
  - Baseline:** 88 percent; calendar year 2014.
  - Benchmarks:**
  - 2016-2019:** Demonstrate improvement each year.
    - **2015 Performance:** 57 percent of children had visits of sufficient frequency to maintain sibling relationships.
    - **2016 Performance:** 63 percent of children had visits of sufficient frequency to maintain sibling relationships.
    - **2017 Performance:** 83 percent of children had visits of sufficient frequency to maintain sibling relationships.

## Progress in 2017

- Development of parenting time training for relative caregivers/foster parents that includes the benefits of increased parenting time and ways caregivers may assist.
- Development of a parenting time observation tool to document progress that enables caseworkers to make informed decisions.
- Expansion of supportive visitation services to 74 counties.
- Provision of Family Incentive Grants to assist relatives with home repairs and other financial barriers to licensure and relative placement.
- Development of local CQI teams to review metrics and practice indicators and form local quality assurance plans.
- Updated guidance to the field on engagement and placement with relatives in policy.
- Enhanced MiTEAM training and support efforts statewide to enhance practice skills. Training and support in case planning and implementation focused on family members' involvement in decision-making and service participation from the time of removal through achievement of permanent homes for children.
- Development of the automated MiTEAM Fidelity Tool was completed. Supervisors will produce a random list of cases to review for their staff and record results in the automated system. Training and full use of the system is taking place statewide in 2018; until rollout is complete, supervisors are using worksheets to monitor select competencies and provide staff feedback.
- Statewide Connect, Strengthen and Achieve Summits in November 2017 focused on foster care social work contact policy and MiSACWIS data entry, as well as effective case planning. While the goal was improving overall performance in social work contacts, there was a strong emphasis on quality and purpose to improve safety, permanency and well-being outcomes. Over 400 child welfare staff attended the events that were held in Gaylord, Battle Creek and Detroit.

## **Progress in 2018**

- Implementation of the Regional Placement Unit (RPU) in Wayne, Oakland, Macomb and Genesee counties allows for streamlined initial placement of youth in these counties with a goal of keeping children in their communities and improving placement stability.
- The Absent Parent Protocol was updated to provide guidance to courts and child welfare staff on the identification and location of parents who are not present at the onset or at any time that children are under the jurisdiction of the court.
- Development of statewide training focused on early identification and engagement of relatives for the purpose of placement and support.
- Relative Licensing Incentive Grant payments were increased to encourage the timely licensing of relatives by private child placing agencies.
- Development of partnerships to increase access to community-based parenting time opportunities for families outside of MDHHS or private agency offices.

## **Plan for Improvement - Activities for 2018 and 2019**

- Establishment of new residential contracts to keep children closer to parents and siblings and facilitate visits and family involvement in interventions.
- Policy on case responsibility is being updated to ensure continuity of services, including visitation between children and their siblings and parents.
- Development of partnerships to increase access to community-based parenting time opportunities for families outside of MDHHS or private agency offices.

MDHHS contracted with the national Building Bridges Initiative for consultation on best practices when young people in child welfare are in need of residential intervention. Permanency resource monitors are assigned to youth who have been in residential treatment facilities without an identified permanent placement.

## **Implementation Support**

In addition to the implementation of the MiTEAM practice model, community involvement and partnership are essential with courts, universities, private providers and child welfare advocates to preserve family relationships and connections. The following steps are being implemented in to strengthen permanency outcomes:

- The Placement sub-team focuses on placement of children in unlicensed relative placements.
- The Permanency sub-team focuses on ensuring all required visits are completed and documented in MiSACWIS.
- The definition of “sibling” was expanded in policy to encourage connection with family.
- Strengthening policy to encourage increasing the frequency of parent-child visits.
- Piloting trauma-informed practice in Genesee, Lenawee, Mecosta/Osceola, Kalamazoo and Kent counties to address factors that may limit the quality of engagement with children and families.
- Enactment of a state law setting minimum standards for frequency of parent and sibling

contact.

- Continuing to collaborate with Tribal Social Services where available and contracted tribal foster care agencies to maintain family connections for Native American children.

### **Program Support**

- MDHHS provides training on how to utilize family team meetings effectively as a resource for developing and revising parenting time plans.
- DCQI provides technical assistance to local counties and agencies on how to use management reports and other data to track case management activities.
- DCQI staff assists counties to develop and implement county CQI plans.
- DCQI staff assists county CQI teams to implement the MiTEAM Fidelity Tool to track the use of the MiTEAM practice model in case management.
- MiTEAM materials are being enhanced to reinforce the use of family team meetings to engage parents, caregivers and other case members in the development of parenting time plans.
- In the QSR, DCQI provides feedback to caseworkers and supervisors on current case practice in local offices and agencies.
- DCQI provides QSR data in the form of county and annual reports that can be used to identify areas for local and statewide improvement efforts.

### **Technical Assistance and Capacity Building**

- MDHHS participates in the Consortium on Improved Placement Decision-Making and Capacity Building sponsored by the Annie E. Casey Foundation.

## **SERVICES FOR CHILDREN UNDER THE AGE OF 5**

- In 2017, 8,914 children ages 5 and under were in foster care. This is a 3.1 percent increase from 2016.
- At the conclusion of FY 2017, 20 children under age 5 did not have an identified permanent family upon termination of parental rights. Of those children, 10 have been adopted, nine have an identified family and one remains unmatched with a family.
- As of February 2018, 12 children under 5 did not have an identified permanent family but by April 2018, one of those had an identified family, and three had a placement pending. The remaining eight children were listed as “open” on April 1, 2018.

### **Activities to Reduce the Time Young Children are Without an Identified Family**

Child-specific recruitment efforts are mobilized when an adoptive family has not been identified at the time of adoption referral. A written, child-specific recruitment plan must be developed within 30 calendar days. The plan is based on the child’s specific needs, and efforts focus on finding an adoptive family that will provide a stable home for the child. The plan may include locating relatives or friends who have an established relationship with the child and

photo listing the child on state and national websites, as well as distribution of information about a specific child. The child is registered for photo listing on the Michigan Adoption Resource Exchange. Quarterly reviews of the plan continue until the child is placed with a family that plans to permanently care for the child.

### **Family First Preservation Services Act**

The Family First Preservation Services Act requires states, in addition to take steps to reduce the time young children are without an identified family, to address the developmental needs of children under 5-years-old that are in foster care or in-home care. Michigan addresses the developmental needs of children under five in the following ways:

- Public and private agency caseworkers and contracted family preservation workers make referrals to Early On for children 3 and under when they are working with them.
- Early Head Start services are provided to children in home and in out-of-home care across the state.
- Family Reunification Program staff are conducting trauma screenings and referrals to targeted services based on findings.
- Michigan offers the Early Childhood Home Visiting program, which provides voluntary, prevention-focused family support services in the homes of pregnant women and families with children ages 0-5.

### **Progress in 2017**

- MDHHS participated in the Early Childhood Comprehensive Systems project, which brings together service providers to develop seamless systems of care for children in the formative years from birth to age 3 to grow up healthy and ready to learn by addressing their physical, emotional and social health in a broad-based and coordinated way.
- MDHHS began implementing trauma screening for CPS ongoing and foster care cases statewide.
- New supportive visitation contracts were awarded on Oct. 1, 2016. The service is now available in 74 of the state's 83 counties. Performance data for supportive visitation contracts from Oct. 1, 2016 to March 31, 2017 includes:
  - Eighty-four percent of parents showed improvement in a minimum of two of the identified target areas on the post-training test.
  - Eighty-six percent of parents participated in all scheduled sessions or contacted the visitation coach prior to the visit time to cancel and/or reschedule.
  - Ninety-eight percent of families who successfully completed services reported satisfaction with the services delivered by the contractor.
  - Ninety-nine percent of referring workers reported satisfaction with services provided and documentation received.
- MDHHS is working on guidance for the development of parenting time plans, ideally to be completed during family team meetings.
  - In the Genesee County Infant/Toddler Treatment court, twelve families were served in 2017, five of whom completed services.
    - As of April 1, 2018, there are seven families participating in services; six

- continued from 2017 and one case was opened in 2018.
  - All of the children received developmental screenings.
  - All of the parents participated in individual and group parenting classes.
  - Sixty percent of families have been reunified since 2009; this drop in reunification rate from 78 percent (2009-2016) appears to be affected by the number of families with severe opiate addictions and/or a significant number of past terminations.
  - Five successfully graduated families have children who have re-entered care since 2009.
- Family Preservation workers and public and private agency caseworkers are making referrals to Early On for qualified children when they are working with them.
- Early Head Start services are provided to parents and children in home and in out of home care in some counties across the state.
- Family Reunification Program staff are conducting trauma screenings and referrals based on findings.
- Michigan continues to offer the Early Childhood Home Visiting program, which provides voluntary, prevention focused family support services in the homes of pregnant women and families with children aged 0-5.

### **Plan for Improvement - Activities for 2018 and 2019**

- Trauma-informed practice continues to be promoted statewide.
- Child welfare staffs are being trained statewide to perform trauma screening for all children entering out-of-home care. Documentation of specific data indicators in MiSACWIS is beginning in 2018.
- MDHHS continues to identify additional funding to expand the number of families served through the supportive visitation program.
- Development of a pilot program is beginning in Ingham County for parenting support groups that focus on appropriate play for parents with young children. Parents and children will attend together.
- MDHHS is piloting trauma informed parenting training for caseworkers, foster/adoptive parents and birth parents.
- Based on opportunities offered through the Family First Prevention Services Act, MDHHS will begin to develop additional programming for young children with the goal of reducing time to permanence, placement stability and assessing and addressing trauma and developmental needs.

## **WELL-BEING**

Well-being includes the factors that ensure children’s needs are assessed and services targeted to meet their needs in the areas of family connections, education and physical and mental health. QACR and QSR results for Well-Being Outcome 1 from 2014 to 2017 are below.

<b>Well-Being Outcome 1 – Families Have Enhanced Capacity to Provide for their Children’s Needs</b>				
<b>QACR Questions</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>
<p><b>Item 12:</b> Needs and services of child, parents and foster parents.</p> <p>Did each report show documentation of a formal or informal initial or ongoing assessment that accurately assessed the mother’s and father’s needs?</p>	Parents: 89%	Parents: 85%	Mother: 92.4% Father: 81.6%	Mother: 96% Father: 95%
Were appropriate services provided or offered to meet the mother’s and father’s needs?	Parents: 89%	Parents: 85%	Mother: 88.1% Father: 78.8%	Mother: 96% Father: 85%
Did each report show documentation of a formal or informal initial or ongoing assessment that accurately assessed the child’s needs?	89%	Not available	95%	100%
Were appropriate services provided or offered to meet the child’s needs?	Not available	Not available	95%	99%
Did each report show documentation of a formal or informal initial or ongoing assessment that accurately assessed the caregiver’s needs?	74%	Not available	95%	98%
Were appropriate services provided or offered to meet the caregiver’s needs?	Not available	Not available	99.2%	100%
<b>Quality Service Review</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>
<b>Assessment and Understanding –</b> Quality Service Review, cases rated satisfactory	56.5%	57%	76.3%	64.4%
<b>Caregiving –</b> Quality Service Review, cases rated satisfactory	94.6%	95%	92.5%	98.7%

<b>QACR Questions</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>
<p><b>Item 13:</b> Child and family involvement in case planning.</p> <p>Did the agency make concerted efforts to involve the mother in the case planning process?</p>	Parents: 25% (defined as a signature on the case plan)	Parents: 26% (defined as a signature on the case plan)	87% (Involvement documented in case file)	100% (Involvement documented in case file)
Did the agency make concerted efforts to involve the father in the case planning process?	Parents: 25% (defined as a signature on	Parents: 26% (defined as	76.4% (Involvement documented	90% (Involvement documented

	the case plan)	a signature on the case plan)	in case file)	in case file)
Did the agency make concerted efforts to involve the child in the case planning process?	18%	35%	90.6% (Involvement documented in case file)	95% (Involvement documented in case file)
<b>Quality Service Review</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>
<b>Voice and Choice</b> – Quality Service Review, cases rated satisfactory	62.5%	44.2%	63.1%	57.5%
<b>Engagement</b> – Quality Service Review, cases rated satisfactory	61.8%	47.1%	70.5%	65%
<b>Teaming</b> – Quality Service Review, cases rated satisfactory	28.8%	23.6%	57.3%	37.4%

<b>QACR Questions</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>
<b>Item 14:</b> Caseworker visits with child  Was the frequency and quality of visits between the child and the caseworker sufficient to address issues pertaining to the safety, permanency and well-being of the child?	96%  Federal requirement: 95%	96%  Federal requirement: 95%	97%  Federal requirement: 95%	96.4%  Federal requirement: 95%
<b>Item 15:</b> Caseworker visits with parents  Was the frequency and quality of visits between the parents and the caseworker sufficient to address issues pertaining to the safety, permanency and well-being of the child?	Not available	Not available	Mother: 88.5%	Mother: 96.4%
			Father: 69.3%	Father: 89%

## Strengths

- In 2017, Michigan had a strong performance in CFSR Item 12, Needs and Services of Child, Parents and Foster Parents in the Quality Assurance Compliance Review (QACR). In 96 percent of cases, mothers and fathers had initial and ongoing formal or informal assessments; and, of those with identified needs, appropriate services were provided to 96 percent of mothers and eighty-five percent of fathers (nearly a 14 percent increase for fathers).
- Michigan exceeded the federal goal of 95 percent of children in the sample having a visit with their caseworker a minimum of once each month, with a score of 96.4 percent.

Ninety-eight percent of visits took place in the child's residence (MiSACWIS, 2017).

- Michigan's 2017 performance in CFSR Item 15, Caseworker Visits with Parents was strong, with caseworkers visiting mothers sufficiently frequently to meet case goals in 96.4 percent of cases and with fathers at 89 percent of cases; for fathers, an improvement of nearly 20 percent from 2016.

## Well-being 1 - Assessment of Performance

Well-Being 1 achievements are tracked through Quality Assurance Compliance Reviews (QACR) and Quality Service Review (QSR). Results are reported for fiscal year 2017 (Oct. 1, 2016 to Sept. 30, 2017). The above reviews are described in detail in the Quality Assurance section.

**Goal:** Families will have enhanced capacity to provide for their children's needs.

- **Objective 1:** Caseworkers will visit with parents at a frequency sufficient to address issues pertaining to the safety, permanency and well-being of the child and promote achievement of case goals.

**Measure:** QACR

**Baseline:** Sixty-nine percent; 2014

**Benchmarks:**

**2015 - 2019:** Demonstrate improvement each year.

- **2015 Performance:** Fifty-seven percent of caseworker visits with parents were sufficient to promote achievement of case goals.
  - **2016 Performance:**
    - In 89 percent of cases, caseworker visits with mothers were sufficient to promote achievement of case goals.
    - In 69 percent of cases, caseworker visits with fathers were sufficient to promote achievement of case goals.
  - **2017 Performance:**
    - In 96.4 percent of cases, caseworker visits with mothers were sufficient to promote achievement of case goals.
    - In 89 percent of cases, caseworker visits with fathers were sufficient to promote achievement of case goals.
- **Objective 2:** Caseworkers will assess the needs of parents, children and foster parents initially and on an ongoing basis to identify the services necessary to achieve case goals.

**Measure:** QACR

**Baseline – 2014:**

- Eighty percent of parents' needs were assessed ongoing.
- Eighty-nine percent of children's needs were assessed ongoing.
- Seventy-four percent of foster parents' needs were assessed ongoing.

**Benchmarks:**

**2016 - 2019:** Demonstrate improvement each year.

**2015 Performance:**

- Eighty-five percent of parents' needs were assessed initially and ongoing.

- Data on assessment of children's needs was not available.
- Data on assessment of foster parents was not available.

**2016 Performance:**

- Eighty-six percent of parents' needs were assessed initially and ongoing.
- Ninety-five percent of children's needs were assessed initially and ongoing.
- Eighty-nine percent of caregivers' needs were assessed initially and ongoing.

**2017 Performance:**

- Ninety-six percent of mothers' needs were assessed initially and ongoing.
- Ninety-five percent of fathers' needs were assessed initially and ongoing.
- One hundred percent of children's needs were assessed initially and ongoing.
- Ninety-eight percent of caregivers' needs were assessed initially and ongoing.

- **Objective 3:** Caseworkers will involve the child and family in case planning.

**Measures:**

- QACR
- QSR score on the Voice and Choice factor. Voice and Choice measures the degree to which the focus child and family have an active and significant role in decisions made in case planning.

**Baseline – 2014:**

- Twenty-five percent of parents signed the treatment plan.
- Eighteen percent of children signed the treatment plan.
- In the QSR, 62.5 percent of cases scored within the acceptable range for Voice and Choice.

**Benchmarks:**

**2015 - 2019:** Demonstrate improvement each year.

**2015 Performance:**

- Twenty-six percent of parents signed the treatment plan.
- Thirty-five percent of children signed the treatment plan.
- In the QSR, 44.2 percent of cases scored within the acceptable range for Voice and Choice.

**2016 Performance:**

- In 87 percent of cases, mothers were involved in the development of the case plan (2016 QACR).
- In 76 percent of cases, fathers were involved in the development of the case plan (2016 QACR).
- In 91 percent of cases, children were involved in the development of the case plan (2016 QACR).
- In the 2016 QSR, 64.7 percent of cases scored within the acceptable range for Voice and Choice.

**2017 Performance**

- In 100 percent of cases, case documentation showed mothers were involved in the case planning process (2017 QACR).
- In 90 percent of cases, documentation showed fathers were involved in the case planning process (2017 QACR).

- In 95 percent of cases, documentation showed the child was involved in the case planning process, if the child was developmentally able. (2017 QACR).
- **Objective 4:** Caseworkers will visit with children in foster care a minimum of once each calendar month.  
**Measure:** MiSACWIS.  
**Baseline:** Ninety-six percent of children in the sample had visits with their caseworker at least once each month, 2014.  
**Benchmarks:**  
**2015:** Achieve 90 percent or more visits by the caseworker each calendar month.  
**2016 – 2019:** Achieve 95 percent or more visits by the caseworker each calendar month.
  - **2015 Performance:** In 96 percent of cases, children had visits with their caseworkers monthly.
  - **2016 Performance:** In 97 percent of cases, children had visits with their caseworkers monthly.
  - **2017 Performance:** In 96.4 percent of cases, children had visits with their caseworkers monthly.

### Progress in 2017 and 2018

- Policy requiring family team meetings at regular and frequent intervals and at critical points ensures that all family members and supporters are involved in case planning and support of the family.
- The statewide rollout of the MiTEAM Fidelity Tool for use by supervisors when observing and monitoring case management activities emphasizes the importance of the use of MiTEAM skills and practices in working with families.
- The QIC Service Array sub-team and the Child Welfare Policy and Programs Division work continuously to identify statewide and regional service needs, resulting in expansion of services to additional areas, including Supportive Visitation, the Family Reunification Program and Families Together Building Solutions, as well as other supportive services.
- A statewide focus on trauma-informed services has led to an awareness of the results of Adverse Childhood Experiences and the need to build resiliency in children and families. The state continues to explore how this knowledge can be used to create a more effective and responsive service array.
- An increasingly mobile child welfare workforce with access to MiSACWIS in the field has enhanced staffs' ability to document contacts quickly and accurately, ensuring all contacts are documented in the case record.
- Caregiver training classes were added to university partnerships on topics pertinent to caring for children, including training on the effects of traumatic events on children.
- The Reasonable and Prudent Parent Standard in policy and case management provides guidance to foster parents when determining whether to allow a child in foster care to participate in extracurricular, enrichment, cultural and social activities while maintaining a child's health, safety and best interests. Training was provided to staff, child-caring

institution providers and foster parents.

- Policy changes have enabled caseworkers to respond more appropriately to the needs of older youth in foster care:
  - The DHS-5333 form, “Conversation Guide on Return from AWOLP” (Absent without Legal Permission) was developed to help a caseworker discuss with a youth the factors that contributed to their being absent from foster care and to discuss their experiences while absent, including trauma and potential victimization in human trafficking. Policy was updated in February 2017 to mandate this discussion with a youth after return and includes instructions if it is suspected that the youth was a victim of trafficking.
  - Foster care policy was updated in 2017 to include the requirement that young people in foster care ages 14 and older assist in the development of their case plan and are able to select two individuals to participate on the case planning team to advocate on their behalf.
  - Foster care policy was updated in 2017 to require that young people 18 years and older or those leaving foster care are provided with a driver’s license or state-issued identification card and educational documents.
  - Foster care policy was updated in 2015 to limit the age to 16 years or older that a permanency goal of Another Planned Permanency Arrangement can be assigned. This requires caseworkers to continue efforts to find permanent placement options for 14- and 15-year-olds.

### **Plan for Improvement - Activities for 2018 and 2019**

- MDHHS will continue to focus on improving the frequency and quality of caseworker visits with parents, emphasizing the need to involve fathers in case planning.
- MDHHS will improve assessment skills of caseworkers through enhanced MiTEAM training, coaching and mentoring and use of the MiTEAM Fidelity Tool in caseworker supervision.
- MDHHS will improve family involvement in case planning through training caseworkers on the family team meeting process.

### **Implementation Support**

- The Reasonable and Prudent Parent Standard was implemented, which included training for staff, child-caring institution providers and foster parents.
- MiTEAM enhancement training for individual counties continues through collaborative efforts between MiTEAM staff and DCQI.
- Policy was updated in the following areas:
  - A requirement that young people in foster care ages 14 and older assist in the development of their case plan and may select two individuals to advocate on their behalf.
  - A requirement that young people 18 years and older or those leaving foster care are provided with a driver’s license or state-issued identification card and educational documents.

- Limiting the age to 16 years or older that a permanency goal of Another Planned Permanency Arrangement can be assigned to a youth.

### **Program Support**

- Caregiver training courses were added to university partnerships on topics pertinent to caring for children, including training on the effects of traumatic events on children.
- DCQI assists county CQI teams to implement the MiTEAM Fidelity Tool to track the use of the MiTEAM practice model in case management. The MiTEAM practice model requires coordination of a family team for service planning and implementation.
- In the QSR, DCQI provides feedback to caseworkers and supervisors on current case practice in local offices and agencies.
- DCQI provides QSR data in the form of county and annual reports that can be used to identify areas for local and statewide improvement efforts.

### **Technical Assistance and Capacity Building**

- DCQI staff assists counties to develop and implement county CQI plans.
- DCQI provides technical assistance to local counties and agencies on how to use management reports and other data to track case management activities.

### **Well-Being 2**

Well-Being Outcome 2: Children will receive appropriate services to meet their educational needs.

MDHHS is committed to ensuring that all children in foster care receive appropriate services to meet their educational needs. To promote educational success, foster care policy requires:

- Children entering foster care or changing placements to continue their education in their schools of origin whenever possible and if it is in their best interest.
- When making best interest decisions for a child, collaboration is necessary between the caseworker, school staff, the child’s parents and the child.
- School-aged foster children must be registered and attending school within five days of initial placement or placement change, regardless of the placement type.
- All educational information and related tasks, activities and contacts must be documented in the service plan.
- Child welfare specialists are trained in education policy in the Child Welfare Training Institute Pre-Service Institute and Program-Specific Transfer Training.
- MDHHS education planners provide educational support to young people ages 14 and older referred because of a specific educational need.

### **Progress in 2017**

- The “Every Student Succeeds Act” of 2015 removed “awaiting foster care placement” from the definition of eligibility for McKinney-Vento Homeless Assistance Act. This transfers the responsibility for a portion of the transportation costs from the local

school district to MDHHS to maintain foster children in their schools of origin. Foster care policy was updated and training provided statewide.

- In the summer 2017, the Michigan Department of Education hired a state foster care consultant, as required by the federal Every Student Succeeds Act of 2015. The MDHHS education analyst collaborated with the consultant to train child welfare and education staff across the state and attending multiple intermediate school district meetings, where school district foster care liaisons are present.
- Training sessions in the provisions of the Every Student Succeeds Act for foster care staff were held at five locations in spring 2018.
- An Every Student Succeeds Act training is scheduled for the statewide foster parent conference in June 2018 and the statewide caseworker conference in July 2018.
- MDHHS local offices participate in the Great Start Collaborative, a coalition of human service agencies, families and other partners working to ensure every child from birth to age 8 has access to a universal, comprehensive and collaborative system of community-based early childhood programs, services and supports.

## **Well-Being 2 – Assessment of Performance**

Well-Being 2 Achievements are tracked through the QACR and the QSR.

**Goal:** Children will receive appropriate services to meet their educational needs.

- **Objective 1:** School-aged children will be registered and attending school within five days of initial placement or any placement change regardless of placement type.

**Measure:** QACR

**Baseline:** Eighty-nine percent; 2014

**Benchmarks:**

**2015 - 2019:** Demonstrate improvement each year.

**2015 Performance:**

- Eighty-eight percent of children were registered and attending school within five days of initial placement.
- Seventy-nine percent of children were attending school within five days of a placement change.

**2016 Performance:**

- Eighty-six percent of children were registered and attending school within five days of initial placement (QACR).
- Eighty-eight percent of children were registered and attending school within five days of placement.
- Eighty-three percent of children were attending school within five days of a placement change.

**2017 Performance:**

- Eighty-three percent of children were registered and attending school within five days of initial placement or placement change (QACR).
- Learning and Development was a strength in 86.41 percent of cases.

- **Objective 2:** Children entering foster care or experiencing a placement change will

remain in their school of origin whenever possible and if it is in the child's best interest.

**Measure:** QACR

**Baseline:** 77.3 percent; 2014

**Benchmarks:**

**2015 - 2019:** Demonstrate improvement each year.

**2015 Performance:**

- Seventy-nine percent of children remained in their school of origin when entering care.
- Seventy-two percent of children remained in their school when changing placements.

**2016 Performance:**

- Seventy-two percent of children remained in their school of origin when entering care.
- Sixty-three percent of children remained in their school when changing placements.

**2017 Performance:**

- Ninety-three percent of cases documented that caseworkers had made efforts to keep children in the same school when entering or changing foster care placements.

- **Objective 3:** MDHHS will ensure children's educational needs are assessed and appropriate services provided.

**Measure:** QACR

**Baseline:** 93.94 percent; calendar year 2014

**Benchmarks:**

**2015:** Establish a baseline.

**2016 - 2019:** Demonstrate improvement each year.

- **2015 Performance:** In 89 percent of cases, the child's education needs were assessed and services provided appropriate to his or her needs.
- **2016 Performance:** In 88 percent of cases, the child's education needs were assessed and services were provided appropriate to his or her needs.
- **2017 Performance:**
  - In 97 percent of cases, efforts were made to assess the child's education needs.
  - In 40 percent of those cases, the child had an identified educational need.
  - In 100 percent of those forty cases, the child's educational need was met through appropriate services.
  - In the QSR, Learning and Development was a strength in 86.41 percent.

### **Plan for Improvement - Activities for 2018 and 2019**

- Strategies to improve data collection will be identified to improve assessment of education outcomes for children in foster care.
- MDHHS will improve maintenance of children in their schools of origin when possible by

assisting with transportation.

- MDHHS will improve educational assessment of children through training in assessment skills in the enhanced MiTEAM practice model through coaching and mentoring.
- MDHHS will improve scores on enrolling children through the education point-of-contacts in each county office, who will assist and monitor school enrollment.

### **Implementation Support**

- An education point-of-contact was identified in each local MDHHS office to serve as the county's liaison with the school district's foster care liaison and a resource to child welfare staff in their geographic area.
- In the summer 2017, the Michigan Department of Education hired a state foster care consultant, as required by the federal Every Student Succeeds Act of 2015. The MDHHS education analyst collaborated with the consultant to train child welfare and education staff across the state and attending multiple intermediate school district meetings, where school district foster care liaisons are present.

### **Program Support**

- The MDHHS education analyst provides technical assistance and training to child welfare staff, education planners and the education points-of-contact on education policy and school transportation procedures.
- DCQI provides technical assistance to local counties and agencies on how to use management reports and other data to track case management activities.
- In the QSR, DCQI provides feedback to caseworkers and supervisors on current case practice in local offices and agencies.

### **Technical Assistance and Capacity Building**

- MDHHS local offices participate in the Great Start Collaborative, a coalition of human service agencies, families and other partners working to ensure every child from birth to age 8 has access to a universal, comprehensive and collaborative system of community-based early childhood programs, services and supports.
- The Education and Youth Services unit is collaborating with the Michigan Department of Education to ensure all aspects of the foster care provisions in the Every Student Succeeds Act are implemented.
- As a requirement of the Every Student Succeeds Act, state education agencies will need to report on students who are in foster care. The Education and Youth Services Unit will work with the Michigan Department of Education and the Center for Education Performance and Information as needed to ensure this requirement is met.
- A Learning Collaborative is in process in Isabella County to improve system partnerships for children in foster care.

### **Well-Being 3**

Well-being Outcome 3: Children entering foster care will receive adequate services to meet

their physical and mental health needs.

### **Physical Health**

MDHHS is committed to ensuring every child in foster care receives the preventive and primary health care necessary to meet his or her physical, emotional and behavioral health and developmental needs. Foster care policy and Michigan's Health Care Oversight and Coordination Plan requirements include:

- Every child entering foster care must receive a comprehensive medical examination including a psychosocial/behavioral assessment, accomplished by either surveillance or screening within 30 calendar days of placement, regardless of the date of the last physical examination.
- Every child in foster care between ages 3 through 20 years must receive annual comprehensive medical examinations.
- Every child in foster care under 3-years-old must receive frequent comprehensive medical examinations as outlined in the Early and Periodic Screening, Diagnosis and Treatment guidelines.
- Every child under 3-years-old listed as a victim in a confirmed abuse or neglect report will be referred to Early On for assessment and services.
- Every child who re-enters foster care after case closure must receive a comprehensive medical examination within 30 days of placement and ongoing comprehensive examinations thereafter.
- Every child in foster care must have a medical home. Whenever possible, the child's existing medical provider will remain the medical home.
- Foster care workers are required to complete each child's medical passport that documents medical and mental health care and share the passport with all providers, including foster parents.
- Health care providers must have the information needed to assist the child and family receiving assessment and treatment for emotional and behavioral needs.

### **Initial Physical Examination**

MDHHS will ensure that children entering foster care receive an initial physical examination within 30 days of entry through the following activities:

- Health liaison officers that focus on addressing system barriers at the county level.
- A brochure, "Guidelines for Foster Parents and Relative Caregivers for Health Care and Behavioral/Mental Health Services" sent to foster and relative providers at placement to outline health care requirements.
- A webinar on the health needs of children in foster care was provided.
- Regular conference calls and meetings between the Child Welfare Medical Unit with health liaison officers to provide policy and practice updates.
- Training and technical assistance provided to local office staff to ensure timely Medicaid opening, and accurate/timely documentation of health care activities in MiSACWIS.
- Streamlining Medicaid opening/enrollment at the time of foster care entry.
- Ongoing outreach/education/technical assistance to the primary care community.

## **Mental Health**

The goal of mental health services for children in foster care is to achieve a system of care that is strength-based, family driven, youth guided, trauma-informed and delivered in community settings whenever possible. The use of psychotropic medication will be based on a comprehensive mental health assessment, the best available evidence and with the assent of the child and the adults responsible for them. Delivery of mental health interventions in a residential setting will be limited in frequency and duration, with an emphasis on service delivery in the community.

MDHHS is committed to identifying and addressing children’s mental health needs as part of comprehensive medical care. Stakeholders continue to identify access to mental health services as an area needing improvement. MDHHS is continuing to work across divisions and departments to improve access to mental health services within the broader systems of care. Foster care policy and the Health Oversight and Coordination Plan contain the following requirements related to mental health:

- Caseworkers must ensure that mental health assessment and treatment are provided when identified by the psychosocial/behavioral assessment at every comprehensive medical examination and assist with obtaining services if needs are identified.
- Children in foster care will receive mental health services through Medicaid health plan behavioral health service providers or community mental health service providers.
- Medical providers must engage legal parents or guardians in an informed consent process prior to prescribing psychotropic medications to children in foster care.

Michigan’s achievement in mental health screening as measured by successful completion of initial and periodic comprehensive medical examinations is listed above. Achievement in informed consent for psychotropic medication use is listed below. Recent performance (2017) appears lower than reported in 2016. This reflects changes in the method of measuring informed consent documentation. In prior reporting periods, DCQI completed a targeted case review to measure compliance. Since July 1, 2016, the Foster Care Psychotropic Medication Oversight Unit tracked consent for psychotropic medications by reviewing Medicaid claims and cross-referencing to consent documents sent by caseworkers. The unit provides outreach to the field when claims appear without accompanying consent.

## **Impact of Protocols on the Use and Monitoring of Psychotropic Medications**

For most categories, the prescribing patterns in 2017 and 2018 are similar to those seen in prior years. The data will be monitored over the next several years to determine trends and address the factors associated with each one.

## **Well-Being 3 – Assessment of Performance**

Well-Being 3 achievements are tracked through MiSACWIS data reports.

**Goal:** Children will receive timely and comprehensive health care services that are documented in the case record.

- **Objective 1:** Children entering foster care will receive an initial comprehensive physical

examination within 30 days of entry.

**Measure:** MiSACWIS data (Monthly Management Report).

**Baseline:** Seventy percent; 2015.

**Benchmarks:**

**2016 – 2019:** Ninety-five percent or higher.

- **2016 Performance:** Seventy-five percent of children had a timely initial physical examination.
- **2017 Performance:** Eighty-three percent of children had a timely initial physical examination and timely initial dental examination.
- **2018 YTD Performance:** Eighty-five percent of children had a timely initial physical examination and 83 percent had a timely initial dental examination.

- **Objective 2:** Children entering foster care will receive a mental health screening within 30 days of entry.

**Measure:** MiSACWIS data (Monthly Management Report – initial medical examinations<sup>1</sup>) and QSR.

**Baseline:** Fifty-one percent; 2015.

**Benchmarks:**

**2016 – 2019:** Ninety-five percent or higher.

- **2016 Performance:** Seventy-three percent of children received a mental health screening within 30 days of entering care.
- **2017 Performance:** Eighty-three percent of children received a mental health screening within 30 days of entering care.
- In 94.87 percent of cases, Emotional Functioning was rated satisfactory (QSR).
- **2018 YTD Performance:** Eighty-five percent of children received a mental health screening within 30 days of entering care.

## Health Care Oversight and Coordination Plan for Improvement

- **Objective 3:** Parents, caseworkers and children will engage in an informed consent process with physicians prescribing psychotropic medication.

**Measures:** Medicaid claims and Foster Care Psychotropic Medication Oversight Unit database.

**Baseline:** In 55 percent of cases reviewed, an informed consent process was completed with parents and physicians prescribing psychotropic medication, 2014.

**Benchmarks:**

**2015 – 2019:** Increase by five percent each year.

- **2015 Performance:** In 18 percent of cases, there was documentation of an informed consent process.

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<sup>1</sup> Psychosocial/behavioral assessment (accomplished through surveillance or formal screening) is a required activity for all comprehensive examinations under Early and Periodic Screening, Diagnosis and Treatment guidelines. Therefore, documentation of a comprehensive examination by definition includes mental health screening.

- **2016 Performance:** In 84 percent of cases, there was documentation of an informed consent process.
- **2017 Performance:** In 68 percent of cases, there was documentation of an informed consent process.
- Medication Management was rated satisfactory in 93.75 percent of cases in QSRs.

### **Progress in 2017**

- The child well-being website launched in 2016 was updated.
- Contracts for comprehensive trans-disciplinary and comprehensive team trauma assessment services are in place.
- Fair market rate counseling contractors working with child welfare clients completed mandated training.
- Witnessed verbal consent for psychotropic medication became available to legal consenters.
- The Psychotropic Medication Oversight Unit refined protocols developed in 2016 to review claims regularly and expedite the documentation process.
- The physician leadership team identified target areas for quality improvement.

### **Progress in 2018**

- Statewide training on using the Trauma Screening Checklist was initiated for CPS, foster care and juvenile justice workers, supervisors and managers.
- A CSA trauma protocol was developed and implemented.
- MDHHS awarded funds to hold Learning Collaborative events statewide to engage local/regional child welfare, medical, dental and mental health providers and other stakeholders in identifying and addressing barriers to achieving the health well-being needs of children in foster care. This project (Fostering Health Partnerships) will continue through calendar year 2019.
- All foster care staff, public and private, have access to CareConnect360. This application provides workers with Medicaid claims information for children under MDHHS supervision.
- Mandatory supervisor training on psychotropic medication and informed consent was provided in 17 sites.
- Webinars for MiSACWIS health screen completion was developed and made available to CPS and foster care staff.
- The joint application design team process for the integration of Medicaid claims information in the medical passport.
- Tasks from the timely medical exams project were completed.

### **Plan for Improvement - Activities for 2018 and 2019**

- Michigan has a grant from the Michigan Health Endowment Fund to implement Learning Collaboratives to achieve the following goals:
  - The Learning Collaboratives bring together partners in the various systems of

care for children in foster care (primary care, dental, mental health, child welfare, schools, courts, etc.) to identify and address challenges/barriers to achieving timely and quality care. These meetings will occur across the state.

- In pilot counties (Ingham, Saginaw, Muskegon), the collaboratives will discuss barriers to birth/legal parent engagement in health/mental health care and pilot activities to improve engagement.
- MDHHS will complete the integration of Medicaid claims information in the medical passport through the joint application design team process.
- Follow-up with residential treatment providers will continue to address challenges in achieving care coordination and parent/guardian/caseworker engagement in informed consent.
- Mandatory caseworker training will be provided in eight sites statewide on a variety of health topics.
- The Child Welfare Medical Unit will conduct evaluation of trauma assessment contracts.
- The Child Welfare Medical Unit will implement a project recommended by the physician leadership team to improve the quality of mental health documentation and its transfer to new providers during transitions of care.
- The Child Welfare Medical Unit will complete contracting for psychological and psychiatric assessments.
- The Child Welfare Medical Unit will update, rename and expand content in the [www.michigan.gov/fosteringmentalhealth](http://www.michigan.gov/fosteringmentalhealth) website
- The Child Welfare Medical Unit will develop and implement child and adult psychological assessment contracts.
- MDHHS will review and amend treatment foster care contracts to expand beds and improve service.

### **Implementation Support**

- All health liaison officers, county-based foster care workers and supervisors have access to CareConnect360, an online, claims-based electronic record.
- A team comprising the Child Welfare Medical Unit, MiSACWIS, the Child Welfare Services and Support Division and community stakeholders developed a revised medical passport.
- The Foster Care Psychotropic Medication Oversight Unit visited hospitals with psychiatric beds for children, described the MDHHS psychotropic oversight process and identified the means to collaborate more effectively.

### **Program Support**

- The Foster Care Psychotropic Medication Oversight Unit updated psychotropic medication policy and documentation requirements to streamline the consent process and assist the field with engaging parties.
- The Foster Care Psychotropic Medication Oversight Unit completed strategic planning to address persistent challenges in achieving the engagement of children and consenting adults in psychotropic medication decisions and consent.

- DCQI provides technical assistance to local counties and agencies on how to use management reports and other data to track case management activities.

### **Technical Assistance and Capacity Building**

- The MDHHS Behavioral Health and Developmental Disabilities Administration developed a cross-systems website on trauma that launched in the fall of 2016.
- DCQI staff assists county CQI teams to implement the MiTEAM Fidelity Tool to track the use of the MiTEAM practice model in case management.
- County implementation teams engage in continuous quality improvement efforts as determined by the data in the monthly management reports.

## **SYSTEMIC FACTORS**

In addition to engaging with families, assessment, service provision and evaluation, the quality of child welfare services is affected by the ability of the system to provide resources, information and communication among divisions, agencies and stakeholders. MDHHS set goals and objectives with yearly benchmarks for the following seven CFSR systemic factors:

1. Information System.
2. Case Review System.
3. Quality Assurance System.
4. Staff and Provider Training.
5. Service Array and Resource Development.
6. Agency Responsiveness to the Community.
7. Foster and Adoptive Parent Recruitment, Licensing and Retention.

## **INFORMATION SYSTEM**

### **Item 19: Statewide Information System**

Michigan is committed to maintaining compliance with federal requirements for a statewide-automated child welfare information system. Michigan submits the data files for the Automated Foster Care and Adoption Reporting System (AFCARS) to the Children’s Bureau semi-annually and the National Child Abuse and Neglect Data System (NCANDS) annually. Weekly meetings are held to discuss data improvement, trends and gaps. Participants include the Dept. of Technology, Management and Budget, MiSACWIS, CSA, DMU and the CPS, foster care and adoption offices.

Note: For the APSR, MiSACWIS training is described in the Information System section to assist matching staff training needs with training opportunities provided by MDHHS.

### **Automated Foster Care and Adoption Reporting System (AFCARS)**

Michigan completed the AFCARS on-site review in July 2015. The review found Michigan to be non-compliant in areas that Michigan had anticipated, as the MiSACWIS system had only been operationalized for one year at the time of the on-site review and operational enhancements continued following launch. As the workforce is accustomed to MiSACWIS functions, data collection has become more consistent and accurate.

Michigan implemented its AFCARS Improvement Plan in April 2016, prioritizing system and reporting improvements. Michigan reduced the number of elements denoted as areas needing improvement in the general requirements from three to one. Likewise, significant work has been done in the foster care and adoption elements, reducing the number of improvements required from 28 to 11 elements.

Michigan's AFCARS submissions in 2017 met all compliance thresholds with one exception, timeliness for the data entry of the discharge transaction date. In response, Michigan implemented improvements to MiSACWIS allowing a caseworker to enter discharge dates for case closure without negatively interfering with outstanding payments to service providers. In addition, training was completed with caseworkers and funding specialists responsible for entering data. Michigan's current AFCARS file, 2017A, passed all elements with no dropped cases. Timeliness to discharge is the only area of non-compliance.

Michigan created a new resource in 2017 to improve AFCARS reporting. The Missing/Outlier Value (MOV) report displays missing values to prompt caseworkers to add missing information and for supervisors to track completion of data entry in open and closed cases. The MOV report is updated in conjunction with MiSACWIS releases and reviewed in routine case management. The MDHHS AFCARS team disseminated information about the report during monthly phone conferences with the field. Missing data elements listed on the MOV report show up as ticklers for caseworkers in MiSACWIS. Ticklers are escalated to higher levels of management until they are addressed.

## **Plan for Improvement**

### **AFCARS Improvement Plan**

Key areas requiring improvement include:

- Adoption: Reporting the primary factor that is a barrier to adoption when the child is identified as having a special need.
- Adoption and foster care: Including the diagnosed conditions of children.
- Foster care: In reporting on foster care removal episodes, excluding children in care for less than 24 hours.
- Foster care: Clarifying the population of young people 18-years-old and older in juvenile justice placements.

### **General Requirements**

The reporting system includes all children who had been in foster care for at least 24 hours. MiSACWIS implemented this change in November 2016 for caseworkers to identify whether the

foster care episode is 24 hours or less in duration.

### **Foster Care Data Elements**

MiSACWIS was modified to require workers to complete the race and ethnicity fields for children and foster care caretakers to address missing values as of March 2016 and options for reason for removal were expanded to include incapacity, safe haven and abandonment.

The information system implemented the question in 2016, “Is this a physical condition that is medically proven and results in a marked and severe functional limitation for the child?” MiSACWIS also implemented a modification to address, “Has the child ever been adopted?” and “If yes, how old was the child when adoption was legalized?” to ensure that if the first question is yes, a value for the second question is entered.

MiSACWIS foster care changes were implemented in 2016, and code for the AFCARS file has been updated to capture this information:

- Date of first removal from the home.
- Total number of removals from the home to date.
- Date the child was discharged from the last foster care episode.

In November 2016, MiSACWIS addressed the Service Type and Living Arrangement fields to improve the accuracy of reporting the child’s current placement setting. The system was also modified to distinguish between children placed outside of the state by identifying whether the current selection of “out of state parent” is the parent from whom the child was removed. The system implemented a change to allow workers to distinguish between a relative or non-relative guardian.

### **Adoption Data Elements**

- MiSACWIS was modified to require the worker to complete the race and ethnicity fields for the child and adoptive parents to address missing values as of March 2016 and the reasons for removal were expanded to include incapacity, safe haven and abandonment.
- The information system was modified to update the list of special needs to be consistent with the state’s policy for special needs determination and to ensure the worker can identify the special need that was the main barrier to adoption.
- MiSACWIS implemented a change to improve identification of the relationship of the person adopting the child by allowing multiple selections.
- MiSACWIS implemented modifications to improve identification of the state, tribe or country other than the United States that the child was placed by and the placement location.
- The data group identifies the areas needing improvement and makes changes to MiSACWIS and program code logic to improve the accuracy and reliability of the data. A plan for additional improvements with projected timelines was approved.

### **National Child Abuse and Neglect Data System (NCANDS)**

Michigan consistently submitted annual NCANDS files timely. In FY 2017, Michigan's NCANDS file was approved with a recommendation to improve reporting of risk factors for both children and caregivers. The CPS program office is finalizing policy updates and instructions for front line staff that will improve reporting on risk factors.

In FY 2017, Michigan made improvements in its ability to report the number of children and families served through Strong Families Safe Children Title IV-B(2) funding, which is distributed to counties to be used for service needs specific to each county. The state anticipates continued improvement in reporting within the agency file the number of children and families served by specific funding sources.

All states are required to report on the Comprehensive Addiction Recovery Act in the NCANDS file for FY 2018. The MiSACWIS application was enhanced to include this reporting functionality.

## **Plan for Improvement**

### **NCANDS Improvement Plan**

Michigan's NCANDS team is reviewing the child and caregiver risk factors to determine appropriate definitions and mapping for federal reporting, as well as how to improve reporting by the field. The NCANDS team is working with the CPS program office to ensure the information is captured and outlined within policy. To ensure promptness of submission and accuracy of reporting data, MDHHS will:

- Participate in Children's Bureau technical assistance to evaluate MiSACWIS and determine information system compliance.
- Track AFCARS and NCANDS data reliability and correct errors.
- Utilize the MiSACWIS system to track progress toward child welfare goals.

## **Information System Review**

Michigan's SACWIS system ensures the state can readily identify the status, demographic characteristics, location and goals for the placement of every child who is, or within the immediately preceding 12 months, has been, in foster care. Procedures are in place to reconcile data and correct errors. There is ongoing collaboration and training to improve the functioning of the system and usability.

To ensure that MDHHS can accurately identify the location, demographic characteristics, legal status and permanency goals of all children currently in foster care, or who were in foster care during the preceding 12 months, DCQI developed an Information System Review. The Information System Review examines the output of information reported within the AFCARS file from the data entered within the MiSACWIS record of a randomly selected sample of children currently in foster care or who were in foster care within the preceding 12 months for a minimum of seven days.

Case information to be reviewed was extracted from the AFCARS file and transmitted to local offices and agencies for review. Case information to be verified included:

- The placement location of the child as of the date of the data pull, or for closed cases, the location at the time of case closure.
- Demographic information on the child, including age, gender, race and disability.
- The child’s legal status as of the date of the data pull, or for closed cases, the legal status at the time of case closure.
- The child’s permanency goal as of the date of the data pull, or for closed cases, the permanency goal at the time of case closure.

Foster care caseworkers in MDHHS local offices and private agencies served as reviewers for the cases they were responsible for during the period under review. The sample size was 265 cases, based on the state foster care population. Cases selected for review were provided on a spreadsheet to the local office or agency responsible for the care of the child. Quality assurance functions were performed by DCQI.

An Information System Review spreadsheet with case information to be validated served as the review tool. The spreadsheet included the child’s person ID, name, date of birth, gender, racial identity, disability (as applicable), placement, legal status and permanency goal. The survey included questions that prompted the reviewer to answer Yes/No to indicate whether the data element as listed was accurate both on the spreadsheet and in the MiSACWIS record. Once the review was complete, the completed review tool was transmitted electronically to DCQI for tallying, compilation and analysis.

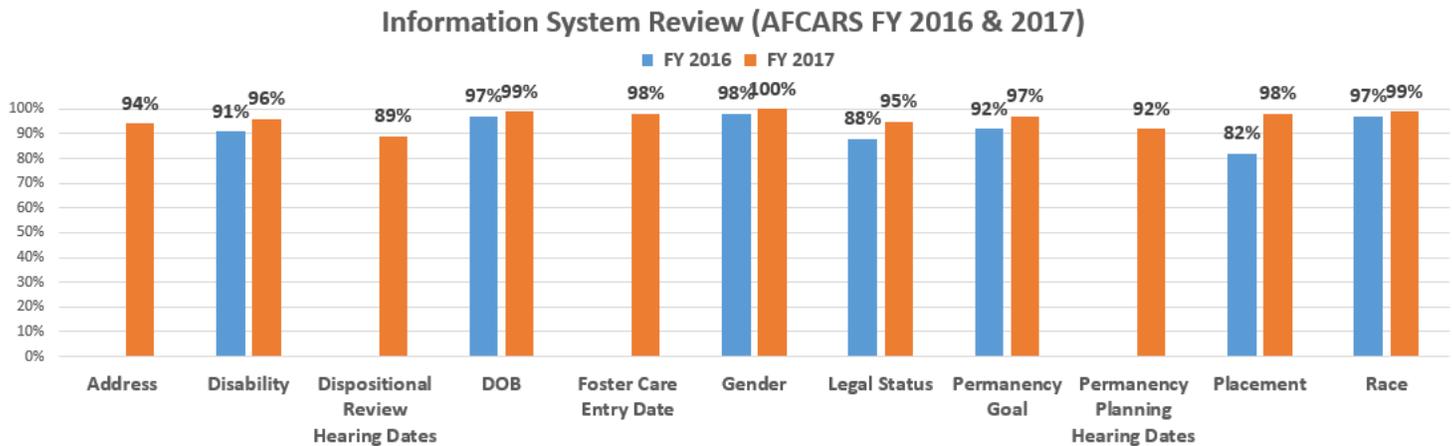
The following is an example of a completed review in 2017. Caseworkers confirmed or denied the accuracy of each item by indicating “Y” for yes or “N” for no in the “Correct Y/N” column to the right of the item on the review tool. If data was inaccurate, workers were asked to provide the correct data and confirm that needed corrections were made in MiSACWIS.

	Agency	Person ID	First Name	Last Name	Placement/ Home Address	Correct Y/N	DOB	Correct Y/N	Gender	Correct Y/N	Race	Correct Y/N	Disability	Correct Y/N	Legal Status	Correct Y/N	Perm Goal	Correct Y/N
Spreadsheet data	Wayne County	#####	Oscar	Grouch	123 Sesame St Detroit MI 48201		1/1/15		Male		White		Specific Learning Disability		43 - Court Ward ' Supervised Adoption		Adoption	
Spreadsheet correction						Y		Y		Y		Y		Y	97- Adoption Subsidy	N		Y
MiSACWIS Correction						N/A		N/A		N/A		N/A		N/A		Y		N/A

Michigan conducted two Information System Reviews in 2017 and 2018. The first review was conducted from November to December 2017 for fiscal year 2016 AFCARS data. Of the 265 cases in the sample, 151 did not produce a response by the worker, a 52 percent response rate. DCQI considered methods to improve the number of responses, resulting in moving to biannual reviews instead of annual.

In March 2018, a second Information System Review was completed utilizing FY 2017 AFCARS data. The new approach yielded a 20 percent improvement in response rate. The randomized, statewide sample consisted of 280 cases; 140 from the 2017A sample and 140 from the 2017B

sample. The graph below shows the percentage of correct data entry for each element reviewed.



### Information System Review Results

The Information System Review results were communicated to stakeholders including the federal Children’s Bureau, CSA management, BSC or local office directors and Child Welfare Services and Support, which shares information with Michigan’s private agency partners. The next Information System Review will occur in summer 2018, reviewing the data accuracy of 140 children included in the 2018A AFCARS submission.

The division observed trends in the last two years. One area was the lack of timely entry of discharge date from foster care. This was believed to be due to MDHHS depending on the court system to provide the court orders timely, dismissing jurisdiction of children, allowing caseworkers to close their cases in MISACWIS. As noted, this was the only area where Michigan was not compliant in the semiannual AFCARS submissions.

There was an observed trend of more accurate reporting of race and ethnicity. DCQI attributes these successes to collaboration with the MiSACWIS team making system changes, such as requiring certain data fields to be completed before proceeding further, in addition to the field use of the MOV report. Findings from the Information System Review will be used for planning to ensure accurate data collection and maintenance on an ongoing basis. In 2018 and moving forward, an Informational System Review will occur every six months after AFCARS data profile submissions; the sample size will be a minimum of 140 for each review.

Michigan has committed to support field staffs’ understanding and development of skills and developed the MiSACWIS Academy training. The academy includes end-user classroom workshops, webinars, web-based trainings and new worker training. A detailed description of MiSACWIS training and the number of trainees can be found in the Ongoing Staff Training section of this report.

### Information System – Assessment of Performance

**Goal:** MiSACWIS will be compliant with federal requirements for statewide automated child

welfare information systems.

- **Objective 1:** MDHHS will submit the AFCARS file to the Children’s Bureau semi-annually and ensure the file contains less than 10 percent errors for each data element.

**Measure:** MiSACWIS federal reporting data.

**Benchmarks:**

**2015 – 2019:** Submission of file with less than a 10 percent error rate.

- **2015 Performance:** The AFCARS FY 2015A and FY 2015B files were submitted timely. Michigan was compliant in all foster care and adoption data elements except for a timeliness error for the foster care discharge transaction date.
- **2016 Performance:** The AFCARS FY 2016A and FY 2016B files were submitted timely. Michigan was compliant in all foster care and adoption data elements with the exception of a timeliness error for foster care discharge date.
- **2017 Performance:** The AFCARS FY 2016A and FY 2016B files were submitted timely with updates to meet the AFCARS compliance thresholds previously not met. At the time of resubmission, MDHHS was non-compliant only with timeliness of discharge date transaction, which was expected.

Michigan improved in three data quality areas originally identified as exceeding the three percent threshold in March 2016 and the preliminary data of the FY 2016A file, dropped cases, missing discharge reasons and missing termination of parental rights dates.

- **Objective 2:** MDHHS will submit the NCANDS file to the federal Children’s Bureau annually and ensure the file is within the allowable threshold for each area in the Enhanced Validation Analysis Application tool, under the Supplemental Validation Tests.

**Measure:** MiSACWIS federal reporting data.

**Benchmarks:**

**2015 – 2019:** Submission of file within the threshold as reported in the Supplemental Validation report.

- **2015 Performance:** The NCANDS FY 2014 file was submitted timely. A data quality issue was identified for perpetrator relationship to victim, which was reported in 91.2 percent of cases, below the 95 percent data quality threshold.
- **2016 Performance:** The NCANDS file was submitted timely and accepted. Data improvements were recommended for child and caregiver risk factors.
- **2017 Performance:** The NCANDS file was submitted timely and accepted with a recommendation to improve reporting of risk factors.

## Progress in 2017

- The CPS program office is finalizing policy updates and instructions for the front-line staff that will provide improved reporting on risk factors for Michigan children and caregivers.
- In FY 2017, Michigan made improvements in the ability to report for the first time the number of children and families served through Strong Families Safe Children Title IV-B(2) funding. The state anticipates continued improvement in reporting within the

- agency file the number of children and families served by specific funding sources.
- Michigan created the Missing/Outlier Value (MOV) report, which displays missing values to prompt caseworkers to add missing information and for supervisors to track completion of data entry in open and closed cases.
- The MiSACWIS application was enhanced to include reporting functionality for the Comprehensive Assessment and Recovery Act requirements. Michigan collaborated with the NCANDS technical liaison to ensure that proper mapping and coding will meet the requirements.

### **Plan for Improvement - Activities for 2018 and 2019**

- The weekly AFCARS and NCANDS workgroups will continue to address accuracy in data collection and reporting.
- Findings from the Information System Review will be used to devise plans for ensuring accurate data collection and maintenance on an ongoing basis. Results from the Information System Review will be reported in the Statewide Assessment prior to Michigan's CFSR Round 3 and in the 2019 APSR.
- Michigan is modifying MiSACWIS to enable the collection of data on identified victims of human trafficking. The state will report it with the NCANDS file in 2019 for FY 2018.

### **MiSACWIS Training**

The MiSACWIS project has a field support and training team comprised of MDHHS and vendor staff. MiSACWIS training materials are developed based on end users' needs and enhancements in MiSACWIS functionality. MiSACWIS project support staff continues to develop the MiSACWIS Training Academy. The academy includes end-user classroom workshops, webinars, computer-based trainings, training environment maintenance and development, job aids, online help, presentations, site support and new worker training. The Office of Workforce Development and Training (OWDT) provides technical support through the Learning Management System (learning management system) to allow end users a means to register for training and complete webinars as well as computer-based trainings. OWDT also provides training facilities so end users can complete training exercises on a laptop during workshops.

### **MiSACWIS Training Academy**

MiSACWIS field support staff conducts training workshops. Identifying the training needs for workshops requires analysis of help desk trends, system updates, site support feedback and input from program and policy offices. Each workshop has a focus area based on the analysis. During training sessions, end users practice system functionality, ask questions and address issues on their own cases. Field support staff provides over-the-shoulder support.

A new curriculum of workshops was developed in late 2017 with a statewide rollout beginning in February 2018. This includes training in foster care placement and payments, CPS payments, service plans and assessments, intakes and investigations and provider management. The MiSACWIS field support will be evaluating the trainings throughout 2018 to ensure end user needs are met.

The MiSACWIS team records webinars and computer-based trainings to provide further support to end users. MiSACWIS project staff also provides a MiSACWIS training environment, job aids and online help to assist end users. The training environment allows end users to practice case management activities in an environment that mirrors a live-production environment.

New worker training is conducted by members of the OWDT team supported by the MiSACWIS field support team. This support includes maintenance of training data and training environments and development of training materials. Additionally, the MiSACWIS team conducts an overview webinar and a payments-specific training during the new worker curriculum. New worker training for licensing staff was jointly conducted by the Division of Child Welfare Licensing and MiSACWIS project staff but is now led by Licensing. MiSACWIS project staff is solely responsible for conducting new worker juvenile justice residential training.

In 2017, the MiSACWIS field support team led 113 different trainings, webinars or presentations with 3,315 participants. In addition, there were 18 computer-based trainings and 227 job aids developed or updated. Since January 2018 through March 2018, MiSACWIS staff have conducted 61 trainings and affected 759 end users. Specific details for all training workshops, webinars, presentations and site support provided through 2017 are listed below by session name.

A training request form is currently in development to solicit requests for training or support to further engage and meet end users' needs. It is expected that this form will be available in spring 2018. This form allows agencies or local offices to request webinars, job aids, computer-based trainings or in-classroom support as needed. The expectation is that staff will review the training calendar and available resources prior to requesting new training or support.

### **MiSACWIS Training Evaluation**

- Level one and two evaluations are completed as standard practice in training.
- Surveys reveal a need for continued training.
- Help desk trends identify training as a need.

### **Plan for Improvement - Activities for 2018 and 2019**

- Provision of workshops, webinars and computer-based trainings as needed.
- Surveying site support participants regarding training needs.
- Surveying child welfare supervisors and/or directors regarding training needs.
- Updating existing training materials and maintaining the training environments to support system enhancements.
- Modernizing computer-based trainings to be more engaging for end users.

### **MiSACWIS Training Academy In-Class Room Training**

#### **New CPS and Foster Care Worker Payment Training**

MiSACWIS field support staff delivers payment training to new CPS and foster care workers

each month as part of the OWDT Pre-Service Institute (PSI) training. There have been 48 classes with 788 new workers receiving MiSACWIS payment training. MiSACWIS staff will continue to provide this training as part of the PSI training calendar. The objectives for the class are to:

1. Understand what is needed to complete a paid placement and paid case service.
2. Be able to enter a paid placement and case service.
3. Know how to review financial information in MiSACWIS.

### **Licensing Worker Training Workshops**

MiSACWIS project staff delivered training on completing licensing management tasks for field staff on new and existing functionality beginning in autumn 2016 and ending in April 2017. The target audience was licensing workers and supervisors in 26 training sessions with 382 total participants. The training objectives for the workshop were:

1. Understanding the inquiry process, initial home evaluation, secure criminal history and Bridges interface.
2. Learning how to complete a special evaluation, home rules compliance record and corrective action plan.
3. Knowing the steps to enter foster parent training information and the importance of using the correct person ID.
4. Understanding how to complete a foster home reevaluation.
5. Learning how to document transactions and variances.
6. Knowing where to record recruitment and retention efforts.

In April 2017, Licensing began providing MiSACWIS training to new licensing workers. From April until November, MiSACWIS field support staff provided back-of-the-room support for eight sessions and 157 participants. Licensing is now able to provide this training without MiSACWIS field support staff.

### **Juvenile Justice Residential Worker Case Management Training**

New juvenile justice residential workers receive a two-day MiSACWIS case management training quarterly. In 2017, three sessions were held with 40 participants for the year. Training objectives include:

1. Navigating in MiSACWIS and learning the resources available for support.
2. Completing an admission, entering education and health information and documenting social work contacts.
3. Entering assessments, documenting services and completing treatment plans.
4. Entering incident reports and grievances.
5. Maintaining medication logs, child transport plans and daily provider logs.

### **BSC 5 Regional Placement Unit Child Placement Network Training**

MiSACWIS field support staff provided BSC 5 Regional Placement Unit (RPU) staff with a train-the-trainer session in how to use the Child Placement Network in MiSACWIS. This training was provided in April 2017 to five RPU staff. Materials included a PowerPoint presentation with instructor notes, a participant guide and supporting job aids. The training session covered:

1. Understanding the Child Placement Network process in MiSACWIS.

2. Learning steps to record the child's characteristics, placement referral and match providers.
3. Knowing how to complete the process by recording the placement.
4. Understanding how to utilize Geo Mapper to assist in identifying potential providers.

## **MiSACWIS Training Academy Webinars**

### **MiSACWIS Overview Webinar Series for New Caseworkers**

New CPS, foster care and adoption workers in the OWDT PSI training participate in a MiSACWIS Overview Webinar series to become familiar with navigating in MiSACWIS. Field support conducts the webinar series over two days with one session per day. To support the PSI training calendar, MiSACWIS field support staff offer the webinar series monthly. In 2017, field support staff presented the overview webinar to 605 PSI participants. The webinar objectives include:

#### **Session 1**

1. Learn MiSACWIS resources.
2. Explore data warehouse portal and the book of business report.
3. Learn MiSACWIS help desk and ticket review processes.
4. Understand case levels in MiSACWIS.
5. Explore member and case clean up.
6. MiSACWIS demonstration on MiSACWIS resources and case members.

#### **Session 2**

1. Maintain and understand households.
2. Understand associated persons.
3. Learn copy to and auto save features in social work contacts.
4. Learn criteria for social work contacts on data warehouse reports.
5. MiSACWIS demonstration on households and social work contacts.

### **CPS Data Warehouse Webinar**

#### **Foster Care Data Warehouse Webinar**

MiSACWIS staff recorded CPS Data Warehouse and Foster Care Data Warehouse webinars. The purpose of each webinar was to help CPS and foster care workers and supervisors understand how information is stored in the data warehouse and how that information can be pulled into many reports that help with caseload management. Each webinar explains information and reports specific to the program area. The webinar assists end users troubleshooting issues that may cause data warehouse reports to have missing information. This recorded webinar is available to all end users in learning management system. The objectives for each webinar are:

1. Explore InfoView in the data warehouse portal and learn the value of generating reports.
2. Understand how information entered in MiSACWIS impacts data warehouse reports.
3. Learn how to troubleshoot possible report issues within the data warehouse.

## **Additional MiSACWIS Training**

### **Connect, Achieve and Strengthen Social Work Summit**

In collaboration with CSA program and policy analysts and leadership, the MiSACWIS field support team participated in a statewide summit in November 2017. The summit covered social work contacts, parenting time exceptions, establishing and maintaining households and other activities that will increase efficiency in casework and data integrity in reporting. The three sessions had 400 participants.

### **Juvenile Justice Specialist Support**

MiSACWIS field support staff continues to support OWDT in training new juvenile justice specialists. Staff provide back-of-the-room support for OWDT trainers while training MiSACWIS functionality. In 2017, staff supported three sessions with 34 participants.

### **Agency-Specific Support**

In collaboration with MDHHS analysts, the field support team attended three onsite visits at specific private agencies to offer hands-on MiSACWIS support as requested in 2017. Forty-two participants received support and training from the team. The support was provided for any case specific assistance the staff at the agency needed. Support was primarily in foster care and licensing case management and data warehouse functional areas.

### **MiSACWIS Training Academy Workshops**

The field support team began developing and writing content for an ongoing series of workshops that targeted training needs based on field feedback and help desk trends in late 2017. The areas targeted include placement, payment, service plans, assessments, managing providers, intakes and investigations. The workshops started in late February 2018 and were ongoing through June 2018. Workshop sessions were available in Lansing, Detroit, Grand Rapids, Gaylord and Marquette. Additional workshops with topics including adoption and Child Care Fund budgets are in development for implementation later in 2018.

### **Miscellaneous**

Field support provided training, support and presentations for other topics throughout 2017. Audiences included central office staff, local office staff, private agency staff, Office of the Inspector General, field supervisors and directors. Topics include:

1. How to navigate in MiSACWIS.
2. How to use Data Warehouse/InfoView.
3. How to complete case management work.
4. How to complete work as a Michigan Youth Opportunities Initiative worker.
5. How to review a case service plan as a supervisor.
6. Over-the-shoulder support for specific case questions.

### **Ongoing MiSACWIS Release Support**

The MiSACWIS field support team supports the MiSACWIS project's release schedule by completing the following activities:

1. **Online help maintenance and development:** Online help is updated as a part of the release for any change controls that affect screen fields or functionality.
2. **Computer based training maintenance and development:** Analysis of existing

computer-based trainings and creation of new computer-based trainings due to new release items.

3. **Job aid maintenance and development:** Analysis of existing job aids that may be affected by change controls in the MiSACWIS release and creation of job aids for new functionality.
4. **Training environment maintenance and development:** Monitoring the MiSACWIS builds to training environments after every release. This includes validation using training materials to ensure that the training environments can be used with all training documents. The team provides troubleshooting for any issues reported in the training environment. Training data is created as needed to support new workshops or new worker and supervisor trainings.

### **Implementation Support**

MDHHS collaborates with several internal and external groups to ensure the state's child welfare information system delivers accurate data that meets federal, state and court standards for tracking service delivery and quality. Collaborative groups include:

- MiSACWIS development and support teams.
- The QIC, which identifies business needs and resources.
- The University of Michigan Child and Adolescent Data Lab, which provides data for tracking Michigan's achievement of CFSR outcomes

### **Program Support**

- The QIC collaborates with Child Welfare Supportive Services to ensure local and private agency staffs understand documentation requirements.
- DCQI provides service data and reports designed to assist local and BSC leadership to track local compliance with requirements and achievements.

### **Technical Assistance and Capacity Building**

- MDHHS will continue contracting with the University of Michigan Child and Adolescent Data Lab to ensure data collection and analysis methodology aligns with CFSR requirements.
- MDHHS will continue to receive technical assistance from the Children's Bureau on improving NCANDS and AFCARS data quality.

## **CASE REVIEW SYSTEM**

Michigan's case review system functions statewide to ensure that case plans are developed and that periodic, permanency and termination of parental rights hearings occur in accordance with federal, state and court requirements. To ensure compliance and improve the functioning of the case review system, MDHHS engages in ongoing collaboration with the State Court Administrative Office, which represents circuit court family divisions on child welfare issues.

## Item 20: Written Case Plan

### Michigan Foster Care and Native American Affairs Policy

As required by 1988 PA 224 of 1988, an initial service plan must be completed within 30 calendar days after the removal date of the child. A copy of the plan is required in each case file regardless of individual court reports. The initial service plan is used to:

- Document information about the family including any Indian ancestry.
- Assess the functioning of the family and child, documenting the specific identified needs and strengths including application of the Indian Child Welfare Act (ICWA) and Michigan Indian Family Preservation Act (MIFPA).
- Identify the permanency goal and the services necessary to achieve it, including the time frame.

Michigan's case service plans were designed to ensure that Michigan complies with the requirement that each child has a written case plan jointly developed with the child's parents that includes the following:

1. Identifying information.
2. Legal status and progress.
3. Reasonable efforts.
4. Social work contacts.
5. Child information, including child engagement and perception of circumstances.
6. Permanency planning including reasonable and active efforts.
7. Foster Care Review Board, if applicable.
8. Placement.
9. Placement resources.
10. Medical.
11. Visitation plan.
12. Family team meeting summary.
13. Family information and assessment.
14. Child(ren)'s best interest/compelling reasons.
15. Recommendation to the court.

Each section guides the worker to include all necessary and relevant information and aid in easy identification of required elements. A copy of the updated service plan must be sent to the court prior to the regularly scheduled review. Through the updated service plan, the foster care worker updates the court on progress and makes recommendations regarding services and ongoing planning for the child and family. At the review, the court may modify the plan. For Indian children, an ICWA performance checklist must be attached to all documents as a coversheet.

- **Timeliness:** In calendar year 2017, 83 percent of CPS service plans were completed timely, an increase of four percent from the previous 12 months. Eighty-four of children's foster care service plans were completed timely.

### Initial Service Plan

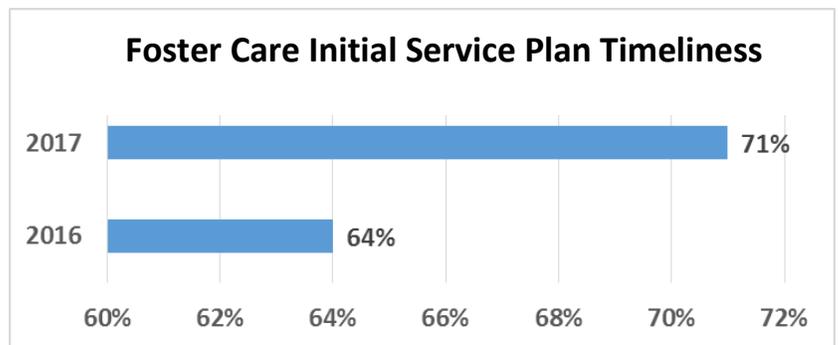
As required by PA 224 of 1988, Michigan's policy outlined in FOM 722-08 requires the initial

service plan be completed within 30 calendar days of the date the child enters foster care. A copy of the plan is required in each case file regardless of individual court reports. The initial service plan is used to:

- Document pertinent information about the family including any Indian ancestry.
- Assess the functioning of the family and child, documenting the specific identified needs and strengths including application of the Indian Child Welfare Act (ICWA) and Michigan MIFPA.
- Identify the permanency goal and the services necessary to achieve it.

If the child was returned to either/both parent(s) and the child was re-removed during this period, a description of the reasonable efforts to prevent the removal must be included. For Indian children, active efforts and testimony from a qualified expert witness are required to prevent removal from the home.

DMU provides monthly statistics of performance on timeliness of initial service plans to all child welfare staff statewide.

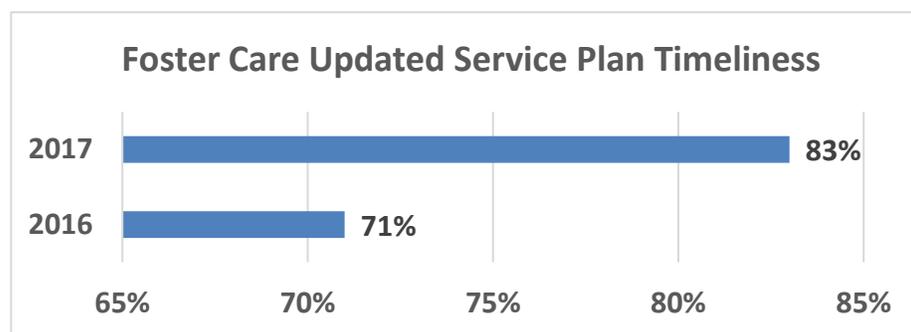


**Updated Service Plan**

Michigan’s policy, FOM 722-09, clearly outlines that updated services plans are completed every

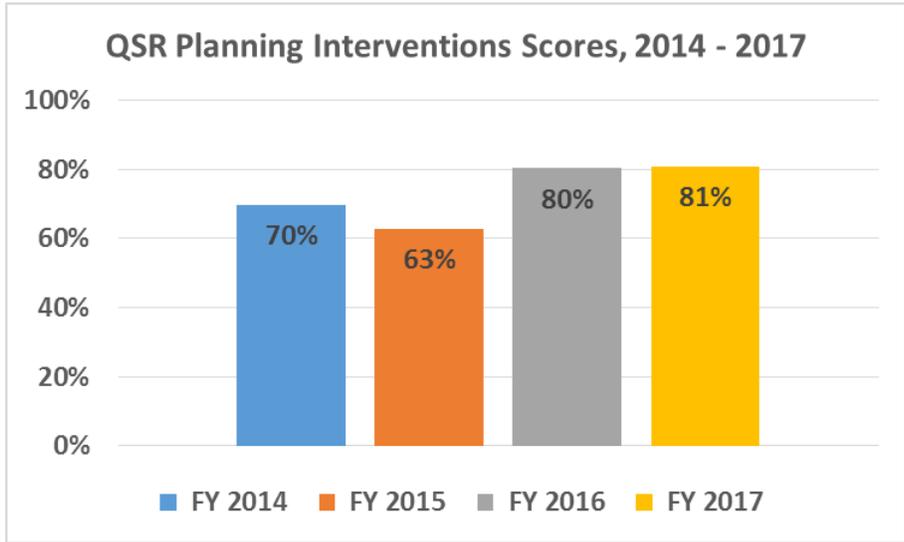
90 days, beginning after the Initial Service Plan. The updated service plan must reassess progress made to alleviate the presenting problem(s) that necessitated entry into foster care. This must include a reassessment of concerns and barriers to reunification as identified in the initial service plan and updated service plans. Compliance or noncompliance with agreed-upon treatment goals by the parent(s), and if applicable, the non-parent adult(s) must be recorded. For Indian children, progress on active efforts and good cause to the contrary recommendations including diligent search for an ICWA-compliant placement must be demonstrated if the child is not placed in an ICWA-compliant home. Documentation of active efforts, diligent search and good cause to the contrary recommendations must be cited in the plan and demonstrated at each hearing until the child is returned home or placed in an ICWA-compliant home.

DMU provides monthly statistics on timeliness of updated service plans to all child welfare staff statewide in the Monthly Management Report.



**Parental Involvement in Developing Case Plans**

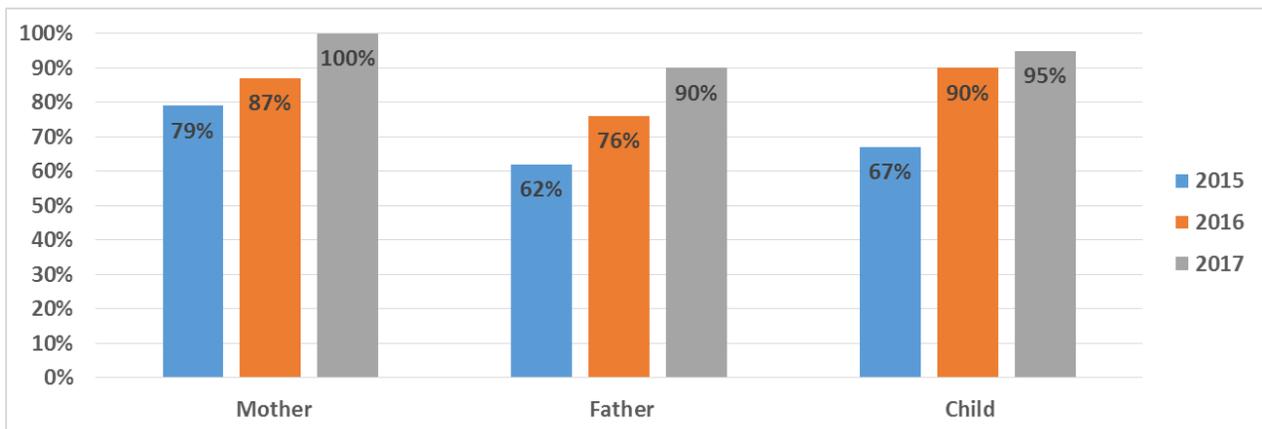
Michigan values joint case planning and implemented the Quality Service Review (QSR) to examine the degree to which meaningful, measurable, and achievable life outcomes specific to safety, permanency, and well-being have been developed in conjunction between the caseworkers and family members.



DCQI completes an annual case record review of documentation within MiSACWIS, the Quality Assurance Compliance Review (QACR), to report on a stratified sample that reflects the population of children in foster care related to compliance of joint case planning with family members. The QACR takes place on a semiannual or annual basis from a statewide representative sample 265 total cases including abuse/neglect temporary state wards, permanent state wards, dual abuse/neglect and juvenile justice state wards.

In 2015, compliance measurement of family involvement in developing case plans was broadened to include documented descriptions of family involvement in family team meetings, planning and decision-making rather than being solely based on the presence of the family member’s signature on the service plan. This change appears to have resulted in a much greater level of compliance because it is based on multiple factors rather than the single factor of a signature on the plan.

**QACR Question:** During the PUR, did the agency make concerted efforts to actively involve the mother/father/child in the case planning process?



## **Item 20: Written Case Plan - Assessment of Performance**

**Objective:** Michigan’s case review system will ensure that the required provisions are included in each child’s case plan.

- Michigan’s Title IV-E Review in 2016 showed 96 percent (77 of 80 applicable cases) were in compliance compared with the Title IV-E Review in 2010, which showed 92.5 percent (74 of 80 applicable cases) were in compliance.
- In 2017, Michigan’s QACR showed that 89 percent of cases reviewed included one or more of the required provisions.

### **Judicial Determinations**

MDHHS and the court collaborate to strengthen the efficiency of actions through training and support of judges, attorneys, and other court staff, particularly regarding the required judicial determinations. While other court orders contained the same language, they also included additional details that clarified and supported the judicial determinations. MDHHS will continue its collaborative efforts to improve the quality of its judicial determinations and court orders.

## **Item 21: Periodic Reviews**

### **Dispositional Review Hearings**

Michigan’s Probate Code, MCL 712A.19, upholds federal requirements to hold dispositional review hearings every six months (182 days). Michigan requires an increased frequency of every 91 days during a child’s first 12 months in foster care if they are not placed with relatives. Parties have the ability to file motions for more frequent hearings.

For a child with a permanency goal of Permanent Placement with a Fit and Willing Relative or Another Permanent Planned Living Arrangement, the dispositional review hearing occurs every 182 days after the permanency planning hearing as long as the child is subject to the jurisdiction, control or supervision of the court, Michigan Children’s Institute Superintendent or other agency.

If the child is returned home, the court shall periodically review the progress as long as it retains jurisdiction. This review must occur no later than 182 days after entry of the original dispositional order or 182 days after the child returns home. A hearing may be accelerated to review any element of the case service plan. Following the hearing, the court may:

- Order the child to be returned home (if parental rights have not been terminated).
- Modify the dispositional order.
- Modify any part of the case service plan.
- Enter a dispositional order.
- Continue the prior dispositional order.

## **Item 21: Periodic Reviews - Assessment of Performance**

Michigan’s achievements in Case Review System outcomes are monitored through the QACR and the QSR, described in the Quality Assurance section of this report. Michigan’s FY 2016 Title IV-E review also provided data for measuring performance.

**Objective:** Michigan’s case review system will ensure that the required provisions are included in each child’s case plan.

- Michigan’s Title IV-E Review showed 96 percent (77/80) of cases were in compliance compared with the Title IV-E Review in 2010, which showed 92.5 percent (74/80) of cases reviewed were in compliance.

**Objective:** For children in foster care, periodic court review hearings will occur timely (every six months).

**Measure:** QACR (see Item 20: Written Case Plan for description)

**Baseline – 2014:** In 91.7 percent of cases, review hearings occurred timely.

**Benchmarks:**

**2015 - 2019:** Demonstrate improvement each year.

- **2015 Performance:** Ninety-five percent of review hearings occurred timely.
- **2016 Performance:** Eighty-two percent of review hearings occurred timely.
- **2017 Performance:** Eighty-six percent of review hearings occurred timely.

SCAO produces data related to compliance with review hearings using the Permanency Indicators Report (PIR). The information in the PIR reports is submitted from each court’s case management system to SCAO. The PIR Statewide Summary Report for 2014, 2015 and 2016 includes information from all counties except those listed below.

The Permanency Indicators Report demonstrates even higher compliance with 182-day (six month) review hearings:

- **2014:** Ninety-seven percent compliance (Oakland and Washtenaw Counties are not included).
- **2015:** Ninety-eight percent compliance (Oakland County is not included).
- **2016:** Ninety-eight percent compliance (Iron County is not included).

If the child is returned home, the court shall periodically review the progress as long as it retains jurisdiction. This review must occur no later than 182 days after entry of the original dispositional order or 182 days after the child returns home. A hearing may be accelerated to review any element of the case service plan. Following the hearing, the court may:

- Order the child to be returned home (if parental rights have not been terminated).
- Modify the dispositional order.
- Modify any part of the case service plan.
- Enter a dispositional order.
- Continue the prior dispositional order.

## **Item 22: Permanency Hearings**

### **Permanency Planning Hearing**

The supervising agency must seek to achieve the permanency-planning goal for the child within 12 months of the child being removed from his/her home. The court must hold a permanency planning hearing within those 12 months to review and finalize the permanency plan.

Subsequent permanency hearings must be held within 12 months of the previous hearing. The only allowable permanency planning goals are the permanency goals recognized by the federal government. The goals, in order of legal preference are:

- Reunification.
- Adoption.
- Guardianship.
- Permanent Placement with a Fit and Willing Relative.
- Another Planned Permanent Living Arrangement.

### **2016 Title IV-E Review**

In collaboration with the Children’s Bureau, Michigan conducted a review of the Title IV-E foster care requirements in FY 2016. The review found that judicial determinations were timely and included rulings that facilitated timely permanency plans.

DCQI reviews permanency planning using the QSR for qualitative information and the QACR for quantitative information. For the counties that were reviewed using the QSR in 2017, the average percent of acceptable cases for the Permanency measure was 84.1 percent. Data for the QACR is as follows:

### **Item 22: Permanency Hearings - Assessment of Performance**

- **Objective 3:** For children in foster care, a permanency hearing will occur no later than 12 months from the date the child entered foster care and no less frequently than every 12 months thereafter.

**Measure:** QACR (see Item 20: Written Case Plan for description)

**Baseline:** Forty-six percent; 2014.

**Benchmarks:**

**2015 - 2019:** Demonstrate improvement each year.

- **2015 Performance:** Ninety-two percent of permanency hearings occurred timely.
- **2016 Performance:** Ninety-seven percent of permanency hearings occurred timely.
- **2017 Performance:** Ninety-seven percent of permanency hearings occurred timely.

The QACR measures permanency hearings by asking reviewers to determine if the child had a permanency planning hearing due during the PUR and if so, was it held within 12 months of the child’s entry into foster care and annually thereafter. The increase in compliance from 92 percent in 2015 to 97 percent in 2016 and maintained in 2017 is encouraging. DCQI will continue to use the QACR to review for this item to ensure continued timely permanency hearings.

### **2016 Title IV-E Review**

The Title IV-E review findings supported findings in the QACR and QSR, that judicial determinations were timely and included rulings that facilitated timely permanency plans. There is no statewide case management system for Michigan courts, as not all courts provide

data to the Judicial Data Warehouse. This makes statewide data collection difficult. To fill this data gap, MDHHS has entered into a data-sharing agreement with SCAO to provide local courts and judges with information on safety and time to permanency in child protective proceedings. These are referred to as Court Improvement Plan (CIP) data reports and are available in the Judicial Data Warehouse to local courts.

### **Item 23: Termination of Parental Rights**

#### **Foster Care and Native American Affairs Policy**

MDHHS policy requires that, unless mandated or ordered by the court in a written order, a petition to terminate parental rights must be filed only when it is clearly in the child's best interest and the health and safety of the child can be ensured in a safe and permanent home.

The filing of the petition to terminate parental rights need not be delayed until a Permanency Planning Hearing. Consultation with legal counsel is necessary to determine if sufficient legal grounds exist to pursue termination of parental rights.

The supervising agency must file or join in filing a petition requesting termination of parental rights if the child has been in foster care for 15 of the most recent 22 months, unless the child is being cared for by relatives or the written court order and the case service plan documents a compelling reason for determining that terminating parental rights would not be in the best interest of the child (MCL 712A.19a). Compelling reasons include:

- Adoption is not the appropriate permanency plan for the child.
- No grounds to file the termination exist.
- The child is an unaccompanied refugee minor.
- There are international legal obligations or compelling foreign policy reasons that preclude terminating parental rights.
- The state has not provided the child's family, consistent with the time in the case service plan, with services necessary for the child's safe return home, if reasonable efforts are required.
- The Indian Child Welfare Act, Michigan Indian Family Preservation Act, or tribe specifies compelling reasons for Indian child(ren) (See Native American Affairs policy 250).

If there is a compelling reason for not filing for termination of parental rights, there must be clear documentation within the case service plan and written court order. Staff from both private and public agencies have access to InfoView data reports that can aggregate statewide data or drill down to BSC, county, agency, supervisor or caseworker level data to keep track of how long a child has been in care. The data can also be broken down by permanency goals.

**State of Michigan**  
**Michigan Department of Health & Human Services**  
**CW-2706 CFC Length Of Time In Care by County - Summary**

**Statewide**

County	Agency	Total Children	Average Length Of Time (In Days) Since Most Recent Removal	Number of Children in Care Since Most Recent Removal (by Month)								
				0 - 3rd Month	4th - 6th Month	7th - 8th Month	9th - 11th Month	12th Month	13th - 15th Month	16th - 18th Month	19th - 24th Month	25th - 36th Month

**Item 23: Termination of Parental Rights - Assessment of Performance**

Item 23 is tracked through the QACR.

- **Objective:** For each child that has been in foster care for 15 of the last 22 months, termination of parental rights petitions will be filed or compelling reasons will be documented.

**Measure:** QACR

**Baseline:** Thirty-eight percent; 2014.

**Benchmarks:**

**2015 - 2019:** Demonstrate improvement each year.

- **2015 Performance:** Sixty-seven percent of termination petitions were filed timely.
- **2016 Performance:** Not available.
- **2017 Performance:** One hundred percent of termination petitions were filed timely.

For counties that were reviewed using the QSR in 2017, the average percent of acceptable cases for the Permanency measure was 84.1 percent.

**Item 24: Notice of Hearings and Reviews to Caregivers**

The Safe and Timely Interstate Placement of Children Act of 2006, PL 109-239, requires state courts “to ensure that foster parents, pre-adoptive parents and relative caregivers of a child in foster care under the responsibility of the state are notified of any proceeding to be held with respect to the child.”

The Michigan Supreme Court incorporated the federal requirement by amending Michigan Court Rule (MCR) 3.921. The rule indicates the court shall ensure that notice is provided to:

- Agency responsible for the care and supervision of the child.
- Person or institution having court-ordered custody of the child.
- Parents of the child, subject to sub-rule (D), and the attorney for the respondent parent, unless parental rights have been terminated.
- Guardian or legal custodian of the child, if any.
- Lawyer-guardian ad litem for the child.
- Attorneys for each party.
- Prosecuting attorney if the prosecuting attorney has appeared in the case.
- Child, if 11-years-old or older.
- If the court knows or has reason to know the child is an Indian child, the child’s tribe,

- Foster parents, pre-adoptive parents and relative caregivers of a child in foster care under the responsibility of the state.
- If the court knows or has reason to know the child is an Indian child and the parents, guardian, legal custodian, or tribe are unknown, to the Secretary of Interior.
- Any other person the court may direct to be notified.

## **Item 24: Notice of Hearings and Reviews to Caregivers - Assessment of Performance**

Item 24 is tracked through the QACR and the SCAO foster parent survey.

- **Objective:** Caregivers will be notified of court hearings and the notification will include how they may exercise their right to be heard.  
**Measure:** QACR and SCAO foster parent survey.  
**Baseline - 2014:** Forty-three percent of caregivers received notification of court hearings and their right to be heard.  
**Benchmarks:**  
**2015 - 2019:** Demonstrate improvement each year.
  - **2015 Performance:** Eighteen percent of caregivers were notified of court hearings, and that they may exercise their right to be heard.
  - **2016 Performance:** Fifty-eight percent of caregivers were notified of court hearings, and that they may exercise their right to be heard.
  - **2017 Performance:**
    - QACR: Sixty-one percent.
    - SCAO foster parent survey: 67 percent received notice of court hearings (300 foster parents responded to the survey).

Notice of hearings is an area needing improvement. It appears that structural and procedural barriers present challenges to notification being provided for every court hearing. Several Michigan county courts provide notice of subsequent hearings to participants prior to ending each hearing. Michigan courts may also provide notice via the postal service. ICWA and MIFPA require Michigan courts and child welfare agencies to send notice to Indian parents, caregivers, tribe(s), and the Secretary of the Interior, including informing tribes of their right to intervene in Indian child custody proceedings. MDHHS sends these notices utilizing the DHS-120 form.

## **Case Review System Plan for Improvement - Activities for 2018 and 2019**

- The adoption program office is collaborating with Casey Family Programs on a pilot to provide Rapid Permanency Reviews in select counties for children on the Michigan Adoption Resource Exchange with an identified adoptive family for greater than twelve months. The goal is to achieve timely permanency for children in out-of-home care. The reviews are designed to simultaneously identify and mitigate case-level and system-level bottlenecks and barriers.
- The DHS 715, Notice of Hearing, is being considered for inclusion in the Central Print Center to be mailed to caregivers from central office, lifting the onus from the caseworker and supervisor and automating the process to improve compliance.

- MDHHS is working with SCAO to develop new court data reports for CFSR Round 3 outcome measures.
- MDHHS will continue to collaborate closely with SCAO to improve foster care case review data collection and analysis and implementation of court improvement efforts.
- DCQI will provide technical assistance to local counties and agencies on how to use management reports and other data to track case management activities.
- The Foster Care Review Board provides third party external review of foster care cases to ensure the system is working to achieve timely permanency for each child.

### **Implementation Support**

- MDHHS continues to collaborate closely with SCAO to improve case review system data collection and analysis and implementation of improvement efforts.
- Collaboration with the Foster Care Review Board continues to inform foster care case management improvement efforts.

### **Technical Assistance and Capacity Building**

- DCQI developed a web-based QACR tool that includes the addition of clarifying language to enable more precise measure of case review system functioning.

## **QUALITY ASSURANCE SYSTEM**

### **Item 25: Quality Assurance System**

Michigan’s quality assurance system functions statewide to ensure that the child welfare system fulfills all five of the federal requirements of a Quality Assurance System:

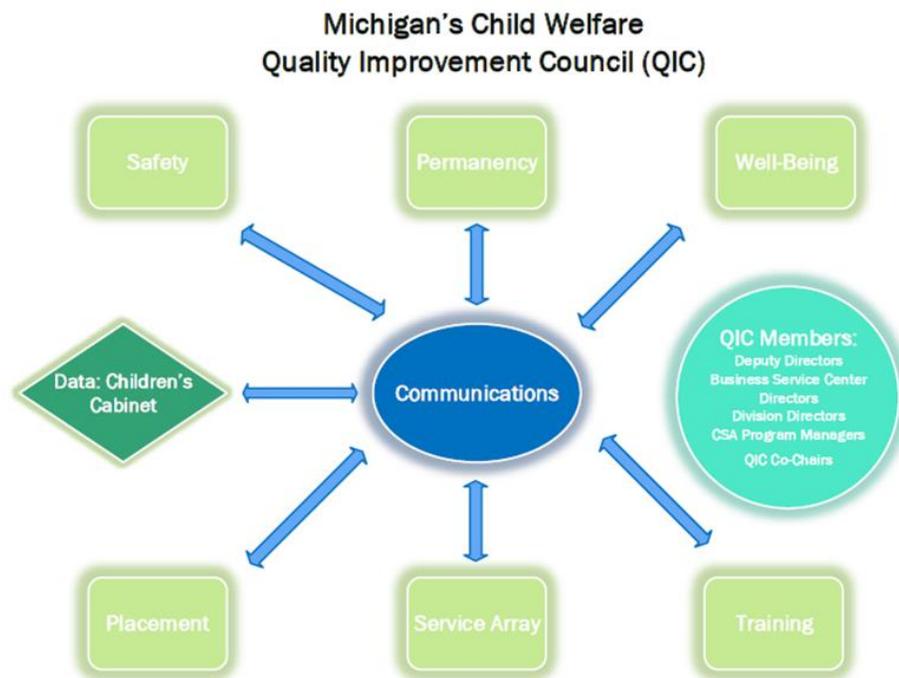
1. Operates in the jurisdictions where the services in the CFSP are provided.
2. Has standards to evaluate the quality of services (including standards to ensure that children in foster care are provided quality services that protect their health and safety).
3. Identifies strengths and needs of the service delivery system.
4. Provides relevant reports.
5. Evaluates implemented program improvement measures.

#### **1. Quality Assurance in the Jurisdictions where CFSP Services Are Provided**

##### **Quality Assurance from the State to the Local Level**

The CSA structure is designed for organizing continuous quality improvement efforts at the state level that funnel into local county and agency levels. Child welfare requirements and concerns are conveyed through the BSCs or for private agencies, Child Welfare Services and Support, coalitions of local MDHHS and private agencies, which, together with CSA management and analysts compose the QIC, the primary state-level child welfare decision-making body. The QIC receives input from the community at large and the federal and state government and develops policies and programs that meet federal standards and respond to the needs of children and families.

Each local MDHHS and private foster care agency has or is establishing a CQI team that ensures the services provided by their agency meet key performance indicators, or implement plans toward meeting standards in their agency. Local MDHHS and agency CQI teams train and reinforce the use of the MiTEAM case practice model with families, ensuring family and child



involvement in goals and service plans by holding effective family team meetings. Technical assistance with local CQI efforts is offered by the division at the state level in developing tools that gather effectiveness data, and at the local level by assisting local CQI teams in implementing program analysis and improvement strategies.

Michigan uses the Quality Assurance Compliance Review (QACR) and the Quality Service Review (QSR) to monitor MDHHS progress serving families in the child welfare system. Performance in Michigan's contracted family preservation services, including Families First of Michigan, the Family Reunification Program and Families Together Building Solutions are monitored through follow-up visits six and twelve months following the conclusion of services to track whether services allowed children to reunite or remain with their families. Technical assistance for these programs is provided by MDHHS Family Preservation Specialists.

**Quality Assurance Processes (QAP)**

Michigan continues to strive to meet statewide requirements of the state's Implementation, Sustainability and Exit Plan (ISEP), following the Modified Settlement Agreement, the product of a lawsuit brought by Children's Rights, Inc. Progress toward each commitment of the plan is tracked through Quality Assurance Processes (QAP). CFSR outcomes are incorporated in some ISEP commitments; hence, work toward completion of those commitments also feeds progress toward federal CFSR and CFSP requirements.

MDHHS implemented targeted reviews of the ISEP commitments below. Each commitment has a web-based review tool that allows for fast, accurate measurement of case documentation in MiSACWIS. QAP reviews are scheduled in response to and in collaboration with the Michigan Monitoring Team, which tracks data reliability and progress. Michigan reviews over 4,000 cases

to determine compliance and quality of work every six months. The samples are representative and statistically significant, based on a 5 percent margin of error with a 95 percent confidence level. DCQI provides technical assistance to local offices and private agencies on proper documentation in MiSACWIS and follows up in any cases in which safety emerges as a concern.

Michigan's current ISEP commitments include:

- 5.2 – Young Adult Voluntary Foster Care.
- 5.3 – Independent Living Services.
- 5.6 – Support for transitioning to adulthood, Family Team Meetings.
- 5.7 – Another Planned Permanency Arrangement Goals.
- 6.10(a) – Separation of Siblings - placement.
- 6.10(b) – Separation of Siblings – efforts to unify siblings.
- 6.16 – Safety requirements for placement with unlicensed relatives.
- 6.22(a) – CPS Investigations – rejected complaints.
- 6.22(b) – CPS Investigations – complaints transferred outside of the agency.
- 6.45 – Immunization requirements completed within three months following placement.
- 6.46 – Immunization requirements completed over three months following placement.
- 6.48 – Child case file complete for medical and psychological.
- 6.49 – Medical passports up-to-date.
- 6.50 – Medical, dental and health content complete in service plans.
- 6.55 – Psychotropic medication documentation.
- 6.56 – Psychotropic medication oversight review.

Commitments listed below have been achieved:

- 5.13 – Maintain health liaison officers to assist provision of medical, dental and behavioral health services for children.
- 5.4 - Provide Michigan Youth Opportunities (MYOI) Initiative programming.
- 5.5 – Providing MYOI services, including local coordinators.
- 5.8 – 5.12 – Permanency Indicators 2 through 5.
- 6.2 – CPS commencements.
- 6.37 – Education enrollment within five days of placement or placement change.
- 6.38 – Education continuity.
- 6.4 – Licensing worker qualifications.
- 6.5 – Maintain foster home array.
- 6.8 – Use of jail facilities for detention of juveniles.
- 6.11 – Maintain treatment foster home beds.
- 6.26 – CPS investigation worker caseloads.
- 6.27 – CPS ongoing worker caseloads.
- 6.28 – Purchase of service caseworker caseloads.
- 6.35 – Use of seclusion and isolation in child caring facilities.
- 6.53 – Psychotropic medication diagnosis.
- 6.56 – Psychotropic medication oversight.

### **Involving Local Stakeholders in Quality Assurance Efforts**

The central office-based QIC and sub-teams include representatives from private agency foster care and adoption agencies, in addition to experts from inside and outside the department that respond to emerging issues and initiatives. The sub-teams refine membership throughout the year to expand collaboration. Specific needs and concerns are assigned to QIC sub-teams according to their field of specialization and sub-teams collaborate to create strategies to address concerns, particularly those from the field.

The QIC consists of eight sub-teams, each of which lead improvement efforts in their area by addressing standards and requirements, concerns expressed by the field and improvement goals on an ongoing basis. Below is a listing of QIC sub-teams and their goals, which demonstrate the use of CQI strategies from the state to the local level in 2017 and 2018.

#### **Safety sub-team**

- **Goal 1:** Maltreatment in care will be reduced below the national standard of 8.5 victimizations. Baseline FY 2015: 14.64
- **Goal 2:** Recurrence of maltreatment during a 12-month period shall be below the national standard of 9.1 percent. Baseline FY 2015: 10.31 percent

#### **Permanency sub-team**

- **Goal 1:** Achieve the national standard of 40.5 percent of children discharged from foster care to permanency within 12 months by increasing the statewide discharge rate 5 percent in six-month period.
- **Goal 2:** Achieve 95 percent for worker-child, worker-parent, parent-child and worker-supervisor contacts in our foster care cases. Performance data is from Monthly Management Reports.

#### **Well-Being Education sub-team**

- **Goal:** Youth in foster care ages 14 and older will be engaged in the development of their service plans and aware of services available to support their development of skills in daily living to become self-sufficient in adulthood.

#### **Well-Being Health sub-team**

- **Goal 1:** At least 85 percent of initial medical exams for children entering foster care will be completed within 30 days. Baseline: 74 percent.
- **Goal 2:** Increase compliance with documentation of informed consent for every psychotropic medication prescribed for a foster child.

#### **Communications sub-team**

- **Goal 1:** Issue informational newsletter to the field based on priorities from QIC goals.
- **Goal 2:** Review effectiveness of current communication strategies to work toward expanding readership. Include new workers and private agency staff.

#### **Placement sub-team**

### Goals:

- **Goal 1:** License 1,129 new foster homes, of which 702 would accept teen placements.
- **Goal 2:** Decrease foster home closures to 27 percent.

### Service Array sub-team

#### Goals:

- **Goal 1:** Identify and implement an efficient mechanism for capturing data from enhanced management and culture tools.
  - Educate child welfare field staff about already existing tools that provide information about local health and human services.
  - Establish a MI Bridges communication campaign and dissemination of training material.
- **Goal 2:** Promote local efforts to evaluate and improve service gap identification.
  - Develop and disseminate material for local county directors/private agency partners in organizing local CQI sub-teams focusing on local service array.
  - Evaluate input from counties and address them with the QIC.
  - Develop a mechanism to perform this activity on an annual basis.

### Training sub-team

- **Goal:** Evaluate efficacy of pursuing a fuller partnership with the universities in provision of child welfare training.

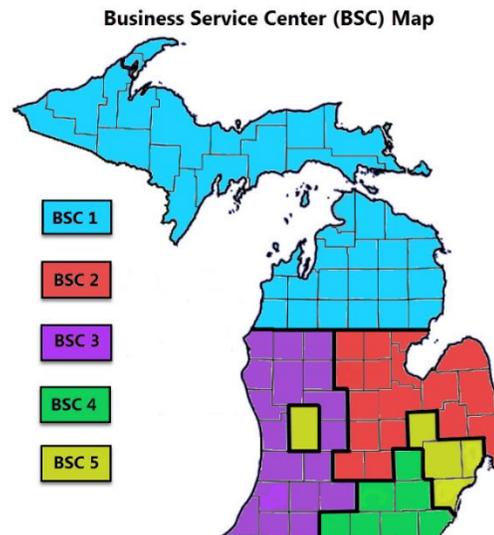
### County Implementation

County CQI teams receive information from the state-level QIC through their respective BSCs, meetings with the CSA executive director and local membership on state-level sub-teams. Each county has its own CQI team and some have sub-teams that guide community efforts, address barriers and direct continuous quality improvement processes. In 2017, MDHHS strengthened county-level teams through the implementation of the enhanced MiTEAM model.

Service data from local counties and agencies is collected and analyzed, and provides direction for future initiatives. Improving local access to data through Infoview and Monthly Management Reports is essential to local improvement efforts. Effectiveness of local efforts is demonstrated in monthly data reports in a feedback loop that in turn drives future efforts. The CSA and the QIC provides strategic leadership that ensures communication and plans are shared statewide and that resources are available in each county for implementing strategies in the field.

### Child Welfare CQI - Quality Service Review

DCQI utilizes the QSR to measure the quality and



effectiveness of services provided to children and families throughout Michigan. Michigan's QSR consists of interviews of case members in child welfare cases to measure the status of children and caregivers during and after service delivery. QSRs also include focus groups or individual interviews of first-line staff, supervisors, community members, the court, foster parents and foster youth to obtain each group's unique perspective. The resulting QSR report provides a robust picture of child welfare services in each community, along with clear documentation of where improvement is needed.

QSRs are conducted in each BSC every year. QSRs are completed in contiguous counties within a BSC, with the exception of the BSC representing the five urban counties. For BSC 5, the QSR is conducted every other year. In all other BSCs, a selection of contiguous counties is made in concert between the division, BSC and county directors. DCQI provides a selection of counties that have not had a QSR to the BSC directors for consideration. The BSC directors and the county directors make the determination on which counties should be selected for the QSR. The selection process takes place between the months of April and July with a final selection of the fiscal year reviews no later than August of the preceding fiscal year.

DCQI has a goal to increase the number of cases reviewed to 25 cases per BSC when doing a contiguous county review. In urban settings, the goal is to review 25 cases. Currently, in each QSR, there are, on average, 16 cases reviewed, totaling a minimum of 80 cases reviewed annually. The process to increase the number of cases for review is dependent upon the number of certified mentors and reviewers available for the review weeks.

### **Statewide QSR Process**

The history of Michigan's QSR development is outlined below:

- The QSR was piloted in 2014 in four county offices: Mecosta/Osceola, Lenawee, Kalamazoo and Kent.
- Following the pilot QSR, four additional county offices underwent a QSR in 2014. Ninety-six total cases were reviewed.
- In 2015, the QSR was conducted in five counties: Bay, Oakland, Wayne, Jackson and Grand Traverse, reviewing 65 cases.
- In 2016, the county selection process was altered to conduct QSRs in contiguous counties or regions, allowing a greater number of counties to receive a QSR each year.
- In 2016, the original pilot counties of Mecosta/Osceola, Lenawee and Kent were reviewed for a second time to track performance levels over the two ensuing years.
- In 2016, the QSR review included 41 open foster care cases and 23 ongoing CPS cases totaling 64 cases.
- Implementation of the enhanced MiTEAM case practice model began in 2016. A MiTEAM Fidelity Tool was created to be used by managers in supervising first-line staff and continue guiding work along MiTEAM principles.
- In 2017, 90 foster care cases were reviewed.<sup>2</sup>

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<sup>2</sup> In 2017, the QSR did not review CPS ongoing cases because several QSR items were reported in the ISEP, which requires a minimum number of cases to be reviewed each period. The ISEP plaintiff class

- In 2017, implementation of the enhanced MiTEAM continued and was fine-tuned. The MiTEAM Fidelity Tool was piloted in three counties, with rollout to the remaining counties planned later in 2018.
- In 2017, it was determined that counties will complete a Practice Improvement Plan (PIP) following their QSR (described below).

### **Reviewer Training**

QSR reviewers complete training consisting of eight hours of classroom training with certified facilitators, followed by shadowing a certified mentor on one or more case reviews. After shadowing, the trainee leads a case review and the certified mentor acts as the trainee's coach through the review and provides feedback. Certification is achieved after a trainee demonstrates understanding of QSR protocol and proper implementation of rating and conducting interviews.

### **Case Selection**

Cases in counties designated for review are randomly selected and included in the review if the parent or guardian is willing to participate. CPS ongoing cases are stratified based on age distribution of the children. Foster care cases are stratified based on age, living arrangement and permanency goal. The sample is stratified proportionate to the public/private foster care agency split in each county.

### **QSR Review Protocol**

QSRs consist of interviews of case members, such as caseworkers, teachers, therapists and other service providers, caregivers, family members and children when appropriate, to obtain diverse perspectives.

In addition to interviewing case members along a standard protocol, each QSR includes stakeholder interviews conducted in individual and group settings (focus groups) that include MDHHS and private agency staff. Stakeholder interviews include judges, attorneys and court personnel, MDHHS and private agency directors and child welfare supervisors. Focus groups include the community's mental health service providers, foster parents, foster youth participating in Michigan's Youth Opportunities Initiative, child welfare supervisors and staff.

### **Quality Service Review in 2017**

DCQI completed reviews in the following BSCs and counties:

- BSC 1 – Luce, Chippewa, Mackinac, Dickinson and Menominee counties (July 2017).
- BSC 2 – Clinton, Eaton, Gratiot and Shiawassee counties (January 2017).
- BSC 3 – Ionia, Montcalm, Allegan and Barry counties (May 2017).
- BSC 4 – Livingston and Washtenaw counties (June 2017).
- BSC 5 – Macomb County (November 2016).
- BSC 5 – Wayne County (March 2017).

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consists of foster care cases only, and DCQI did not have the staffing capacity to review CPS ongoing cases in addition to the required minimum. In 2018 and going forward, CPS ongoing cases will be included in QSRs.

- BSC 5 – Genesee County (September 2017).

Ninety foster care cases were randomly selected for review that included 671 case interviews. Each case was randomly selected from a sample that was stratified based on children’s age, placement type and case status representative of each county’s current child welfare population.

### **Quality Assurance Compliance Review (QACR)**

Michigan measures compliance with federal CFSR standards, state law and MDHHS policy in the QACR through examination of case documentation. The QACR reviews the following information in MiSACWIS and paper files:

- Assessments and service plans.
- Educational status and services.
- Medical Passport.
- Medical, dental and mental health services.
- Medical insurance coverage.
- Compliance with the Indian Child Welfare Act and the Michigan Indian Family Preservation Act.

The QACR review tool is a web-based, automated tool, which selects, assigns and tracks cases, and provides post-review results. QACR results on CFSR requirements are reported in the Annual Progress and Services Report (APSR).

The QACR takes place semi-annually and reviews 265 cases from a statistically valid sample representative of all jurisdictions statewide. Cases of dual abuse/neglect and juvenile justice wards are included in the sample. The QACR instrument is modified as needed to ensure evolving practice in the field matches best practices as identified by the Children’s Bureau, MDHHS administration, QIC sub-teams, the court monitoring team and other stakeholders.

### **Case Selection**

- The sample of cases to be reviewed is stratified to reflect the population of children in foster care.
- The cases are divided into two samples by date of entry into foster care to capture data on initial and updated service plans and initial and yearly medical, behavioral and dental health requirements.
- The DCQI lead analyst screens cases in the sample prior to the review to ensure that each case meets the criteria for inclusion.

## **2. Standards to Evaluate the Quality of Services**

### **Quality Service Review Standards**

Michigan’s QSR protocol utilizes 12 indicators for measuring child and family status and seven indicators for measuring case practice performance in open CPS and foster care cases. Child and Family Status Indicators are determined based on a review of the focus child and the

parent(s)/caregiver(s) for the most recent 30-day period, with the exception of Safety – Behavioral Risk to Self or Others, which reviews behavioral risk in the past 180 days. Practice Performance Indicators are determined based on a review of the most recent 90-day period for cases that have been open for at least the past 90 days.

**Child and Family Status Indicators<sup>3</sup>**

1. Safety from Exposure to Threats of Harm.
2. Safety from Behavioral Risks to Self or Others.
3. Stability.
4. Permanency.
5. Living Arrangement.
6. Physical Health.
7. Emotional Functioning.
- 8a. Early Learning and Development (under age 5)
- 8b. Academic Status (age 5 and older)
9. Independent Living Skills (age 14 and older)
10. Voice and Choice.
11. Family Functioning and Resourcefulness.
12. Family Connections.

**Practice Performance Indicators**

1. Engagement.
2. Teaming.
3. Assessment and Understanding.
4. Long-Term View.
5. Case Planning.
6. Implementing Interventions.
7. Tracking and Adjustment.

Each indicator is rated on a six-point scale to determine the level of the child status and the quality of performance indicators. The ranges are depicted below:

Child and Family Status		Practice Performance		Performance Zones	Overall Rating
6	Optimal status	6	Optimal practice	Maintenance	Acceptable
5	Good status	5	Good practice		
4	Fair status	4	Fair practice	Needs	
3	Marginal status	3	Marginal practice	Refinement	Not acceptable
2	Poor status	2	Poor practice	Needs	
1	Serious and worsening status	1	Absent or adverse practice	Improvement	

<sup>3</sup> Child and Family Status and Practice Performance Indicators are changed slightly in the updated QSR Protocol, and those listed above are the updated indicators. Data cited in other areas of this report reflect the performance and practice indicators in the original QSR Protocol.

QSR results are provided to local communities through feedback at the time of the QSR and through a written summary following their QSR. The written summary includes suggested steps for improvement.

### 3. Strengths and Needs of the Child Welfare System

QSR and QACR results provide high-level information on MDHHS' progress on federal and state requirements and inform case practice improvement efforts statewide. QSR and QACR findings are below.

#### Quality Service Review Findings

The tables below illustrate the results of QSRs since its inception in 2014 through FY 2017, as shown in percentage of cases that were rated satisfactory for each child and family status or practice performance indicator. Generally, Michigan communities perform better in the areas of the Child and Family Status Indicators than in the Practice Performance Indicators.<sup>4</sup> It is expected that over time, as the enhanced MiTEAM implementation continues, Michigan's performance in the QSR Practice Performance will continue to improve.

Child and Family Status Indicator	Percent Cases Rated Satisfactory			
	2014	2015	2016	2017
Safety: Exposure to Threats	94.4	93.7	95.4	97.7
Safety: Behavioral Risk	90.1	88.3	88.0	93.4
Stability	71.8	78.3	81.5	86.3
Permanency	79.3	77.4	89.7	84.1
Living Arrangement	94.8	89.2	95.3	97.8
Physical Health	98.4	97.7	96.1	98.9
Emotional Functioning	84.3	80.8	84.3	94.9
Learning and Development	75.4	85.3	86.3	86.4
Voice and Choice	62.5	44.2	63.1	57.4
Family Functioning/Resourcefulness	38.2	44.3	56.5	31.4
Caregiving	94.6	95.0	92.5	98.7
Family Connections	64.6	55.6	79.6	62.3
<b>Child and Family Status Indicator Average</b>	<b>77.1</b>	<b>67.7</b>	<b>79.7</b>	<b>76.7</b>

Practice Performance Indicator	Percent Cases Rated Satisfactory			
	2014	2015	2016	2017
Cultural Identity and Need	84.4	95.4	96.9	97.8
Engagement	61.9	47.1	70.5	65.0
Teaming	28.8	23.6	57.3	37.4
Assessment and Understanding	56.5	57.1	76.3	64.4
Long-Term View	44.8	38.5	67.2	64.4

<sup>4</sup> QSR results are also provided in the Safety, Permanency and Well-Being Statewide Assessments.

Planning Interventions	69.9	62.9	80.8	80.8
Implementing Interventions	61.4	50.8	81.3	74.4
Medication Management	90.9	94.4	95.0	93.8
Tracking and Adjustment	51.2	43.1	75.0	52.2
<b>Practice Performance Indicator Average</b>	<b>41.7</b>	<b>33.9</b>	<b>71.9</b>	<b>60.0</b>

### Strengths

- In the two QSR Safety indicators, Michigan has historically performed above 85 percent, and this figure is trending upward.
- Living Arrangement, Physical Health and Emotional Functioning (of the target child) and Caregiving also demonstrate strengths.
- Practice Performance Indicators demonstrate strengths in Cultural Identity and Need and Medication Management over the period from 2014 through 2017.

### Concern

Voice and Choice, Family Functioning/Resourcefulness and Family Connections show there is room for improvement that has persisted over time.

- Teaming and Engagement scores indicate a need for improvement in collaborating with families, as well as Assessment and Understanding and Long-Term View.

Since QSR results are case-specific, the feedback provided to county and agency staff at the end of each review provides specific and actionable steps that can be taken to improve status and practice in current cases.

### Family Preservation Services Continuous Quality Improvement

Michigan offers an array of evidence-based contracted family preservation services:

- Families First of Michigan, available in all 83 Michigan counties.
- Family Reunification Program, available in 73 Michigan counties.
- Families Together Building Solutions, available in 42 Michigan counties.
- Protect MiFamily, piloting in three counties.

To ensure high quality services are being provided with model integrity, MDHHS Family Preservation Specialists complete case record reviews at least annually for each supervisory team. They attend staff meetings in which cases are discussed and feedback offered. Results from follow-up visits, case reviews and staff meetings form the basis of ongoing technical assistance and training for family preservation staff.

Michigan's family preservation contractors are responsible for following up in person with families at six and 12 months after the conclusion of services to learn whether the children have remained in the family home. If a family is in need of services to prevent removal at the time of the follow-up, they are provided with referrals and short-term assistance.

The tables below show Family Preservation Program data for the years 2014 through 2017.

<b>Family Preservation Service 2014</b>	<b>Number of families served In 2014</b>	<b>Intact at 12 mos.</b>
Families First of Michigan	2,381	88.3%
Family Reunification Program	903	83%
Families Together Building Solutions	415	95%
<b>Total families served</b>	<b>3,699</b>	

<b>Family Preservation Service 2015</b>	<b>Number of families served In 2015</b>	<b>Intact at 12 mos.</b>
Families First of Michigan	2,440	89%
Family Reunification Program	952	88%
Families Together Building Solutions	2,922	93%
<b>Total families served</b>	<b>6,314</b>	

<b>Family Preservation Service 2016</b>	<b>Number of families served In 2016</b>	<b>Intact at 12 mos.</b>
Families First of Michigan	2,026	89%
Family Reunification Program	1,031	85%
Families Together Building Solutions	2,283	94%
<b>Total families served</b>	<b>5,340</b>	

<b>Family Preservation Service 2017</b>	<b>Number of families served In 2017</b>	<b>Intact at 12 mos.</b>
Families First of Michigan	2,520	87.3%
Family Reunification Program	943	89%
Families Together Building Solutions	3,043	94%
<b>Total families served</b>	<b>6,506</b>	

#### **4. Provision of Relevant Reports**

Quality assurance data reports provided to local offices and private agencies include:

- Weekly staff caseload reports by county and agency to allow tracking of child welfare caseloads.
- Monthly management reports, which report on CPS investigation initiation and face-to-face contacts, standards of promptness for CPS and foster care reports and timely medical and dental exams.
- Infoview data reports, accessible in MiSACWIS aggregate statewide data or drill down to BSC, county, agency, supervisor or caseworker level data. Staff can run this report for specific dates and capture point-in-time data to track their progress before the monthly management report is released.

The above reports provide MDHHS, QIC and sub-teams, BSC and local management with the

information needed to gauge whether local offices and agencies are meeting policy requirements and where to direct improvement efforts.

DCQI conducts a variety of reviews on an ongoing and as-needed basis, which provide detailed information on areas of concern and special projects. These include:

- Maltreatment in Care Review.
- Centralized Intake Review.
- Protect MiFamily Review, Michigan’s Title IV-E waiver pilot.
- Information System Review.

**Quality Service Review Feedback Process**

QSRs provide valuable reports to local offices and agencies on current and recently closed CPS and foster care cases. Immediate feedback on the cases reviewed is provided during the week of the QSR to the local director and staff that include the scoring results of the child and family status and practice performance indicators for each case. This includes a presentation of each case that includes the family and child’s recent progress and prognosis for the next six months.

Preliminary feedback from stakeholder interviews and focus groups is also provided, showing compiled strengths and challenges in casework and suggesting trends that may affect service quality. From this feedback and other information, agency caseworkers and supervisors devise the next steps to overcome concerns and ensure success in their cases.

Following the QSR, each county or agency receives a written report that includes compiled status and practice indicator results showing the strengths and challenges observed in the review, as well as case stories, detailed descriptions showing the strengths and concerns in each case reviewed. Report document suggested steps to facilitate improvement based on compiled ratings of each indicator.

**QSR Practice Improvement Plans**

Among recent revisions to the QSR protocol, a Practice Improvement Plan (PIP) is required of each county following their QSR (details later in this section). The PIP is due to the BSC director 30 days from the county’s receipt of the final QSR report.

**Quality Assurance Compliance Review Results**

The QACR examines CFSR items that are measured in regular data reports and reported in each APSR. A results comparison from 2015, 2016 and 2017 for selected QACR questions is in the table below.

QACR Review Question	Percent Satisfactory		
	2015	2016	2017
Did the child have visits of sufficient frequency with the mother to promote the parent/child relationship?	84	93.2	100.0
Did the child have visits of sufficient frequency with the father to promote the parent/child relationship?	65	81.0	94.0

Was the child placed with a relative during the period under review?	46	55.8	56.0
At the time of the initial out-of-home placement, were there active efforts documented to identify, locate, inform and evaluate relatives as potential placements?	97	84.1	94.0
Was there documentation of concerted efforts to maintain the child's connections with his/her neighborhood and community?	74	80.7	94.0
Was there documentation of concerted efforts made to ensure that visitation with siblings was of sufficient frequency to maintain or promote the continuity of sibling relationships?	Not available	62.9	83.0
Was there documentation that concerted efforts were made to maintain the child's connections with his/her extended family?	87	75.5	45.0
Did the caseworker visit the child a minimum of once each calendar month?	96	97.1	96.4
Was the school-aged child registered and attending school within five days of any placement change?	86	Not available	83.0
Was the child's need for educational services assessed and if needed, were educational services provided?	88	96.3/92.2	97.0/100.0

### Strengths

- Michigan's performance in children's visits with their parents has improved since 2015.
- The state's performance in caseworker visits with children has remained above the National Standard of 95 percent since 2015.
- Michigan has shown a strong and improving performance in assessing and providing for children's educational needs.

### Areas for Improvement

- Michigan's performance on sibling visitation, although improved since 2015, remains an area needing improvement.
- Michigan has work to do to improve maintaining a child's connections with their extended families.
- Michigan has room for improvement in timely enrollment of children in school after a foster care placement or placement change.

## 5. Evaluation of Implemented Quality Improvement Efforts

### Quality Service Review Practice Improvement Plans

As a part of recent revisions to the QSR protocol, a Practice Improvement Plan (PIP) is required of each county following their QSR. The PIP is due to the BSC director 30 days from the county's receipt of the final QSR report.

- Practice Improvement Plans are developed by the CQI team in each county office.
- The local CQI team reviews the QSR and identifies three findings on which to base a PIP for the next 12 months.
- The CQI team indicates which QSR findings have been previously noted within other

audits or reviews (i.e., Division of Child Welfare Licensing, Ombudsman, Family Advocate). The county reviews compliance with previously established improvement plans, progress and barriers and includes progress with the PIP.

- The county provides quarterly progress reports to the BSC director by the 15<sup>th</sup> day of the month following the end of the quarter.
- The BSC director monitors progress and approves the completion of each PIP. For PIPs that are not completed satisfactorily, the BSC director determines the appropriate course of action to bring the county into compliance.

### QSR Participant Survey

In 2017, MDHHS conducted a survey of staff in each county that was the subject of the QSR. Sixty-seven responses to the survey were received, representing all five BSCs. Direct service workers and their supervisors were the most strongly represented, with 25 and 24 responses respectively. Thirty-eight responses came from MDHHS offices, while 29 were received from private agencies.

Survey Question	Agree	Neutral	Disagree
1. During the QSR planning process, I was fully informed of all expectations.	56	8	3
2. During the planning process, I was able to ask questions and was provided with clear answers.	58	9	0
3. I was provided with adequate time to prepare for the QSR.	58	6	3
4. I was treated respectfully during the QSR process.	64	2	1
5. The assigned QSR team members were professional and timely.	64	2	1
6. The QSR process was fair.	57	5	5
7. The QSR process was helpful.	50	11	8
8. I was fully engaged by the assigned team members during the QSR process.	59	6	2
9. I have a clear understanding of the QSR.	56	7	4

### What things did you like about the QSR process?

- Many respondents liked receiving feedback regarding their case from a neutral party.
- Many respondents enjoyed the case debriefings, as they were able to obtain a new perspective or explore new ideas.
- Many respondents liked that the QSR reviewed quality of case management, rather than what was documented in the case file.

### Do you have any suggestions for changes that would be helpful to the QSR process?

- Some respondents stated there was confusion regarding focus groups, as to who was responsible for scheduling and who should attend.
- Some respondents would like more cases to be reviewed.
- Some respondents did not believe the weekly conference calls were necessary.

## **QSR Strengths**

- The majority of QSR participants found the process to be helpful.
- Most QSR participants were satisfied with the way the QSR was conducted and were able to get the information they needed about the QSR process.
- The vast majority of participants felt the QSR was fair.

Overall, the majority of negative feedback concerned the process or communication regarding the focus groups. Participants felt the feedback on their cases was helpful.

## **Continuous Quality Improvement Feedback**

CQI reports provide the CSA, the QIC and sub-teams, BSC and local directors and managers with the information needed to gauge whether local offices and agencies are meeting policy requirements and where to direct improvement efforts. Below is a sampling of the feedback loops active in Michigan's child welfare system.

- In 2015, QACR results on parental involvement with the development of case plans were shared with the foster care program office, which addressed family involvement through amending policy to require family team meetings at key points during foster care cases and enhanced training on conducting family team meetings. Data from 2016 and 2017 QACRs show improved documentation of parent involvement is present.
- BSC directors review and approve county Practice Improvement Plans (PIP) from local QSRs and monitor progress toward PIP goals. A lack of progress necessitates further work with the assistance of BSC analysts, with ongoing monitoring by BSC directors.
- In the enhanced MiTEAM training, county offices and agencies receive specialized training and coaching in the model to assist caseworkers with involving parents and documenting their involvement in development of service plans. DCQI uses the information collected in QSR and QACR reviews to complete reports for distribution to stakeholders and publishing on the MDHHS public website. Analysis of data and reporting results is critical in a feedback loop that drives ongoing efforts.
  - Reports include an analysis of compliance with policy as well as strengths and opportunities to improve practice.
  - Results are used to develop training, track progress and demonstrate to stakeholders the status of service provision.
  - Feedback from tribes informs MDHHS decisions on training, supervision and mentoring of caseworkers on sufficient inquiry of Indian heritage and provision of active efforts in cases of Indian children.
  - QACR results on assessment of need and provision of educational services are shared with the foster care program office and the Education and Youth Services Unit for monitoring of progress and planning for ongoing improvement.

## **Review Protocols and Targeted Reviews**

In developing case reviews, DCQI:

- Develops review protocols and tests the efficacy of the protocols prior to full use.
- Determines the type and number of cases to be reviewed, the manner of selecting cases and the implications of the number and selection process for generalizing findings.

- Ensures that trained staff is available to conduct case reviews.
- Determines data analysis.
- Reports findings in a timely manner to assure strengths and areas needing improvement are identified and communication with key stakeholders facilitated.

## **Item 25: Quality Assurance System – Assessment of Performance**

**Goal:** MDHHS will maintain an identifiable quality assurance system.

- **Objective 1:** The MDHHS quality assurance system will operate in jurisdictions where services in the Child and Family Services Plan are provided.

**Measure:** Implementation of QSRs.

**Baseline:** Completion of eight QSRs; 2014.

**Benchmarks:**

- **2015:** Completion of seven QSRs, including Michigan’s largest county, Wayne (in three districts, counting as three QSRs).
  - **2016:** Review of the original pilot counties of Mecosta/Osceola, Lenawee and Kent for a second time. QSRs were conducted in nine counties total, reviewing 64 cases. In addition, in 2016, two test CFSR reviews were conducted.
  - **2017:** The QSR was completed in 18 counties, reviewing 90 cases.
- **Objective 2:** The MDHHS quality assurance system will have standards to evaluate the quality of services, including standards to ensure that children in foster care are provided quality services that protect their health and safety.
- Measure:** Completed revision of the QSR protocol.
- Baseline:** Completed the QSR protocol; 2014.
- Benchmarks:**
- 2015:** The new QSR protocol was used to review 47 foster care and 18 CPS cases, totaling 65.
- 2016 – 2019:** Evaluate QSR and revise as necessary.
- **2015 Performance:** The new QSR protocol was released in November 2014 and utilized in 47 foster care and 18 CPS case reviews in five counties.
  - **2016 Performance:** The QSR protocol was used to review 41 foster care cases and 13 CPS cases in 13 counties.
  - **2017 Performance:** The QSR protocol was used to review 90 foster care cases.
- **Objective 3:** The MDHHS quality assurance system will identify strengths and needs of the service delivery system.
- Measures:** Completion of county QSR reports and annual QSRs.
- Baseline:** Completion of county and annual report of the QSRs; 2015.
- Benchmarks:**
- **2015 Performance:** County and annual QSR reports were completed.
  - **2016 Performance:** County and annual QSR reports were completed.
  - **2017 Performance:** County and annual QSR reports were completed.
  - **2018 Performance:** The CFSR Statewide Assessment was completed.

- **Objective 4:** The MDHHS quality assurance system will provide relevant reports.  
**Measures:** Annual QSR Report, county QSR reports, monthly management reports, CFSR data provided by the University of Michigan Child and Adolescent Data Lab.  
**Baseline:** Completion of 2015 Annual QSR Report and county QSR reports.  
**Benchmarks:**
  - **2015 Performance:** The 2015 Annual QSR Report and county QSR reports were completed.
  - **2016 Performance:** The 2016 Annual QSR Report and county QSR reports were completed.
  - **2017 Performance:** The 2017 Annual QSR Report and county QSR reports were completed.
  
- **Objective 5:** The MDHHS quality assurance system will evaluate program improvement measures.  
**Measure:** A process for providing feedback to the field that facilitates self-evaluation and program improvement on an ongoing basis.  
**Baseline – 2015:** Development and utilization of a comprehensive feedback process.  
**Benchmarks:**
  - **2015 Performance:** QSR county reports and verbal feedback was provided.
  - **2016 Performance:** A comprehensive feedback process was developed in collaboration with the field.
  - **2017 Performance:** A program improvement plan protocol was developed for counties after undergoing QSR.

### **Plan for Improvement - Activities for 2018 and 2019**

- DCQI will continue to provide training and technical assistance for the BSCs, local offices and private agencies to assist the use of data to target outcomes specific to each community.
- QSR results will continue to be provided to local directors and staff through on-site meetings and a written report. Counties will submit Practice Improvement Plans to respond to needs identified in the review.
- DCQI will review the results of the 2017 QSR Participant Survey and consider making changes to the QSR process in response to feedback.
- DCQI will conduct the QACR semiannually, reviewing cases from a statistically valid sample representative of all jurisdictions statewide. Cases of dual abuse/neglect and juvenile justice wards are included in the review population. The sample of cases is stratified to reflect the population of children in foster care. The cases are further divided into two samples by date of entry into foster care to capture data on initial and updated service plans and initial and yearly medical, behavioral and dental health requirements.
- DCQI will use a web-based application developed in 2017 that automates data collection, which improves data quality. QACR results will be used to determine training and other activities in the field to improve performance.

- DCQI will continue to develop and refine case review protocols to provide information on the functioning of services to children and families throughout the state.
- MDHHS will engage stakeholders as reviewers and train them to ensure reviews are conducted in a consistent and systematic manner.
- DCQI will provide technical assistance on how local offices and agencies can use data from the following sources to inform on trends, strengths and opportunities for improvement:
  - University of Michigan Child and Adolescent Data Lab.
  - Child and Family Services Review.
  - QSR.
  - Quality Assurance Process reviews (ISEP).
  - Monthly Management Reports.
  - InfoView.
- DCQI will conduct appropriate data analyses and report the data in clear and easily readable formats.
- DCQI reports will include an interpretation of the data in a manner consistent with the methodology and that answers the questions posed in the review.
- MDHHS will use data and feedback from stakeholders to implement measures to improve performance in an ongoing continuous quality improvement cycle.

### **Implementation Support**

- DCQI is working with the BSC and county directors to develop a standard process for county agencies to use for incorporating QSR feedback into their county-level improvement plans.
- MDHHS is developing processes for providing training and technical assistance to the BSCs, local offices and private agencies for using data to target outcomes specific to each community.

### **Program Support**

- MDHHS engages and trains stakeholders as case reviewers to ensure reviews are conducted in a consistent and systematic manner.
- DCQI provides technical assistance to local counties and agencies on how to use management reports and other data to track case management activities.
- County implementation teams engage in continuous quality improvement efforts as determined by the data in the monthly management reports.

### **Technical Assistance and Capacity Building**

- MDHHS implemented a statewide plan for the MiTEAM enhancement that included virtual learning, practice and application exercises and observation and support.
- Michigan contracts with the University of Michigan Child and Adolescent Data Lab to monitor Safety and Permanency outcomes.
- With support from the Children’s Bureau, MDHHS underwent the Round 3 CFSR in 2018.

## STAFF AND PROVIDER TRAINING

To prepare child welfare professionals in Michigan to carry out their responsibilities, the Office of Workforce Development and Training (OWDT) collaborates with the CSA through the QIC Training sub-team. This sub-team:

- Provides input to the training plan for child welfare and assists in monitoring progress.
- Reviews curricula, learning objectives, training outlines, job aids and other training materials developed by MDHHS, contractors or partners for delivery.
- Reviews evaluation summaries and identifies workforce performance gaps and recommends, reviews and prioritizes training solutions.

The learning management system is working well for both MDHHS and private agency staff. A dedicated learning management system quickly responds to individual and systemic issues.

Note: For the APSR, MiSACWIS training is described in the Information System section to assist matching staff training needs with training opportunities provided by MDHHS.

### Staff and Provider Training Reporting

- Child welfare training funded through Title IV-E is included on the Title IV-E Training Matrix can be seen in Attachment K.
- Child welfare courses completed between Oct. 1, 2016 and Dec. 31, 2017, are listed on the attached OWDT course list, along with the number of trainees in Attachment L.
- University data reflects Oct. 1, 2016 through Sept. 30, 2017; see the in-service Child Welfare Training Initiative Final Evaluation Report, Attachment M.
- Additional information can be found in the attached Staff and Provider Training Plan, Attachment Q.

### Item 26: Initial Staff Training

Michigan's performance in initial staff training is tracked through learning management system data, training evaluations and through the Training sub-team of the QIC.

Between Oct. 1, 2016 and Dec. 31, 2017, 922 new caseworkers completed the nine-week Pre-Service Institute training. Caseworkers are required to complete initial training within 112 days of hire; 98 percent of caseworkers completed training timely. The breakdown between MDHHS and private agency caseworkers:

- MDHHS: 593
- Private agency: 329

The breakdown by program:

- Adoption: 38
- Adoption Child Welfare Certificate: 3
- CPS: 418

- CPS Child Welfare Certificate: 18
- Foster care: 475
- Foster Care Child Welfare Certificate: 30

MDHHS continues to collaborate with 13 Michigan undergraduate schools of social work and three graduate schools of social work to offer the Child Welfare Certificate. Students who complete this program are able to complete a condensed version of the Pre-Service Institute prior to being assigned a caseload. This program continues to grow and thrive each year; in 2017, 57 Child Welfare Certificate holders were hired.

Program Specific Transfer Training is available for specialists who have completed initial training and are changing programs. In 2017, Program Specific Transfer Training completions included:

- Adoption: 65
- CPS: 139
- Foster care: 128

### **Level One Evaluation – Initial Staff Training**

Level one evaluation is feedback provided by trainees immediately after completing training. Highlights from level one evaluation feedback of pre-service institute training include:

- After three weeks of training:
  - Eighty-eight percent of trainees strongly agree or agree that the training provided them with the knowledge and/or skill that were identified in the course objectives.
  - Eighty-seven percent strongly agree or agree that they could explain the eight phases of a forensic interview.
- After nine weeks of training:
  - Ninety-seven percent of trainees strongly agree or agree that they understand and are confident that they could meet the policy requirements of their position.
  - Ninety-nine percent strongly agree or agree that they understand the importance of meeting social work contacts.

### **Level Two Evaluation – Initial Staff Training**

In level two evaluation, the effectiveness of training is measured through completion by the trainer and field supervisor of a competency-based evaluation of each trainee. Trainees are required to pass (70 percent or higher) two written exams and a competency evaluation. Trainees who do not pass receive additional support and re-take the exam.

Post-training exam scores in 2017:

<b>Exam</b>	<b>Range</b>	<b>Average</b>
General child welfare	65-100%	86%
Adoption	70-94%	85%
Children’s Protective Services	62-97%	88%
Foster care	61-97%	85%

Trainees who do not pass the competency evaluation are not permitted to assume a full caseload. In some instances, this has resulted in the local office placing the person in a non-caseload carrying position, or the person being separated from child welfare service.

### **Level Three Evaluation – Initial Staff Training**

In level three evaluation, trainees' skills are measured by the caseworker and supervisor to track whether trainees are able to apply the skills they learned on the job. The level three evaluation measures job performance of a new hire at three and 12 months post training completion. The evaluation asks questions about how well new caseworkers are meeting Pre-Service Institute training objectives. Data from the level three evaluations has provided valuable feedback. Many supervisors indicate that training is providing staff with a base knowledge and opportunities to learn. Recommendations for improvement include:

- Increased MiSACWIS training.
- Stronger emphasis on locating and interpreting policy while in the field.
- More training around report writing, petition writing and court testimony.
- Increased communication between trainers and field supervisors.

In addition to the information above, the level three evaluations collected what the supervisors feel are barriers to the transfer of learning. Because trainees receive cases during training, some of the supervisors suggest that trainees struggle between the priorities of leaning their new job and doing their new job. Supervisors also indicate that a strong mentor and more on-the-job training would be beneficial.

The collection of this data will continue to take place as part of continuous quality improvement and regularly informs consideration of innovative ways to improve and strengthen the pre-service institute.

### **Progress in 2017**

- Extensive discussions with partners, and analysis of evaluation results provided a foundation for improvements to the Pre-Service Institute. In January 2017, the reformatted Pre-Service Institute was implemented to reflect the changes piloted in 2016.
- The Child Welfare Certificate Program continues to grow and provide opportunities to hire well-prepared child welfare caseworkers.

### **Initial Supervisory Training**

New supervisors are required to complete a five-day child welfare supervisory training within three months of hire or promotion. Between Oct. 1, 2016 and Dec. 31, 2017, 295 people completed supervisory training, 123 participants were not new supervisors, and attended without having a requirement to do so; 172 new supervisors completed initial training. Ninety-six percent completed training timely. The seven who completed the training after three months, completed it between 110-151 days.

The breakdown between MDHHS and private agency:

- MDHHS: 105
- Private agency: 67

The breakdown by program:

- Adoption: 15
- CPS: 61
- Foster care: 96

A three-day program-specific training is offered for supervisors who have completed initial training; 50 supervisors completed these trainings. The breakdown by program:

- Adoption: 19
- CPS: 12
- Foster care: 19

### **Level One Evaluation - Initial Supervisory Training**

Evaluation results indicate that trainees would like more hands-on information on managing staff and fewer guest speakers. Trainees indicated the sessions were too long and mainly discussed policy. Trainees requested more training on MiSACWIS during the classroom sessions. Trainees rated their trainers as knowledgeable, engaging and effective, and reported that the material was understandable and useful. However, they are more interested in topics on engaging staff, such as communication.

### **Level Two Evaluation - Initial Supervisory Training**

Trainees must pass (70 percent or higher) a written exam at the end of training. Post-training exam scores in 2017:

<b>Exam</b>	<b>Range</b>	<b>Average</b>
Adoption	76-98%	92%
CPS	78-100%	93%
Foster care	79-100%	94%

### **Level Three Evaluation - Initial Supervisory Training**

Level three evaluations were not implemented in 2017. Upon implementation of the new supervisory training in 2018, a level three evaluation will be administered to trainees and their supervisors three and 12 months after completion.

### **Progress in 2017**

A redesign of initial supervisor training was developed with the assistance of stakeholder input. This training is being implemented in 2018. The training is five weeks long and must be completed within 112 days. The revised training is responsive to feedback and includes general management skills and specific skill development critical to supervising in child welfare.

Highlights of the training include:

- Blended learning in the classroom, on-the-job and webinar.
- Six-hour classroom days instead of eight hours.
- An online student guide with regularly updated resources.
- Hands-on skill development in the classroom utilizing adult learning principals.
- MiSACWIS training on supervisory functions and data report utilization.
- The MiTEAM Fidelity Tool will be taught once it is automated statewide.
- Guest speakers will still be utilized. They will engage new supervisors to gain a deeper understanding of the roles of various MDHHS offices and partners.

### **Item 26: Initial Training – Assessment of Performance**

**Goal:** MDHHS will ensure that initial training is provided to all staff that delivers services.

- **Objective:** MDHHS will ensure that initial training teaches the basic skills and knowledge required for child welfare positions and that the training is completed timely.

**Measure:** MDHHS learning management system.

**2014 Performance:**

- Ninety-eight percent of new caseworkers completed initial training within 112 days.
- Ninety-nine percent of new supervisors completed initial training within 90 days.

**2015 Performance:**

- Ninety-eight percent of new caseworkers completed initial training within 112 days.
- Ninety-eight percent of new supervisors completed initial training within 90 days.

**2016 Performance:**

- Ninety-eight percent of new caseworkers completed initial training within 112 days.
- Eighty-five percent of new supervisors completed initial training within 90 days.

**2017 Performance:**

- Ninety-eight percent of caseworkers completed initial training within 112 days
- Ninety-six percent of supervisors completed initial training within 90 days.

### **Plan for Improvement - Activities for 2018 and 2019**

- MDHHS will continue monitoring institutional and residential staff training processes through the learning management system.
- MDHHS will continue meeting with BSCs to track the effect of initial and ongoing training on the quality of case management.
- MDHHS will respond to training needs identified in the QIC Training sub-team through collaboration with the CSA and BSCs.
- MDHHS will send surveys to supervisors three and 12 months after training completion to track learning over time.

## **Item 27: Ongoing Staff Training**

Michigan's performance in ongoing staff training is tracked through learning management system data, levels one, two and three training evaluation and through the training sub-team of the QIC. MDHHS requires child welfare caseworkers and those in supportive positions to complete 32 hours of ongoing training per year. Supervisors must complete 16 hours of ongoing training per year.

Training offered by the OWDT, as well as the number of people who completed each training is listed on Attachment L "2019 Training Course List." In addition to training offered directly by the training office, MDHHS has a partnership with Michigan university schools of social work to deliver and evaluate child welfare training for MDHHS and contracted private agency staff, and foster/adoptive parents. Ongoing training is also offered by the State Court Administrative Office, the Prosecuting Attorneys Association of Michigan and local community partners.

### **MiTEAM Training**

In 2017, the statewide implementation of the enhanced MiTEAM practice model was completed. The training approach utilized adult learning principles in the form of virtual training modules, leadership practice calls, application exercises and practice with the fidelity process within four training cycles. In 2017, child welfare staff finished the final components of the second training cycle (assessment competency) and conducted and completed all components of the third and fourth training cycle (case planning and case plan implementation, and placement planning and mentoring competency).

MiTEAM specialists and liaisons continue to provide support and technical assistance in the application of the MiTEAM practice model. The MiTEAM Fidelity Tool was automated in June 2016. Supervisors in three counties piloted and continued to utilize the automated tool in anticipation of statewide implementation in 2018. All child welfare supervisors were trained in the use of the MiTEAM Fidelity Tool from February to April 2018. CPS, foster care and adoption supervisors will implement the tool starting in the second and third quarter of 2018.

### **Training for Residential and Institutional Staff**

The Division of Child Welfare Licensing (DCWL) monitors training of residential staff by reviewing staff training files during the child caring institutions' annual and renewal inspections. During annual inspections of institutions, the division reviews training documentation for all new hires and a sample of records of staff employed for more than one year.

### **2016 Inspections:**

- The division conducted 97 annual reviews of private contracted child-caring institutions eligible for Title IV-E funding. Of these, 18 agencies had violations related to initial staff orientation and ongoing staff training.
- DCWL conducted 86 annual reviews of institutions ineligible for Title IV-E funding, including court and secured detention facilities, training schools and private non-contracted institutions. Of 86 annual reviews, 19 institutions had violations of R 400.4128, Initial Staff Orientation and Ongoing Staff Training.

## **2017 Inspections:**

- DCWL conducted 85 annual reviews of private contracted child-caring institutions eligible for Title IV-E funding. Of the 85 annual reviews that were submitted, 22 agencies had violations related to rule R 400.4128, Initial Staff Orientation and Ongoing Staff Training.
- DCWL conducted 87 annual reviews of institutions ineligible for Title IV-E funding, including court and secured detention facilities, training schools and private non-contracted institutions. Of the 87 annual reviews submitted, 11 institutions had violations of R 400.4128, Initial Staff Orientation and Ongoing Staff Training. One institution had a violation of R 400.10125, Initial Staff Orientation and Ongoing Staff Training. The lack of documentation in employee files influences the Licensing's ability to determine if training requirements were met.
- Corrective Action Plans (CAPs) are required to address noncompliance/violations to licensing statutes and rules, ISEP, MDHHS policy and contract (if applicable). CAPs are due within 15 calendar days upon receipt of a licensing inspection report. The licensing field consultant will review the CAP within seven calendar days of receipt, sooner if necessary to avoid expiration of the license. If the CAP is adequate to ensure compliance, the licensing field consultant will notify the institution in writing. If the CAP is not acceptable, the Licensing field consultant will advise the institution in writing and will assist the institution in development of a plan that would lead to compliance.

## **Training Updates**

In February 2017, DCWL initiated a workgroup to discuss crisis management, physical restraint methods and the factors that would be considered by the department when reviewing a program's training model. The workgroup included representatives from DCWL and over 16 public and private child-caring institutions. Recommendations made by the workgroup have been approved by the Licensing director and CSA executive director.

The workgroup developed elements that must be included in the child-caring institution's training model in order for the model to be approved by DCWL. Written approval of the licensing director is required and must include the following:

- Identification of the institution's training curriculum used to teach crisis intervention and prevention and physical management/restraint.
- Documentation that the institution's training model includes the required seven elements stated above.
- Explanation of the institution's use of seclusion if applicable and documentation of the training provided to staff involved in the placement of residents into seclusion.
- The written request must be submitted to the institution's assigned Licensing field consultant for processing.

Failure to obtain written approval of the child-caring institution's training model will result in findings of noncompliance with CCI rule 400.4128(5) in future licensing inspections. Written approval or denial of the request will be provided to the child-caring institution's chief administrator by the licensing director

## **Plan for Improvement - Activities for 2018 and 2019**

- MDHHS will continue to respond to training needs for residential and institutional staff as identified in licensing reviews and by licensing agencies.
- MDHHS will collaborate with the DCWL to identify additional training opportunities for residential and institutional staff.
- DCWL area managers collaborated with licensing consultants and the division director to develop standardized staff interview questions regarding their training experiences. Both qualitative and quantitative training questions were developed and responses will be evaluated by the field consultants conducting the annual review to determine staff training needs.
- DCWL will continue to evaluate the training needs for residential staff as identified in the rule violations during licensing reviews.

## **Training Caseworkers on Supporting and Affirming Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth**

The training office has a contract with the Ruth Ellis Center in Detroit. This agency has experience providing support and services for LGBTQ young people in Michigan. They continue to provide subject matter expertise on the training content and technical assistance in the development of a multi-module computer-based training. The computer-based training is currently being reviewed by the CSA LGBTQ workgroup. MDHHS offers training related to providing appropriate and culturally sensitive services to people who identify as LGBTQ in the following ways:

- During initial training, caseworkers complete a computer-based training to introduce them to the unique needs of young people who identify as LGBTQ. Classroom discussions provide context and resources to meet the needs of those youth.
- Training on Michigan's Youth in Transition program includes content on serving LGBTQ young people to ensure they have sufficient supports in place prior to their case closing.
- A variety of LGBTQ training opportunities are included each year in the university training list.
- The foster parent training curriculum for caregivers includes training on caring for LGBTQ foster children, and a vast array of support is available through the Child Welfare League of America.
- "A Practice Guide for Working with Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex and Two Spirit Youth in Michigan's Child Welfare System" was created in 2017 to teach effective practices for working with youth and their families. The guide will be published later in 2018.

## **Collaboration with Universities to Deliver Ongoing Training**

During fiscal year 2017, Michigan State University managed the child welfare in-service training program, through a contractual partnership with the eight universities in Michigan with Master of Social Work programs.

- Forty-eight classroom and 19 online trainings were offered free of charge to MDHHS and private agency child welfare staff and foster/adoptive caregivers.

- More than 1,088 trainees attended classroom training in 24 locations across the state; more than 510 participated in online trainings.
- Three classroom and four online leadership trainings were completed by more than 50 trainees.
- More than 100 trainees completed four classroom and two online trainings for caregivers.

### **Level One Evaluation – University Training**

The vast majority of all three targeted populations, child welfare professionals, caregivers and leaders, reported high levels of satisfaction with the trainings. They indicated that the trainings increased their knowledge of the topic, were relevant to their current work, and that they would recommend them to coworkers.

### **Level Two Evaluation – University Training**

Level two evaluations were discontinued, as the quizzes yielded the same results as the self-reported post-test results.

### **Level Three Evaluation – University Training**

For each in-person training, a two-month follow-up evaluation was administered. To assess participants' self-rated competency in the training objectives, all trainees received a follow-up survey. The rate of return for the two-month follow-up survey in the 2017 in-person training cohort was 19.4 percent. This is similar to the follow-up survey response rate for the 2015 cohort (23.6 percent) and better than that of the 2014 cohort (12 percent).

The vast majority of trainees in 2017 responded with "Agree" or "Strongly Agree" when asked whether they would recommend the training to coworkers. The vast majority of trainees in 2017 responded with "Agree" or "Strongly Agree" when asked whether the trainings increased their understanding of the topic and whether they were relevant to their current work. This finding supports the findings from the level one evaluations, and indicates that people are benefitting from these training opportunities.

## **Item 27: Ongoing Training – Assessment of Performance**

Michigan's performance in Ongoing Staff Training is tracked through learning management system data, levels one, two and three training evaluation and through the training sub-team of the QIC.

- **Objective:** MDHHS will ensure ongoing training is provided that includes the basic skills and knowledge required for child welfare positions.

Measure: Learning management system.

#### **2014 Performance:**

- Over 99 percent of caseworkers completed at least 32 hours of ongoing training.
- There was no ongoing training requirement for supervisors in 2014.

#### **2015 Performance:**

- Ninety-nine percent of caseworkers completed 32 hours of ongoing training.
- Ninety-nine percent of supervisors completed 16 hours of ongoing training.

**2016 Performance:**

- Ninety-eight percent of caseworkers completed 32 hours of in-service training.
- Ninety-nine percent of supervisors completed 16 hours of in-service training.

**2017 Performance:**

- Ninety-eight percent of 3,234 child welfare caseworkers completed a minimum of 32 hours of ongoing training in 2017.
- Of 788 supervisors, 99 percent completed at least 16 hours of ongoing training.

**Plan for Improvement - Activities for 2018 and 2019**

- MDHHS will continue distributing a course catalog and other communication about training opportunities, with a special focus on recruiting those with zero through four years of employment in child welfare.
- MDHHS will increase participation in leadership and caregiver training.
- MDHHS will continue to explore ways to increase survey response rates.
- The OWDT will be offering ongoing training packages for BSCs. Each BSC can choose from a list of instructor-led training, which will be delivered in that service area.

**Item 28: Foster and Adoptive Parent Training**

Between Oct. 1, 2016 and December 31, 2017, 249 individuals were trained using the PRIDE (Parent Resources for Information, Development and Education) model of practice to prepare them to provide training for potential foster and adoptive parents. The PRIDE model of practice allows for a standardized, consistent, structured framework for the competency-based recruitment, preparation, assessment and selection of foster and adoptive (resource) parents.

The aim of the competency-based team approach is to assure that resource families are able, and have the resources to meet the needs of traumatized children and their families fully. The PRIDE model must be used for all resource parent training which is built upon five core competency categories:

- Protecting and nurturing children.
- Meeting children's developmental needs and addressing their delays.
- Supporting relationships with birth families.
- Connecting children to safe, nurturing relationships intended to last a lifetime (permanency).
- Working as a member of a professional team.

Persons seeking approval as adoptive parents must participate in a minimum of 12 hours of training prior to the legal adoptive placement of a child.

MDHHS and the Statewide Foster, Adoptive and Kinship Parent Collaborative Council joined forces to sponsor the Fourth Annual Foster, Adoptive and Kinship Parent Conference on May 5 and 6, 2017 in Traverse City, where over 300 people attended. There were relevant topics including:

- Trauma-informed parenting.

- Strategies for parenting picky- or over-eaters.
- Understanding mental health diagnoses.
- Accessing services for youth.
- Parenting children who have been exposed to opioids.

Supportive services continue to be provided through the Post Adopt Resource Center and the National Resource Center for Diligent Recruitment at AdoptUSKids.

## **Item 28: Foster and Adoptive Parent Training – Assessment of Performance**

**Goal:** Michigan will expand training for foster and adoptive parents.

**Objective:** Michigan will explore centralizing training for foster and adoptive parents.

**Measure:** MDHHS learning management system

- **2016:** Determine funding sources for implementing centralized foster and adoptive parent training. This budget enhancement request was not selected.
- **2017:** Explore alternative approaches to improving the quality and consistency of foster and adoptive parent training.
- **2018:** Develop a more robust observation tool to provide a consistent, standardized and structured framework for certifying potential PRIDE trainers.

### **Plan for Improvement**

- Regional resource teams were implemented in each BSC. Their focus is recruitment, support and development of foster families. Achievement in these three areas helped to increase the number of existing foster families remaining in the program, meeting annual non-relative goals and enhancing the skills of existing experienced foster families to meet the needs of foster children with challenging behaviors. The regional resource teams are responsible for conducting PRIDE training throughout the state for all foster and adoptive parents in private and public agencies.
- OWDT continues to provide the PRIDE model of practice train-the-trainer and is currently developing a more robust observation tool to provide a consistent, standardized and structured framework for certifying potential PRIDE trainers. All efforts will enable the department to evaluate the consistency of PRIDE training for all prospective foster and adoptive parents, as well as trainers.

### **Implementation Support**

- MDHHS will continue to collaborate with schools of social work in Michigan to prepare students for careers in child welfare and to provide caseworker, supervisor and caregiver training.
- MDHHS will continue to work with SCAO, the Prosecuting Attorneys' Association of Michigan and the Wayne County Attorney General's office to deliver training on legal matters.
- MDHHS will continue to collaborate with the Licensing to track staff training needs.

## **Program Support**

- MDHHS will continue to provide training in the enhanced MiTEAM model and collaborate with MiTEAM staff as needed.
- MDHHS will continue to collaborate with the MiSACWIS team to provide information system training to staff.
- MDHHS will continue collaboration with the Licensing to identify training needs for residential staff and caregivers.

## **Technical Assistance and Capacity Building**

- Technical assistance from the National Resource Center for Diligent Recruitment at AdoptUSKids continues to be provided.

## **SERVICE ARRAY AND RESOURCE DEVELOPMENT**

### **Item 29: Array of Services for Children and Families**

MDHHS is committed to providing services tailored to meet the individual needs of children and families throughout the state. MDHHS prioritizes evidence-based services to ensure children and families benefit from the latest research on child safety and risk and the effectiveness of the services offered. Services provided by MDHHS emphasize engaging with families effectively and working with the entire family system to increase safety and sustained change.

### **Service Array**

Michigan offers a broad service array throughout the state. Many of the services offered reach beyond families served directly by MDHHS Children's Services and its contractors:

- Michigan provided two funding streams to local offices to purchase services matched to the needs identified in a local needs assessment: Child Protection/Community Partners and Strong Families/Safe Children. Each of those funds is a source for specific assistance for needs identified by individual families.
- The Children's Trust Fund provides direct service grants to local communities for programs aimed at preventing child abuse and neglect, including technical assistance for small and new programs.
- Early On assesses children ages 3 and under for developmental delays; if the child does have delays, Early On provides continued assessment and developmental services. Once a child is 4-years-old, Early On can refer the child to Head Start and Early Head Start.
- Michigan's Great Start programs provide home-based and classroom learning for development and pre-school education. Head Start, Early Head Start and Michigan's Great Start programs also accept referrals directly from the community.
- Infant mental health services are provided by community mental health agencies to families where a parent or caretaker of an infant has a mental health diagnosis. The infant mental health specialist provides home visits to families. The service includes addressing the needs of the infant and other young children in the family and the

mental health needs of the parents.

- Substance abuse disorder prevention, treatment and recovery, residential, outpatient and day treatment services are provided by community mental health authorities and many private agencies.
- Developmental services for disabled children and adults are provided through community mental health authorities as well as private providers.
- Domestic violence shelter and services are provided for residents in all of Michigan's 83 counties. The Michigan Coalition Against Domestic and Sexual Violence provides support and technical assistance to the shelters and sexual assault service providers.
- Michigan's Early Childhood Home Visiting programs provide voluntary, prevention focused family support services in the homes of pregnant women and families with children aged 0-5. The programs connect professionals with vulnerable and at-risk families to nurture, support, coach, educate, connect them with community resources and offer encouragement so their children may grow and develop in a safe and stimulating environment.

### **Service Identification and Referral**

Michigan has a 2-1-1 referral service that operates statewide through eight regionally located offices, as well as a website. The eight centers work together to provide easy access to information about health and human services in Michigan communities. 2-1-1 has a toll-free number that can be utilized outside the state. The website provides referral information for needs such as food, utilities, housing, disaster relief, transportation and veteran's assistance. Individuals can also subscribe to email lists through the regional centers. 2-1-1 is available 24 hours a day, 365 days per year. In addition, 2-1-1 tracks the types of service requests received. Of the most recent 12 months, the most frequent service requests have been for utility assistance, housing and food.

### **Trauma-Informed Services**

To ensure children and families are provided services that effectively address trauma resulting from child abuse and neglect, MDHHS implemented several efforts focused on trauma-informed practice and intervention in 2017 and their development continues in 2018. Major efforts include:

- Statewide secondary traumatic stress training for child welfare staff began in January 2018. The training includes role-specific training for county directors and program managers, supervisors and caseworkers to recognize and effectively address secondary trauma in staff.
- Secondary traumatic stress teams will be trained and implemented in county offices in 2018 and 2019 to respond to secondary trauma on a peer-to-peer level. Training is based on the success of a 2015 pilot training that occurred in eight counties.
- Culture/climate assessment and development began in January 2018. Assessments include a survey for local office staff, individual county/agency plan development based on survey results and a six-month reassessment to gauge progress. Strategies will be developed with local CQI teams to create physically and psychologically safe working

environments that are necessary to achieve performance outcomes.

- Statewide trauma screening training started in November 2017. Use of the Trauma Screening Checklist, developed by the Children’s Trauma Assessment Center at Western Michigan University, is required for all CPS ongoing cases and all foster care cases. Guidance for resiliency-based case planning based on the results of the screening tool is also provided.
- Residential care transformation is being addressed by a workgroup focusing on effective community-based behavioral health intervention and the inclusion of trauma-informed training and practices in contracts for residential treatment providers.
- Trauma assessment service contracts were initiated in June 2017 for regional comprehensive transdisciplinary trauma assessments. These services ensure that comprehensive trauma assessments are provided to foster children as needed in accordance with MDHHS standards.
- MDHHS developed the Trauma and Toxic Stress website as part of the Defending Childhood State Policy Initiative. The website includes information on:
  - Trauma and its impact on children and families.
  - Tools to address trauma.
  - Building trauma-informed systems and communities.
  - Resources for parents and caregivers.
- A statewide initiative to address adverse childhood experiences, led by the Michigan Association of Health Plans, developed “Creating Healing Communities: A Statewide Initiative to Address Adverse Childhood Experiences.” The initiative expands awareness of the effects of adverse childhood experiences and creates a coalition for development of state policy and implementation of Medicaid policy. The initiative will train social workers, teachers, community mental health staff and parents to understand and address behaviors in children resulting from adverse experiences and promote resiliency.
- The Children’s Trauma Initiative provides training and coaching in trauma assessment, trauma-specific treatment and caregiver education to community mental health providers and their contract agencies in 81 of the state’s 83 counties.
- MDHHS trauma policies were developed for various service providers, including the Behavioral Health and Developmental Disabilities Administration and the Medical Services Administration. A trauma policy for child welfare in alignment with the MITEAM practice model is currently being finalized.
- A LEAN Process Improvement is scheduled to begin in June 2018. This process will bring together various stakeholders, including MDHHS, community mental health service providers, Medicaid Health Plans, Prepaid Inpatient Health Plans among others, to streamline the trauma assessment process for children in the child welfare system.

### **Statewide Services to Prevent Abuse and Neglect**

- **Prevention** services are provided by MDHHS Family Independence Specialists to families receiving financial and other assistance statewide. In addition, Wayne County has four prevention specialists providing services to families in that county.

- **Community Resource Centers** based in schools with high numbers of families receiving financial assistance, offer assistance and referrals for food, housing and other needs. See the Pathways to Potential section for more information.
- **Child Protection/Community Partners (CPCP)** funding is provided to all MDHHS offices for services to families at low to moderate risk of child abuse or neglect. Services are determined locally, depending on needs identified in each community. The purpose is:
  - 1) Develop services targeted to the specific needs identified in the community.
  - 2) Reduce the number of referrals for substantiated abuse and neglect.
  - 3) Improve the safety and well-being of children.
  - 4) Improve family functioning.
- **The Children’s Trust Fund** supports a statewide network of 73 local councils that fill the critical role of prevention in a full array of services for children and families. The Children’s Trust Fund provides resources to over 20 community direct service programs, which target the needs of the most vulnerable and challenged families. The Children’s Trust Fund is leading or collaborating on critical policy and education efforts on research and cutting-edge approaches to serving families.
- **Children’s Trust Fund Direct Service Grants** are awarded to provide prevention services to meet community need, identified. Services are provided to families that have risk factors for child maltreatment but do not have active CPS cases. The following are some examples of how the direct services grants are used:
  - Parent/guardian skills training and support programs designed to educate and/or provide peer support in child development, childcare skills, stress management and general advocacy and support.
  - Services that include respite care, parent education programs and support groups, fatherhood programs, home visitation programs, family resource and support centers, early care and education, evidence-based practice, and positive youth development to prevent child abuse.
  - Programs that adhere to culturally competent guiding values and principles.
  - Projects that serve special populations.
- **Families Together Building Solutions** is an evidence-based service that provides long-term in-home services to support vulnerable families and prevent abuse and neglect. FTBS provides counseling, parenting coaching, housing and budgeting assistance and other services in the family home for up to four months. Outcomes for Families Together Building Solutions are provided in the Quality Assurance section.

### **Statewide Services to Protect Children from Abuse and Neglect**

- **CPS investigation and ongoing services** are provided statewide by MDHHS. MDHHS operates a statewide Centralized Intake hotline, which is available 24 hours each day, seven days a week. Centralized Intake is responsible for receiving reports of abuse and neglect of children statewide and assigning them for investigation by CPS investigators in each county office. Ongoing CPS services to children in the home are provided through local CPS staff, who are responsible to assisting the family to alleviate the conditions that are endangering the safety of children in the home.
- **The Maltreatment in Care unit** investigates and provides services to children who have

experienced abuse or neglect while in out-of-home placements.

- **Mandated Reporter Training** is delivered by MDHHS local offices in their communities upon request and is available online.
- **Children’s Advocacy Centers** are child-focused programs in which representatives from law enforcement, child protection, prosecution, mental health, victim advocacy and child advocacy conduct multi-disciplinary interviews and make team decisions about investigation, treatment, management and prosecution of child sexual abuse cases. Services include forensic interviewing, crisis counseling, advocacy, medical evaluation, service coordination, support groups, and child and family therapy.
- **Forensic Fluids** is a statewide contract for drug testing of clients affected by substance use that provides prompt, accurate results that allow for consistency among counties in addressing substance abuse needs.

## Services to Preserve Families

Michigan offers several family preservation services, all of which are evidence-based and monitored for outcomes.

- **Families First of Michigan** is a home-based, intensive (up to 10 hours a week in the family home) crisis intervention model designed to keep children safe and prevent foster care placement or to provide intervention to return children to their home. This service supports the CPS, foster care, adoption and juvenile justice programs. Designated domestic violence shelter programs may refer families with children at risk of homelessness due to domestic violence. The program also accepts referrals from Michigan’s 12 federally recognized Native American tribes. Families First is available in all 83 Michigan counties. Examples of individualized intervention services the model provides include family and child assessment, safety planning and parenting skill modeling and coaching. Families First outcomes are included in the Quality Assurance section of this report.
- **Family Reunification Program** is an intensive, in-home service model that facilitates safe and stable reunification when children in out-of-home placement return to their homes. In 2017, the Family Reunification Program expanded services by 29 counties, now serving 73 counties. Services may begin as early as 30 days prior to the return of children from foster care and may last up to six months to ensure stability is achieved. Out-of-home placement may include residential treatment, family foster care, relative placement, psychiatric hospitalization or shelter care. Family Reunification Program outcomes are provided in the Quality Assurance section.
- **Supportive Visitation** is provided in several regions throughout the state to coach parents during parenting time to assist development of skills and promote parent-child relationships.
- **Family Group Decision-Making** services include the coordination of a group of family members and other supporters for lesbian/gay/bisexual/transgender/questioning (LGBTQ) young people in residential care in Wayne County. The pilot will be expanded as additional funding is secured.
- **The Parent Partners Program** is a collaborative effort that connects parents with

children in foster care to “veteran” parents who have been successfully reunited with their children. Parent Partners go to hearings with parents, connect them to other resources in the community and provide support and encouragement in working toward reunification.

- **Strong Families/Safe Children** is a funding resource for enhanced family preservation and support services. Funds are provided for service needs determined in collaboration with local stakeholders and contracted with private agencies and individuals.

### **Statewide Services to Promote Permanency**

- **Foster care and adoption services** are provided by county MDHHS and private agencies. Medical and dental health care and assessment of behavioral health needs are provided to all Michigan children in foster care. When mental or behavioral health needs are identified, appropriate services are provided to children and families. Adoption services also include child evaluations and family assessments that identify immediate and potential needs that the child and family may have as they transition to creating a permanent family.
- **The Adoption Assistance Program** provides adoption financial subsidy, medical subsidy and assistance with non-recurring adoption expenses for children and their adoptive families.
- **Post Adoption Resource Centers** support families who have finalized adoptions of children from the Michigan child welfare system, children who were adopted in Michigan through an international or a direct consent/direct placement adoption and children who have a Michigan subsidized guardianship agreement. Family participation is voluntary and free of charge. Adoption Resource Centers offer the following services:
  - Case management, including short-term and emergency in-home intervention.
  - Coordination of community services.
  - Information dissemination.
  - Education.
  - Training.
  - Advocacy.
  - Family recreational activities and support.
  - Website and newsletter on topics relevant to adoptive families.
- **Adoption resource consultant services** are available statewide and provide services to young people who have a permanency goal of adoption and have been legally free for adoption for one year or more without an identified family.
  - Utilize a solution-focused model.
  - Develop, review and amend the Individualized Adoption Plan with specific recruitment steps to place a child in an adoptive or pre-adoptive home.
  - Assist with problem solving to eliminate barriers and enhance the specificity of each Individualized Adoption Plan.
- **The statewide Parent-to-Parent Program** contracts with the Adoptive Family Support Network and provides support, education, information and referral services to adoptive parents through:
  - Adoption support groups.

- Adoptive parent seminars/trainings/workshops.
- Adoptive family fun events.
- Parent-to-parent hotline.
- **Regional Resource Teams (RRT)** focus on recruiting, supporting and developing foster families in order to meet annual non-relative licensing goals, retain a higher percentage of existing foster families, appropriately prepare families for the challenges associated with fostering and develop existing foster family skills in order to enable them to foster children with more challenging behaviors. RRT contracts went into effect in December 2017/January 2018. The six RRTs are located across the state and provide regional recruitment, retention and training for foster and adoptive parents.
- **The Guardianship Assistance Program** provides financial support to ensure permanency for children who are placed in eligible guardianships. The purpose of the guardianship assistance program is to provide financial support to ensure permanency to children who may otherwise remain in foster care until reaching the age of majority.
- **Permanency resource managers** lead individualized efforts to find permanency for children who have been out of the home for over 24 months. Efforts include targeted recruitment, “mining” for identifying relatives for potential placements,
- **Michigan Adoption Resource Exchange** operates a registry of children available for adoption and employs many strategies to increase awareness of the need for adoptive families, the Heart Gallery, a traveling exhibit of photos of waiting children, a photo-listing online “catalogue” with details of waiting children.

## Statewide Services for Youth Transitioning to Adulthood

- Foster care caseworkers provide assistance to older youth to transition to independence. After age 14, quarterly meetings are held with the youth to identify supporters, assess their independent living needs and assist in learning budgeting and home management skills and resources available in the community.
- **Michigan’s John H. Chafee Foster Care Program** offers assistance to current and former foster youth between ages 14 and 21 statewide to achieve self-sufficiency, including juvenile justice youth, tribal youth and unaccompanied refugee minors. Services include supervised independent living and independent living stipends, an opportunity to join the Michigan Youth Opportunity Initiative (MYOI), local and state-level groups for mutual support and leadership skills. In 2019, eligibility will extend to age 23.
- **The Tuition Incentive Program and Education and Training Vouchers** are available to foster youth to help them attend college. MDHHS also collaborates with the public universities in Michigan to provide scholarship funds and support to foster and former foster youth attending college.
- **The Michigan Youth Re-Entry Initiative** operates through a contract for care coordination, with an emphasis on assisting young people with medical, mental health or other functional life impairments that may impede success when re-entering the community. Juvenile Justice Programs also provides reentry services to youth with disabilities who are adjudicated through an Interagency Agreement with Michigan Rehabilitation Services.

- **Homeless and Runaway Youth Services** include crisis-based services available to youth ages 12 to 17, their siblings and families. Services are available statewide and include crisis intervention, community education, case management, counseling, skill building and placement. Homeless and Runaway Youth Services are provided to young people ages 16 to 17 who require support for longer periods. Services are available statewide and include crisis management, community education, counseling, placement and teaching of life skills.
- **Unaccompanied Minor Program**, which provides living expenses and assistance to for over 200 unaccompanied minors each year.

## Behavioral Health Services for Children and Youth

Medicaid-funded mental and behavioral health services are provided through Michigan's community health system with partners in state and local health and education systems. Each service must be determined medically necessary, as defined in the child's individualized plan of service. Although children and families involved in the child welfare system are among the clients served through these projects, eligibility criteria are based on mental health diagnoses and Child and Adolescent Functional Assessment scores rather than risk of abuse or neglect. The most recent service data for the following services are provided, as available.

- **Applied Behavior Analysis (ABA)** is a behavioral health service for eligible Medicaid enrolled children, youth and young adults with Autism Spectrum Disorder (ASD) birth to age 21. ABA is recognized as the most effective treatment for individuals with ASD, with over 40 years of scientific research and evidence demonstrating its effectiveness. ABA services are individually tailored to address social behaviors, improve communication, socialization and teach daily living skills, as well as increase inclusion in general educational and community settings by addressing or averting aggressive or self-injurious behaviors that pose a threat to an individuals' development and to families remaining together. Medicaid served 5,035 individuals with ASD in 2017.
- **Wraparound** is a Medicaid-covered service that serves children with serious emotional disturbance. Wraparound offers a team planning process and is one of the few mental health services that can be used when a child in residential care is transitioning to the community. Outcomes for Wraparound consistently show clinically significant (over 70 percent of children served) improvement in functioning. The Division of Mental Health Services expanded the timeframe for provision of Wraparound for transitioning from a residential facility or the children's state psychiatric hospital to 180 days. In 2017, 2,743 children received Wraparound services.
- **Youth Peer Support** is a Medicaid-covered service under the behavioral health managed care waiver. This service provides a Youth Peer Support Specialist that engages a youth with serious emotional disturbance currently receiving services. The Youth Peer Support Specialist provides support, shares information about resources and helps in skill development. Youth Peer Support Specialists are available in nine Community Mental Health service areas with 22 working in the state in 2018. Since 2015, 41 Youth Peer Support Specialists have been trained.
- **Parent Support Partners (PSP)** is a statewide initiative that provides peer-to-peer

support to eligible families as part of Michigan’s Early Periodic Screening Diagnosis and Treatment State Plan. PSP increases family involvement and engagement in the mental health treatment process and equips parents with the skills to address the challenges of raising a youth with special needs. There are 102 Parent Support Partners providing services throughout Michigan within 37 Community Mental Health agencies. Since 2010, 206 parents have completed the five-day training and 137 have been certified.

- **The Early Childhood Comprehensive Systems Grant** brings together primary care providers, teachers, families and caregivers to develop seamless systems of care for children from birth to age 3. Working with health care providers, social services and early childhood education programs, Early Childhood Comprehensive Systems helps children grow up healthy and ready to learn by addressing their physical, emotional and social health in a coordinated way. In 2016, the most recent year for which data is available, the grant funded over 25 presentations, trainings, conferences and meetings, with 1,425 professionals participating.
- **Project AWARE** provides funding to increase awareness of mental health issues of school-aged youth and provides Youth Mental Health First Aid training for school personnel and other adults to detect and respond to mental health issues in children and young adults. Project AWARE operates in the Kent, Jackson, Hillsdale and Oakland intermediate school districts and provided school-based services to 1,462 students and 567 referrals to community services in 2017.
- **Safe Schools/Healthy Students (SS/HS)** provides funding to increase access to behavioral health services for children, increase supports for early childhood development and decrease substance abuse and exposure to violence. The four-year project includes pilots in three Michigan school districts. In 2017, 13,859 children were served through implementing strategies in their individual plans, and 1,349 students received school-based mental health services. SS/HS data for school-based mental health services in 2016/2017 are believed to be higher than reported, given several factors related to the transition of the Education Achievement Authority to the Detroit Public Schools Community District.
- **The Family Support Subsidy Program** provides financial assistance to families with a child with severe developmental disabilities. The goal is to make it possible for children with developmental disabilities to remain with or return to their birth or adoptive families. The program provides a monthly payment, which families can use for special expenses incurred while caring for their child. In 2017, the program served 6,162 children and only 15 children (0.4 percent) were placed out-of-home. Also in 2017, four children returned to their family homes from previously being placed in out-of-home placement and re-applied to the program.
- **Parent Management Training** is an evidence-based service for parents and caregivers of children with serious emotional disturbance. Parent Management Training provides individual, group and home-based services. Michigan currently has 174 clinicians delivering services through local community mental health agencies.
- **Parenting Through Change - Reunification** is training for parents of children who are currently in foster care. Parenting Through Change – Reunification is available in 11 counties, reduced from 2013 due to loss of trained clinicians. Plans are to expand the

number of trained clinicians available across the state.

- **Intensive Mobile Crisis Response** is an intensive face-to-face, short-term mental health service initiated during a crisis to help a child return to the child's baseline level of functioning. This service is provided on-site by a mobile crisis response team outside of urgent care, inpatient or outpatient hospital settings.
- **The Intensive Crisis Stabilization for Children Services** are structured treatment and support activities provided by a multidisciplinary team designed to provide a short-term alternative to inpatient psychiatric services. In 2016, the most recent year for which data is available, 324 children were served.
- **Crisis Residential Services** provide a short-term alternative to inpatient psychiatric services for children experiencing an acute psychiatric crisis. Services are designed for children who meet psychiatric inpatient or substance use disorder residential criteria or are at risk of admission to a more restrictive setting. Services may be used to avert an inpatient admission or to shorten the length of an inpatient stay. In 2016, the most recent year for which data is available, 394 children received services. There are currently six MDHHS-enrolled programs statewide.
- **Infant Mental Health Services** provide home-based support and intervention services to families in which the parent's condition and life circumstances or the characteristics of their infant threaten the parent-infant attachment. Therapeutic interventions support attachment and the consequent social, emotional, behavioral and cognitive development of the infant. The infant mental health specialist provides weekly visits to enrolled families during pregnancy, around the time of birth through 47 months.
- **The Serious Emotional Disturbance Children's Waiver (SEDW)** provides intensive home and community-based services for children up to age 21 with serious emotional disturbance who meet the criteria for admission to a state inpatient psychiatric hospital and who are at risk for hospitalization without waiver services. The SEDW serves two priority populations; traditional (non-child welfare involved) and MDHHS-Project (children with open foster care cases through MDHHS and children adopted out of the Michigan child welfare system). The SEDW is a fee-for-service program administered by the Community Mental Health agency in partnership with other community agencies. Wraparound is a mandatory component of the SEDW service.
- **Early On**, Michigan's early intervention service assists families with infants and toddlers who display developmental delays or have a diagnosed disability. Referral to Early On is required by CPS policy for all families with an infant that have CPS Category 1 or 2 substantiations. Early On is also described in the Populations at the Greatest Risk of Maltreatment section of this report.
- **The Race to the Top Early Learning Challenge** federal initiative awarded Michigan \$51.7 million to improve community early learning programs in a collaborative effort with the Michigan Departments of Education, Health and Human Services and Management and Budget.

### **Protect MiFamily**

Protect MiFamily, Michigan's Title IV-E Waiver project, is a long-term (15-month) in-home

prevention and preservation service for families with children ages 0 - 5 who are at high risk for future CPS involvement. Protect MiFamily is being piloted in Macomb, Kalamazoo and Muskegon counties. The Protect MiFamily project integrates the goals and objectives of the Child and Family Services Plan by:

- Providing evidence-based services to families.
- Engaging families as partners in service planning.
- Improving family functioning.
- Reducing abuse and neglect.
- Keeping children safely in their own homes.
- Improving the well-being of children.
- Implementing continuous quality improvement practices.
- Evaluating program effectiveness on established outcomes.

### **Service Gaps Assessment**

The adequacy of Michigan's array of services systemic factor is monitored through:

1. QSR interviews and focus groups.
2. QIC Service Array sub-team.
3. Feedback from foster parents and other community groups.

Of the QSRs conducted since 2014, 100 percent of reviews and focus groups have outlined three opportunities to improve Michigan's service array:

- 1) Affordable housing.
- 2) Transportation.
- 3) Mental health services for children and adults.

### **Housing**

Lack of adequate affordable housing leads to delays in achieving reunification and/or permanency. Parents who have otherwise shown significant progress in reducing barriers to reunification and benefiting from services at times cannot be reunified with their children due to lack of adequate housing. Housing needs are present in both urban and rural areas across the state.

In 2016, Michigan received more than \$5.5 million in U.S. Department of Housing and Urban Development (HUD) funding to provide affordable rental housing and supportive services to extremely low-income persons with disabilities. The Section 811 Project Rental Assistance grant application process was a collaborative effort between the Michigan State Housing Development Authority (MSHDA) and the Michigan Department of Community Health (MDCH). A workgroup consisting of representatives from MSHDA and MDCH collaborates to identify, refer and support target populations throughout Michigan.

MDHHS provides State Emergency Relief funds for housing for families who become homeless due to a natural disaster or crisis. Local offices can utilize Child Safety and Permanency Planning Title IV-B(2) funds to assist child welfare families with housing needs. Many families receive

temporary housing through the Red Cross while family preservation service flexible funds may help with deposits and rent. Michigan continues to explore ways to increase clients' access to affordable housing through collaborative planning with community groups, charities and government grants.

### **Transportation**

Transportation is needed by caregivers, particularly relatives, to get children to medical, mental health, and other service appointments. Lack of transportation adversely affects visitation plans, maintaining familial bonds, employment and treatment plan completion. A financial burden is placed on families who have to pay individuals to assist with transportation.

MDHHS provides bus fare and gas cards for family visits and attending services and caseworkers commonly drive families to appointments and visits, as do family preservation service providers. However, the lack of public transportation in most cities places a burden on friends and family who have automobiles and increases the chance that visits and appointments may be missed. MDHHS is exploring ways to increase clients' access to reliable transportation through community partnerships.

### **Mental Health and Behavioral Health Services**

Some Michigan counties have experienced an influx of older children with significant mental health needs and behaviors that the parents or caregivers report they cannot handle themselves and/or results in inappropriate discipline. Lack of mental health services for youth has been shown to affect placement stability. Lack of access to targeted mental health services can also delay permanency for children and families. Families with health insurance may not have insurance for mental health services, or services are often limited because of high demand. Due to the nature of mental health needs, individuals may not benefit from other services until their mental health needs are addressed.

Delays for mental health and substance abuse services occur at both the assessment and service provision stages for children and families across the state. Assessments may recommend a service, only to find that the service is not available or is wait-listed. Michigan uses many contracted services for mental health and substance abuse assessment and treatment throughout the state, many of which were described earlier in this assessment. Family preservation services provide the comprehensive types of supports caregivers with mental illness require. MDHHS continues to explore ways to improve access to mental health and substance abuse services for parents and children.

### **QIC Service Array Sub-Team Activities**

The Service Array sub-team collaborated with leaders within the state-level Recovery Oriented System of Care to gather information on substance abuse services around the state and accessibility for child welfare families. The sub-team developed a substance abuse resource list for all regions that includes services provided, costs/insurance and contact persons.

In 2017, the Service Array sub-team developed a strategy to educate child welfare field staff

about the use of already existing tools that provide information about local health and human services and establish an action/implementation plan to inform the field. The sub-team will work with United Way, who operates the 2-1-1 system to identify and fill gaps in that system. Communication with the field about using 2-1-1 system to identify services includes:

- How to set up and use MiBridges accounts for field staff.
- How workers can support families with their own and clients’ MiBridges accounts.
- How community partners/private agencies can support families with MiBridges (navigators).
- How to provide feedback to MDHHS central office on issues with usability and content.

### QSR Findings

Findings from the QSR demonstrating effective targeting of services in case practice are below:

Child and Family Status or Practice Performance Indicator	Percent Cases Rated Satisfactory			
	2014	2015	2016	2017
Physical Health	98.4	97.7	96.1	98.9
Emotional Functioning	84.3	80.7	84.3	94.9
Learning and Development	75.4	85.3	86.3	86.4
Caregiving	94.6	95.0	92.5	98.7
Cultural Identity and Need	84.4	95.4	96.9	97.8

### Service Array and Resource Development Assessment of Performance

**Goal:** MDHHS’ service array and resource development system will ensure an array of services is accessible and individualized to meet the needs of children and families served by the agency.

- **Objective 1:** MDHHS will provide a service array and resource development system to ensure that accessible services are provided to:
  - Assess the strengths and needs of children and families and determine other service needs.
  - Address the needs of individual children and families to create safe home environments.
  - Enable children to remain safely with their parents when it is safe to do so.
  - Help children in foster and adoptive placements achieve permanency.

**Measure:** To be determined.

**Baseline:** 2014 array of services.

**Benchmarks:**

- **2015:** Identify available services and gaps in services statewide.
- **2016:** Establish a plan to expand effective services and supports.
- **2017 - 2019:** Develop or expand supports.

- **Objective 2:** MDHHS’ service array and resource development system will ensure services can be individualized to meet the unique needs of children and families.

**Measure:** To be determined.

**Baseline:** 2014 array of services.

**Benchmarks:**

**2015:** Identify available services and gaps in services statewide.

**2016:** Establish a plan to expand effective services and supports.

**2017 - 2019:** Develop or expand supports.

**Plan for Improvement**

MDHHS recognizes the need for continued, coordinated efforts to tackle the multi-factored challenges faced by client families and children. MDHHS continues assist local efforts to evaluate service gaps by encouraging local offices to:

- Ensure worker, supervisor, court, Community Mental Health and private agency input.
- Develop and disseminate material for local county directors/private agency partners in organizing local CQI sub-teams focusing on local service array and establish an action/implementation plan.
- Develop a template for reporting county-based service gap information.
- Convene to discuss and identify service strengths and weaknesses in the county.
- Address issues about availability, ease of access and tangential issues such as housing vouchers but no housing options to use the voucher.

The Service Array sub-team will:

- Evaluate input on service gaps from counties and address with the QIC.
- Complete a service gap analysis and field direction enhancement for housing resources and services.
- Complete a service gap analysis and field direction enhancement for mental health services for children and families.
- Complete a service gap analysis and field direction enhancement for substance abuse services for families
- Develop a mechanism to perform the above activities on an annual basis.
- Complete the implementation of staff supports through the effective roll out of the culture enhancing tools and strategies developed in 2016.
- Identify and implement an efficient mechanism for the effective capture and distribution of the data from the enhanced management and culture tools

**Plan for Improvement – MDHHS Activities for 2018 and 2019**

- Expanding trauma screening for children and families to additional counties and enhancing CPS investigation and ongoing services through continued development of trauma-informed services and training.
- Implementing a new contract for in-home substance abuse services.
- Continuing to collaborate with Medicaid-funded behavioral health services to address the needs of children and families with mental and behavioral health concerns.
- Continuing to promote and support the work of the Children’s Trust Fund to prevent child abuse and neglect in local communities.
- Continue offering technical assistance to contracted family preservation program staff to ensure services are provided with fidelity to evidence-based models.

- Continued exploration of expanding the Family Reunification Program to additional counties to promote successful reunification with their families or in permanent placements.

### **Item 30: Individualizing Services**

#### **Child Welfare Practice – the MiTEAM Model**

The MiTEAM model incorporates family engagement, family team meetings and concurrent planning into a unified practice model for child welfare. The use of core MiTEAM skills ensures each service plan is developed for the specific needs of each family served. Caseworkers receive feedback and coaching by MiTEAM specialists and their supervisors to ensure consistency in engagement, team formation, assessment and mentoring families.

#### **Ensuring Fidelity to the MiTEAM Model**

The MiTEAM Fidelity Tool will be operationalized statewide in 2018. The MiTEAM Fidelity Tool assists child welfare supervisors to track use of the critical components of the MiTEAM model and identify strengths and needs in local case management activities. County staff members that need assistance will be identified through use of the MiTEAM Fidelity Tool by supervisors. DCQI develops and provides technical assistance to local offices and agencies resulting from fidelity tool findings and supports the Office of Workforce Development and Training in training the model to new and transferring child welfare staff.

#### **Locally Allocated Funds for Community Needs**

MDHHS' commitment to providing accessible services to families includes community-based programs. Allocation of funds to local county offices ensures that the services offered to families are appropriate to the needs of each geographical region and local needs. Funds allocated to MDHHS local offices may be consolidated to allow counties with low populations to combine funds in contracts that serve a broader population or geographic area.

#### **Child Protection Community Partners**

Funding is provided to MDHHS local offices for preventive services to children of families at low to moderate risk of child abuse or neglect. The purpose of the funding is to:

- Reduce the number of re-referrals for substantiated abuse and/or neglect.
- Improve the safety and well-being of children and family functioning.

Services contracted with these funds include:

- Parenting education.
- Parent aide services.
- Wraparound coordination.
- Counseling.
- Prevention case management.
- Flexible funds for individual needs.

### **Child Safety and Permanency Plan**

Funding is provided to 83 MDHHS local offices to contract for services to families with children at high risk of removal for abuse and/or neglect, or families with children in out-of-home placement. The purpose of the funding is to:

- Keep children safe in their homes and prevent the unnecessary separation of families.
- Return children in care to their families in a safe and timely manner.
- Provide safe, permanent alternatives for children when reunification is not possible.

Purchased services include:

- Counseling.
- Parenting education.
- Parent aide services.
- Wraparound coordination.
- Families Together Building Solutions.
- Flexible funds to meet individual needs.

### **Individualized Service Provision**

Contracted family preservation activities, including Families First of Michigan, the Family Reunification Program and Families Together Building Solutions focus on high-risk families and families where maltreatment has occurred (substantiated) and seek to reduce the negative consequences of the maltreatment and to prevent recurrence. These programs include:

- Individualized service plans that include families in identification of their needs, strengths and replacement behaviors.
- Intensive family preservation activities designed to strengthen families who are in crisis and protect children who are at risk of harm.
- Parent mentor programs with stable, non-abusive families acting as “role models” and providing support to families in crisis.
- Parent support groups that help parents transform negative practices and beliefs into positive parenting behaviors and attitudes.
- In-home mental health services for children and families affected by maltreatment to improve family communication and functioning.

### **Progress in 2017**

- Protect MiFamily, Michigan’s Title IV-E waiver demonstration project, provides families with enhanced screening, assessment and in-home case management for a 15-month period, coupled with access to an array of support services. Evaluation results will determine efforts to expand the project.
- Protective factors were incorporated into Families First of Michigan contracts and the Title IV-E waiver, Protect MiFamily.
- Trauma-informed practice is included in the enhanced MiTEAM practice model.
- MDHHS collaborated with the Defending Childhood State Policy Initiative, in which national experts and state agencies and stakeholders developed a strategic plan to screen, assess and treat trauma using evidence-based interventions.

- MDHHS worked with the Children’s Trauma Assessment Center on a statewide trauma screening and functional assessment for children in the child welfare system. Screening with this tool was added to the services in family preservation contracts.
- Protective factors were incorporated in Family Reunification Program contracts effective spring 2016.
- MDHHS is responding to requirements outlined in the Preventing Sex Trafficking and Strengthening Families Act, including provisions to identify, report, document and determine services for young people victimized by, or at risk of, sex trafficking.

### **Services for Specific Populations**

To ensure services provided to children and families are accessible to all, Michigan provides access to tools to reach out to special populations and groups statewide.

#### **Interpreter and Translation Services**

MDHHS provides interpreter or translation services free of charge for individuals and families with limited communication skills, including speaking, hearing, reading or writing the English language. MDHHS must provide services to all consumers who have Limited English Proficiency within a reasonable time, and at no cost to the consumer, during the delivery of all significant treatment, legal procedures and when obtaining informed consent. Some MDHHS staff are multi-lingual and often serve a dual role as interpreter when necessary. MDHHS also collaborates with community groups that may be able to serve as interpreters, or provide access to interpreters.

MDHHS has a contract with Linguistica International to provide assistance when a client who is not English speaking is in need of services. Linguistica provides a telephone interpreter and written translation services. Linguistica International provides services in: Spanish, Chinese (Mandarin and Cantonese), French, Japanese, Polish, Russian, Vietnamese, Armenian, Cambodian, German, Haitian Creole, Italian, Korean, Portuguese, Farsi, Tagalog, Thai, Urdu and other languages.

#### **Indian Outreach Workers**

MDHHS offices in areas with tribal populations employ Indian Outreach Workers, who work within the tribal community to provide access to all MDHHS services to Indian families, and to assist MDHHS and private agency workers reach out to tribal communities.

#### **Office of Migrant Affairs**

MDHHS is the lead state agency responsible for the assessment, development and coordination of services for Michigan’s migrant and seasonal farmworkers. The Office of Migrant Affairs’ mission is to deliver public benefits, provide assistance, and coordinate statewide services that meet the economic and cultural needs of marginalized migrant and seasonal farmworkers. The Office of Migrant Affairs enhances the delivery of MDHHS services to farmworkers and their families by:

- Analyzing, recommending and advocating for improvements in the department’s program policies and procedures.

- Coordinating the allocation, recruitment, testing, hiring and training of MDHHS bilingual (English/Spanish) migrant program staff.
- Advocating for farmworkers.

### **Refugee Assistance Program**

The Refugee Assistance Program helps persons admitted into the U.S. as refugees to become self-sufficient after their arrival. Temporary refugee cash assistance is available to eligible refugees who do not qualify for cash assistance (through the Temporary Assistance for Needy Families program), Supplemental Security Income or Medicaid.

Refugee cash assistance is available for up to eight months after entry into the U.S.

Employment services, health screenings and foster care services for unaccompanied minors are other programs available to refugees. Assistance from Refugee Services for those with the following immigration statuses:

- Refugee or asylum seekers.
- Cuban/Haitian entrants.
- Amerasian entrants.
- Parolees.
- Victims of trafficking.
- Iraqi or Afghan Special Immigrant VISA holders.

Services to refugees include:

- **Employment Services** - to address barriers to employment such as social adjustment, transportation, interpretation, day care for children, citizenship and naturalization. Agencies also serve refugee cash assistant clients in meeting their required employment participation.
- **Education - School Impact Services** - activities that lead to the effective integration and education of refugee children.
- **Preventive Health Services** - provides a preventive health care liaison in each contracted agency to ensure each refugee needing referral or follow-up medical services will get the necessary assistance and education.
- **Services to Older Refugees** - to decrease older refugee isolation and dependence and to overcome cultural, language and educational barriers. The goal is to increase the number of older refugees using mainstream services and to connect with other older refugees who share common backgrounds, difficulties and barriers when coming to a new country.
- **Health Screening** - MDHHS partners with local health departments and clinics in each of the seven major geographic resettlement areas of the state to provide health screenings to newly arriving refugees on a per capita basis.
- **Unaccompanied Refugee Minors** - Provides foster care services to unaccompanied refugee, asylum seeker, trafficked, and special immigrant juvenile youth. The Unaccompanied Refugee Minors Program helps unaccompanied minors develop appropriate skills to enter adulthood and to achieve social self-sufficiency.

## **Hearing, Speech or Visual Impairments**

MDHHS recognizes the obligation to ensure effective communication with individuals who have hearing, speech or visual impairments. MDHHS must advise individuals with disabilities, or their representatives that they may be provided with auxiliary aids and services to afford effective communication with other MDHHS employees. Auxiliary aids and services include qualified language or sign language interpreters, written material, translated material, note pad and pen, note-takers, materials in alternative formats, including Braille, large print, audio tape, CD, email, etc. and TTY numbers for persons who are deaf/hearing impaired.

## **Plan for Improvement - Activities for 2018 and 2019**

- DCQI will collaborate with MiTEAM staff to assist caseworkers and supervisors to provide services with fidelity to the MiTEAM practice model. Technical assistance in teaming is being focused on in 2017 to ensure ongoing collaboration with families in developing their service plans.
- MDHHS will explore funding options for developing a prevention/preservation contract targeting families with children ages 5 and under experiencing challenges with substance abuse. Workers certified through the Michigan Certification Board for Addiction Professionals will provide assessment, treatment and strength-based interventions to families for six months.
- MDHHS will monitor the progress of the Title IV-E waiver service, Protect MiFamily and consider expansion of the program to additional counties.

## **Implementation Support**

- MDHHS will continue to collaborate with leaders within the state-level Recovery Oriented System of Care in 2016 to ensure substance abuse recovery services are available statewide.
- MDHHS will continue supporting the Children's Trust Fund to fill the critical role of prevention leadership statewide.
- Michigan will continue to provide evidence-based family preservation services through contracts with private agencies.
- MDHHS will continue to work with Behavioral Health and Disabilities Services to ensure children who meet eligibility criteria for Serious Emotional Disturbance or Intellectual and Developmental Disability are provided services statewide.
- MDHHS will continue to provide accessible services to families through funding of community-based programs. Allocation of funds to local county offices ensures that the services offered to families are appropriate to the needs of each geographical region and local needs.

## **Program Support**

- In collaboration with MiTEAM staff, DCQI will create processes for providing ongoing technical assistance in the creation of local continuous quality improvement teams to enable local offices to respond quickly and accurately to the needs identified by local staff and managers.

## Technical Assistance and Capacity Building

- MDHHS will continue to seek technical assistance as needed from the Children’s Bureau to ensure the state’s Service Array system meets federal and best practice standards.
- MDHHS will continue to assess the state’s Service Array system through interviews and focus groups to address service needs identified by the groups.

## AGENCY RESPONSIVENESS TO THE COMMUNITY

### Item 31: State Engagement and Consultation with Stakeholders

MDHHS is responsible for a broad range of child welfare services and initiatives in implementing the provisions of the Child and Family Services Plan (CFSP), including education and raising awareness of issues of child safety, permanency and well-being, as well as providing direct and contracted services to children and families. Actively seeking feedback from stakeholders at all levels and acting on that feedback to target resources, training or technical assistance effectively in a continuous quality improvement feedback loop is essential to providing appropriate and accessible services in all areas of the state on an ongoing basis.

Assessment of Michigan’s performance in this systemic factor is monitored through the work of the QIC and its sub-teams, QSR interviews and focus groups, consultation with Native American tribes, the Foster Care Review Board, the Governor’s Task Force for CPS, Foster Care and Adoption and the Michigan Federation for Children and Families, CFSR and CFSP/APSR planning, among others. The membership and focus of each group is below.

- **Quality Improvement Council (QIC)** as the CSA organizational body responsible for ensuring that experts and stakeholders are involved in assessing need and developing responsive programs and facilitating decision-making at every level. The council consists of central office and local MDHHS and private agency managers and staff who oversee the work of sub-teams that specialize in addressing specific issues. QIC members are recruited to represent both public and private child welfare agencies to evaluate current performance and opportunities for improvement, identifying goals and action steps accordingly.
- **Quality Service Review (QSR)** includes seeking feedback from all parties involved in the cases being reviewed. Feedback on current cases and at the community level is obtained through individual interviews and focus groups. Individual focus groups consist of CPS caseworkers, foster care caseworkers, supervisors, court system partners, service providers, and foster parents. Counties use the feedback to create practice improvement plans. This feedback loop provides immediate information on cases reviewed and drives timely local efforts to improve services. Focus group interviews are held at every QSR site for supervisors; foster care, adoption and licensing caseworkers; children’s protective services caseworkers; directors of public and private local agencies; judges; prosecutors; foster parents; foster youth; and local services providers. Feedback from 2016 and 2017 interviews and focus groups is summarized below.
- **State Court Administrative Office (SCAO)** receives monthly data from MDHHS that is

incorporated into the Judicial Data Warehouse (JDW). The merged data is accessible to courts statewide and helps to inform jurists regarding county-specific and statewide trends in child welfare. MDHHS also collaborates with SCAO regarding the Court Improvement Program (CIP), with the director of MDHHS' DCQI and SCAO's Child Welfare Services director co-leading the workgroup. MDHHS also cooperates with the Ombudsman's Office, collaborates with the Child Support Office and participates in the Foster Care Review Board program, all under SCAO.

- **Foster Care Review Board** provides independent review of cases in the state foster care system. The board also hears appeals by foster parents who believe that children are being unnecessarily removed from their care.
- **Secondary Traumatic Stress Training** was provided in 2017 by the Children's Trauma Assessment Center to conduct secondary traumatic stress training for child welfare directors, supervisors and staff. This training focuses on secondary trauma in child welfare work, including how to recognize and effectively respond to its effects. Staff complete surveys regarding their office culture/climate and directors create action plans focused on making improvements based on survey results. Reassessment is conducted six months following the completion of action plans, providing an opportunity to modify plans if necessary.
- **CSA Hiring Protocol Workgroup** focuses on the effective recruitment of all prospective hires, faster processes for onboarding new staff and strategies for improving the chances for success of new hires. Activities began in 2016 and continued to date. These activities include better use of technology-based job applicant search tools, collaborating with Michigan universities and developing approaches for current employees to serve as ambassadors to help recruit qualified candidates. CSA worked with PricewaterhouseCoopers on creating job fit assessment tool specific to Michigan child welfare. As a result, the department gained a better understanding of the individual characteristics that will likely allow an applicant to become a successful child welfare specialist. The tool will be used throughout CSA during 2018.
- **The Local Office Culture Assessment and Development (LOCAD)** work group is comprised of regional and county directors, human resources leadership and the training office. The group is actively working on implementing the Leadership Development Tool, which affords a safe, constructive means for managers to elicit feedback from their staff to improve the overall efficacy of their work unit. This work group will also align training resources with manager needs as well as further the utilization and dissemination of exit survey activity.
- **MDHHS employee engagement** is measured by annual department-specific employee surveys. Based on these annual surveys, employee engagement action plans are developed with specific goals. Current goals are to energize department culture, improve department communications, increase employee development opportunities and increase employee engagement.
- **Director's Roundtables** held by MDHHS director, Nick Lyon, are available for any MDHHS employee and provide a direct line of communication and opportunity for feedback. Director Lyon also travels for site visits at local offices and central office buildings to achieve the same goal.

- **Directors Steering Committee** was established to convene the executive director of the CSA, along with the West Michigan Partnership for Children Board of Directors and executive leadership. Other stakeholders include MDHHS central office and local staff, representatives from the Michigan Federation for Children and Families and the Kent County Administrator's Office. This group works to assure that MDHHS and the West Michigan Partnership for Children meet key milestones by identifying potential roadblocks and solutions and making critical decisions to support the pilot's successful development and implementation.
- **Michigan Child Welfare Partnership Council** is comprised of statewide representatives from MDHHS, private child welfare agencies, court and county administrators, county commissioners, and others with an interest in developing a performance-based child welfare system throughout the state. This group meets monthly and has as a standing agenda item updates from the West Michigan Partnership Council.
- **Child Welfare Services and Support (CWSS)** analysts support private child placing agencies, similar to the supports offered to MDHHS child welfare staff through their assigned BSCs. Statewide utilization of Monthly Management Report (MMR), Infoview Data Reports, Caseload Count and Book of Business, along with tools such as job aids and consultation are critical to achieving this goal. The analysts review and analyze data, ongoing training requirements and caseload compliance reports on a continuous basis to identify areas of inquiry that require attention. If an analysis indicates that an agency is not achieving its key performance indicator goals, the analysts assist the agency to understand the possible reasons and devise steps that will address the areas of concern. The analysts conduct ongoing monitoring of improvement efforts to assess whether the efforts are resulting in improved scores, ongoing training and caseload compliance.
- **Listening Sessions** are being facilitated by Public Consulting Group, the contractor that establishes actuarial rates for private agency providers and residential programs, at various venues across the state to gather information and feedback from child welfare stakeholders for opportunities to improve the child welfare system. The sessions are a preliminary step to consider opportunities for change that may be available resulting from the federal Family First Prevention Services Act of 2018.
- **The Guy Thompson Parent Advisory Council** is in the beginning stage of development with the Michigan Public Health Institute. The council will be comprised of birth parents who will review and make recommendations to child welfare policies and programs.
- **Michigan Race Equity Coalition** examines and implements strategies to address the root causes of minority overrepresentation in child welfare, state-level stakeholders formed the Michigan Race Equity Coalition. The coalition includes Michigan's child welfare services leadership, juvenile justice leaders, the judiciary, state and local officials, educators, health professionals, philanthropic leaders and advocates for children and families.
- **MDHHS Diversity, Equity and Inclusion Committee** brings together the health and human services sides of the department. This group meets monthly and is developing a mission statement for community health, human services, human resources, community mental health and leadership. The committee is working on proposals to ensure diversity, equity, and inclusion is infused in the MDHHS workforce's culture and climate.

The community is evaluating current policy and service delivery through an inclusion lens from gathering feedback from customers. The committee is considering how to ensure that outside vendors working with MDHHS support equity and inclusion.

- **Michigan Coalition Against Homelessness, Michigan Network for Youth and Families, the Michigan State Housing Development Authority and Local Continuums of Care** collaborate with CSA to meet the needs of homeless youth in Michigan, Children’s Services partners the Michigan State Housing Development Authority (MSHDA), the Michigan Coalition Against Homelessness and local Continuum of Care organizations. In addition, the CSA works with the Michigan Network for Youth and Families comprised of the homeless youth providers in Michigan. The network helps to shape homeless youth programs, reshape organization and share information. The network is a source of expertise, experience and innovation used to maximize services.
- **MDHHS Bureau of Community Services, Housing Services Section** received results from QSRs showing the ongoing need for adequate housing and how need for housing can delay reunification. In a meeting with the Housing Services Section, it was established that most families needing housing assistance do not technically qualify for federally funded housing support or they have a criminal limitation to meeting the requirements. The Housing Services Section is in the beginning collaboration process with Kent and Wayne Counties to see if any MDHHS funds being used for housing could potentially be met through federal funding. There is also a meeting planned with Detroit’s Children’s Services director and the Housing Services Section to bring local housing resource agencies together with Children’s Services to explore ways to collaborate.
- **Statewide MDHHS Community and Faith-Based Initiative on Foster Care and Adoption** seeks to build partnerships with local community leaders, business representatives and faith leaders to meet the needs of foster and adoptive children and their families by promoting awareness of the need for quality foster and adoptive parents and connecting children and youth to supportive resources and relationships.
- **Collaboration with professional and citizen groups** ensures broad participation in developing and managing child welfare services. MDHHS has standing committees and task forces that meet regularly and provide ongoing oversight, advisement and, in some cases, supportive funding for initiatives and training.
- **Children’s Trust Fund** provided direct service grants in 2017 and 2018 that provided 28 counties evidence-based and evidence-informed services. Details about grant-funded activities are provided in the Child and Family Services Continuum section of this report.
- **Children’s Trauma Assessment Center (CTAC)** at Western Michigan University has been a collaborator with MDHHS in different capacities. CTAC has assisted MDHHS in several counties, collaborating with mental health service providers to streamline access to trauma assessments for children after a need has been identified. These counties were also trained on CTAC’s Trauma Screening Checklist to aid in accurate need identification. The collaboration is being expanded through a contract awarded to CTAC to train on the Trauma Screening Checklist statewide for all public and private child welfare staff.
- **Michigan Child Death Review Team (Citizen Review Panel for Child Fatalities)** supports voluntary, multidisciplinary child death review teams in all 83 counties. These teams, totaling over 1,400 professionals, meet regularly to review the circumstances

surrounding the deaths of children in their communities. The MDHHS director selects members that include key MDHHS leadership, law enforcement, a county prosecuting attorney and medical examiner, the Children's Ombudsman and the State Court Administrative Office. Quarterly meetings include review of current state-level issues affecting children's health, safety and protection.

- **Governor's Task Force on Child Abuse and Neglect (Citizen Review Panel for Children's Protective Services, Foster Care and Adoption)** gives stakeholders an opportunity to voice their observations and concerns and gain information and knowledge about the functioning of the child welfare system. The Governor's Task Force focuses attention on trauma issues, and composes a number of recommendations for systemic improvement based on the information learned from community and consumer feedback.
- **Michigan Youth Opportunities Initiative (MYOI)** serve as the leadership and advocacy arm of MYOI. Young people are trained in leadership, media and communication skills, including how to strategically share their story and present on panels. Local MYOI Youth Boards are among the focus groups that participate in providing feedback on child welfare services in their communities through a variety of venues, including conferences, panels and local QSRs.
- **Tribal State Partnership** consists of Tribal Social Service directors, state and private agency directors and MDHHS staff that meet quarterly for consultation between the MDHHS Office of Native American Affairs and Michigan's 12 federally recognized tribes. The partnership collaborates to achieve and strengthen application of the Indian Child Welfare Act and the Michigan Indian Family Preservation Act and promote effective and culturally sensitive services to Native American children and families.
- **State-Tribal Summit** in 2017 featured conversations between tribal leaders, Governor Snyder and legislative leaders that resulted in legislation designed to ensure that Native American tribes in Michigan have access to certain state child protection records of children in tribes.
- **Medical Care Advisory Council** advises MDHHS on policy issues related to Medicaid. The Council is involved with the issues of access to care, quality of care and service delivery for managed care and fee for service programs. The Medical Care Advisory Council consists of members who represent consumers and consumer advocates, health care providers and the community.
- **Human Trafficking Health Advisory Board** was created to collect and analyze information concerning medical and mental health services available to survivors of human trafficking. The board identifies state, federal and local agencies involved with issues relating to human trafficking and coordinate the dissemination of medical and mental health services available to survivors of human trafficking.
- **Michigan Committee on Juvenile Justice** is a 15-member committee that advises on juvenile justice issues and guides effective implementation of juvenile justice policies and programs. Membership includes MDHHS juvenile justice personnel, judges, law enforcement personnel and private agencies.
- **Michigan State Council for Interstate Juvenile Supervision** monitors compliance with the interstate compact and to problem-solve and initiate changes accordingly. The council also serves to advocate for improved operations, resolve disputes between

states and conduct training.

- **The Michigan Office of Children’s Ombudsman (OCO)** assures the safety and well-being of Michigan’s children in need of protection, foster care and adoption services and to promote public confidence in the child welfare system. The OCO receives complaints from the community regarding specific cases, provides reports to the legislative and executive branches of Michigan government and recommends changes to improve child welfare law, policy and practice. MDHHS cooperates with the OCO’s independent investigations of complaints and recommendations.
- **Prosecuting Attorney Advisory Council** meets quarterly to discuss issues of mutual interest to the county prosecutors who represent MDHHS and MDHHS and private placing agencies in child protective proceedings. The meetings focus on information sharing and problem resolution to enable more effective and efficient collaboration between child welfare staff and prosecutors to improve legal representation for MDHHS. The group has representation from MDHHS, several prosecuting attorneys and private agency providers across the state.
- **Judicial Advisory Council** meets quarterly and serves as an opportunity to discuss issues of mutual interest to the courts and MDHHS in child protective proceedings, CPS, foster care and adoption cases. The meetings focus on information sharing and problem resolution to enable more effective and efficient collaboration between child welfare staff and the courts. Ultimately, the goal is to improve the system for children and families being served. The group has representation from MDHHS, SCAO and jurists from various localities across the state.
- **Michigan Graduate Schools of Social Work** collaborate with MDHHS partners from Michigan State University, University of Michigan, Eastern Michigan University, Western Michigan University, Wayne State University, Grand Valley State University, Ferris State University, Spring Arbor University and Andrews University to offer training that meets in-service training requirements and earn continuing education credits. The partnership has been expanded to include free trainings for foster parents, adoptive parents, kinship/relative parents and birth parents that are customized to help support their needs, understanding some of the unique and sometimes challenging needs that children and their families often face in the child welfare system.

### **Agency Responsiveness to the Community: Assessment of Performance**

- **Objective:** MDHHS will engage in ongoing consultation with tribal representatives, consumers, service providers, foster care providers, the juvenile court and other public and private child and family service agencies to ensure collaboration addresses the implementation of the Child and Family Services Plan and annual updates.

**Measure:** Annual Implementation Report.

**Baseline:** Strengthening Our Focus Advisory Council (now known as the QIC) and sub-teams, 2015.

**Benchmarks:**

**2016 – 2019:** Utilize the QIC and QSR findings for consultation and collaboration.

- **Objective:** MDHHS will utilize the QIC and sub-teams to operationalize a continuous quality improvement plan that includes engaging internal and external stakeholders in assessment and development of effective strategies.

**Measure:** Annual Implementation Report.

**Benchmarks 2016 – 2019:**

- MDHHS will utilize the QIC and sub-teams for consultation and collaboration.
- MDHHS will develop local organizational structures, resources and activities that reach the QIC and sub-team for communication about strengths and areas needing improvement and strategies to improve the child welfare system.

## Progress in 2017

The implementation of the MiTEAM practice model enhancements in 2016 and 2017 included collaboration and implementation by external stakeholders that includes local courts, private agency providers and service providers. Highlights of the enhancements include:

- Emphasis on family team meetings that include family input regarding:
  - Family team participants.
  - Family strengths and cultural norms.
  - Case planning through the life of the case.
  - Family guided group decision-making.
- Incorporation of cultural awareness, competence and inclusion in the MiTEAM model.
- The MiTEAM Fidelity Tool assists child welfare staff to identify strengths and needs in the implementation of the model.
- Prudent Parent Standards policy was developed to ensure that children in foster care are allowed to live and socialize according to their own cultural standards and norms.
- “The Michigan Equity Practice Guide for State-level Public Health Practitioners” was developed to provide strategies, resources and examples that health and social service professionals can use to put equity into practice in their everyday work.
- Developed family team meeting facilitation training to enhance family engagement by caseworkers.
- MiTEAM materials and policy were reviewed to ensure that racial equity/cultural awareness language is aligned with QSR and MiTEAM fidelity reviews.
- Leadership training was presented by Eliminating Racism and Creating/Celebrating Equity from Kalamazoo and Robert T. Blackwell of the Illinois Office of Racial Equity Practice. The training provided an overview of race equity issues in child welfare, steps forward and utilizing specific language to raise awareness.
- The QSR measures “Responsiveness to Cultural Identity and Need.” The QSR assists the department in identification of case practice needs and trends.
- MDHHS developed parenting time planning tools and resources to address individual family needs.
- A full day of cultural awareness training was incorporated into pre-service training for new CPS, foster care and adoption workers.

## **Agency Responsiveness at the Community Level**

MDHHS county offices are tasked with working closely with local human services organizations including private agencies, schools, early childhood programs, courts, law enforcement, public health, housing assistance, employment services, substance abuse services and community foundations. These local multidisciplinary teams formed for various topics allow counties to affect change in their communities, problem solve challenges particular to their region, discover mutually beneficial partnerships, and share grants. MDHHS staff, including caseworkers, are encouraged to participate in these local multidisciplinary teams.

Collaboration between the department and these agencies occurs through ongoing collaborative councils and as needed when task-specific issues arise that require collaboration. This community engagement provides feedback that can be addressed through existing channels to ensure it is afforded necessary attention.

Community feedback is also received through three-person MDHHS county boards. These advisory boards work collaboratively with MDHHS county directors, typically through monthly meetings. The experience of each board member helps shape conversation and strategy planning for improvement at the state and local levels.

The Wayne County Third Circuit Court and the department are collaborating with Casey Family Programs to improve child welfare services in Michigan's most populous county, Wayne County. The collaboration focuses on five areas:

- Increasing timeliness to permanency.
- Developing procedures that identify and assess the need for trauma-informed interventions.
- Exploring the need to increase parenting time beginning at the preliminary hearing.
- Developing a psychiatric questionnaire to identify and monitor children receiving psychotropic medication.
- Collecting data on compliance with the Indian Child Welfare Act to ensure proper and timely notification is occurring.

## **Plan for Improvement - Activities for 2018 and 2019**

- MDHHS will continue to provide consultation and coordination with Native American tribes through Tribal State Partnership meetings, meetings with individual tribes and through technical assistance in Chafee-funded programs.
- MDHHS will continue participation with the Michigan Race Equity Coalition to assess progress and identify opportunities for improvement in addressing issues of racial inequality in child welfare.
- MDHHS will continue to seek feedback from the State Court Administrative Office Foster Care Review Board.
- MDHHS will continue to seek feedback from the three Citizen Review Panels.
- MDHHS will continue to sponsor Michigan Youth Opportunities Initiative activities and youth participation in focus groups.

- Michigan will continue to use stakeholder feedback to address practice issues and increase the capacity to track outcomes. Collaboration on every level remains a priority.
- MDHHS will continue to identify and participate in opportunities for technical assistance and collaboration to enhance services to families in need of multiple forms of help.
- MDHHS will sustain the efforts taken in the last year and use QSR findings to develop strategies to improve outcomes for children and families.
- MDHHS will continue to train caseworkers in MiSACWIS to enable accurate and timely entry of data into the system.
- MDHHS will continue to streamline feedback processes to enable prompt responses to needs identified by stakeholders.

### **Item 32: Coordination of CFSP Services with other Federal Programs**

MDHHS' child welfare goals are based on the successful functioning of a continuous quality improvement process that measures and analyzes progress systematically. The plan relies on collaboration with public and private stakeholders, including national and state government groups, courts, universities, private agencies, children and families and the public.

#### **Assessment of Performance**

- **Objective:** MDHHS will integrate analysis of state data on child welfare indicators and outcomes to assess performance and trends and ensure the state's services are coordinated with services and benefits of other federal programs.

**Measure:** Annual Implementation Report.

#### **Benchmarks 2016 - 2019:**

- MDHHS has developed and is implementing a state level organizational structure, resources and activities to assess child welfare data and trends, including feedback from stakeholders in the QSR process.

Michigan's child welfare services are developed at the state level and delivered by county offices and private agencies. Local MDHHS offices operate under five BSCs that are geographically based. In addition to child welfare services, MDHHS administers:

- Federal Temporary Assistance for Needy Families funding.
- Child Care and Development Block Grant programs.
- Supplemental Nutrition Assistance Program.
- Low-income Home and Energy Assistance Program.
- Title IV-D Child Support Program.
- Disability Determination Services for Title II and XVI funds.
- Mental Health Block Grant.
- Medicaid Services.
- Family Support Subsidy.

#### **Service Coordination at the State Level**

- MDHHS determines eligibility, provides case management for Medicaid and administers Disability Determination Service for Title II and XVI funds.

- MDHHS Bureau of Community Action and Economic Opportunity provides support and oversight to Michigan’s 29 community action agencies, covering 100 percent of the state. Local agencies develop community partnerships, involve low-income clients in their operations and coordinate an array of services within their communities. They provide low-income individuals with services including Head Start, housing assistance, weatherization, senior services, income tax preparation, food, transportation, employment assistance and economic development.
- In addition to child welfare services funded through Title IV-B(1), MDHHS allocates funds annually to all 83 counties for community-based needs assessment, service planning, contracting and service delivery to children and families. Local funding of services ensures diversified and appropriate services are available in each community. The programs provided under the community-based services umbrella incorporate CFSR standards.
- MDHHS coordinates with other federal and state programs for youth, including transitional living programs funded under Part B of the Juvenile Justice and Delinquency Prevention Act of 1974, in accordance with Section 477(b)(3) of the Act. Young people meeting the criteria for Chafee-funded services are eligible, regardless of race, gender or ethnic background. A youth who has or had an open juvenile justice case and is placed in an eligible placement under the supervision of MDHHS is eligible for Chafee funded goods and services.
- The Office of Child Welfare Policy and Programs and the Office of Child Support collaborate to enable foster care and CPS staff to obtain paternity information from the Central Paternity Registry to ascertain parental responsibility and coordination for child support payment for children in the child welfare system.
- Michigan’s Title IV-E state plan demonstrates compliance with the Fostering Connections Act. MDHHS finalized policies for Young Adult Voluntary Foster Care, Juvenile Guardianship Extension and Adoption Subsidy Extension programs to extend benefits through age 21 for young people who meet the requirements.
- Juvenile Justice Programs implements the Michigan Youth Reentry Initiative that operates through a contract for care coordination, with an emphasis on assisting young people with significant medical, mental health or other functional life impairments that may impede success when re-entering the community.
- The Child Care Fund is a collaborative resource between state and county governments that supports programs serving neglected, abused and delinquent youth in Michigan. Michigan’s county courts design and administer the programs.
- Michigan’s Interstate Compact staff serves as a liaison between local MDHHS offices and other states to ensure compliance with compact regulations and effective coordination.

## **Local Coordination of Financial and Child Welfare Assistance Pathways to Potential**

Pathways to Potential is MDHHS’ cash assistance service delivery model that focuses on three elements: 1) location in the community where clients live, 2) working with families to remove barriers by connecting them to a network of services and 3) engaging stakeholders and school

personnel to help students and families find their pathway to success. Pathways to Potential is focused on identifying barriers to academic success and offering solutions to the student, family and school personnel. Pathways to Potential places MDHHS workers in schools to address families' barriers to self-sufficiency in key areas: safety, health, education and school attendance. Pathways objectives include:

### **Safety**

- Increase access to prevention services.
- Engage disconnected youth.
- Connect vulnerable youth and adults to a protective network.

### **Health**

- Remove barriers that prevent access to health care.
- Increase access to healthy foods.
- Increase access to behavioral health care.
- Support good hygiene.
- Support physical fitness.

### **Education**

- Remove barriers to attendance.
- Remove barriers to active participation.
- Enhance and support parental involvement.

### **School Attendance**

- Increase school attendance rates/decrease chronic absenteeism.
- Actively seek parental engagement.

### **Self-Sufficiency**

- Remove barriers to employment.
- Assist in accessing quality childcare.
- Promote adult education.
- Support access to transportation.

### **Progress in 2017**

During the 2016/2017 school year, success coaches interacted with or on behalf of students, adults/caregivers and community members to address barriers and provide referrals, resources and follow-up, as identified by success coaches. The success coaches had 131,285 interactions identifying barriers and providing referrals, resources or follow-up as identified by the success coaches. In the total number of interactions, the success coaches had contact with 46,108 students. Some of the barriers addressed by the success coaches were:

- Chronic absenteeism.
- School uniforms.
- Student behavior.
- Homelessness.

- Employment.
- Medical needs.
- Hygiene.
- Holiday giving.
- Resources.
- Transportation.

Through the removal of these barriers, success coaches were able to identify resources and remove barriers to attendance.

### **Areas with Pathways Schools**

- Pathways to Potential is currently in 270 schools in 43 counties. MDHHS will be adding additional schools and counties later in 2018.
- Counties with Pathways to Potential programs include: Allegan, Bay, Benzie, Berrien, Calhoun, Clare, Genesee, Gladwin, Gogebic, Huron, Jackson, Kalamazoo, Kalkaska, Kent, Lapeer, Macomb, Manistee, Marquette, Mason, Mecosta, Midland, Muskegon, Newaygo, Oakland, Ogemaw, Ontonagon, Ottawa, Roscommon, Saginaw, St. Clair, Tuscola, Washtenaw and Wayne.

### **Planned Activities for 2019**

- Michigan’s child welfare implementation plan provides a structure for addressing federal and state compliance with legal and policy requirements and other initiatives that fall within the scope of MDHHS. Collaborative assessment, planning and coordination central to this structure will continue.
- The Pathways model will undergo an expansion into new schools and counties.

## **Coordination of Financial and Child Welfare Assistance**

### **Assessment of Performance**

**Goal:** MDHHS will be responsive to the community statewide through engagement with stakeholders.

- **Objective 1:** MDHHS will engage in ongoing consultation with tribal representatives, consumers, service providers, foster care providers, the juvenile court and other public and private child and family service agencies to ensure collaboration addresses the implementation of the Child and Family Services Plan and annual updates.

**Measure:** Annual Implementation Report.

**Baseline:** Strengthening Our Focus Advisory Council (now known as the QIC) and sub-teams, 2015.

**Benchmarks:**

**2016 – 2019:** Utilize the QIC and QSR findings for consultation and collaboration.

- **Objective 2:** MDHHS will utilize the QIC and sub-teams to operationalize a continuous quality improvement plan that includes engaging internal and external stakeholders in assessment and development of effective strategies.

**Measure:** Annual Implementation Report.

**Benchmarks 2016 – 2019:**

- MDHHS will utilize the QIC and sub-teams for consultation and collaboration.
  - MDHHS will develop local organizational structures, resources and activities that reach the QIC and sub-team for communication about strengths and areas needing improvement and strategies to improve the child welfare system.
- **Objective 3:** MDHHS will integrate analysis of state data on child welfare indicators and outcomes to assess performance and trends and ensure the state’s services are coordinated with services and benefits of other federal programs.

**Measure:** Annual Implementation Report.

**Benchmarks 2016 - 2019:**

- MDHHS has developed and is implementing a state level organizational structure, resources and activities to assess child welfare data and trends, including feedback from stakeholders in the QSR process.

### **Plan for Improvement - Activities for 2018 and 2019**

- The Pathways model will undergo a three-year evaluation by the Johnson Center at Grand Valley State University through a grant funded by the Kellogg Foundation.
- Michigan’s child welfare implementation plan provides a structure for addressing federal and state compliance with legal and policy requirements and other initiatives that fall within the scope of MDHHS. Collaborative assessment, planning and coordination central to this structure will continue.

### **Implementation Support**

- Pathways to Potential outcomes are supported by interagency partnerships with the Michigan Department of Education (Office of Great Start and Race to the Top), Michigan Rehabilitation Services and the Michigan Economic Development Corporation.
- The Foster Care Review Board will continue to review permanent ward cases as required by Michigan law, as well as conduct foster parent appeals of children being replaced by the foster care agency. The appeal process is consistently identified as valuable for improving placement stability for children.
- CSA will continue to participate in workgroups stemming from the Michigan Race Equity Coalition to address issues of racial inequality in child welfare. The MDHHS Diversity Equity report was recently released.

### **Technical Assistance and Capacity Building**

- MDHHS will continue participation with the Michigan Race Equity Coalition to assess progress and identify opportunities for improvement in addressing issues of racial inequality in child welfare.
- The Wayne County Third Circuit Court and the department will continue collaborating with Casey Family Programs to improve child welfare services in Wayne County, focusing on timeliness to permanency, need for trauma-informed interventions,

increasing parenting time, monitoring children receiving psychotropic medication, compliance with timely ICWA notification.

- The Pathways to Potential model will undergo a three-year evaluation by the Johnson Center at Grand Valley State University through a grant funded by the Kellogg Foundation.

## FOSTER AND ADOPTIVE PARENT RECRUITMENT, LICENSING AND RETENTION

Infants, children and youth from various geographic, ethnic and cultural backgrounds need foster and adoptive homes. Michigan's demographic and cultural diversity ranges from northern and rural, to urban southeastern Michigan, and the foster care population is similarly varied. Maintaining an adequate array of placements that reflect the ethnic and racial diversity of children in care continues to be a top priority. Placement with relatives for foster care and adoptive care is a strength, and the state-administered structure ensures a smooth process for placement of children across jurisdictions.

Michigan has over 13,000 children in foster care and relies on public and private child placing agencies to find temporary and permanent homes for these children. Michigan has over 90 contracts with private child placing agencies for foster care case management and over 60 contracts for adoption services.

### **Diligent Recruitment that Reflects the Ethnic and Racial Diversity of Children**

CSA provided data and resources to counties to assist them in completing their Adoptive and Foster Parent Recruitment and Retention plans in 2017. Each county received data regarding:

- Demographics of children in care by county.
- Children entering and exiting care by county.
- Total number of foster homes licensed by county.
- Foster home closures by relative and non-related foster homes.
- Data to complete the Foster Home Estimator, a foster home needs assessment tool.

For fiscal year 2017 planning, MDHHS used the Foster Home Estimator developed by Wildfire Associates in collaboration with Dr. Denise Goodman with support and funding from the Annie E. Casey Foundation. The Foster Home Estimator enabled each county to analyze its data including:

- The number of children in care.
- Trends over the past two years of the number of children in care.
- The races of children in care.
- The number of children who are over age 13 or in a sibling group.
- The number of foster homes available.
- The average number of beds in a home.
- The percentage of beds in that county that are viable.
- The percentage of homes that were closed the previous year.

The tool identified a need for homes for specific age ranges, sibling groups and homes that match the race of children in the county. This information was valuable to local counties as they developed data driven recruitment plans to adequately serve their foster care population within their own community.

Local MDHHS offices and private agencies reviewed the data and Foster Home Estimator results to identify targeted populations. MDHHS offices and private agencies collaborated to identify non-relative licensing goals and strategies to recruit homes for the targeted populations.

In 2017, county licensing goals were analyzed and monthly targets were established to assist counties in monitoring their progress toward licensing unrelated foster and adoptive homes. Michigan's plan for diligent recruitment of foster and adoptive families is presented in Attachment H, Foster and Adoptive Parent Diligent Recruitment, Licensing and Retention Plan.

### **Recruitment of Foster and Adoptive Parents for Diverse Youth**

In addition to the information previously provided about the Foster Home Estimator, targets are shared with each county for the recruitment of foster and adoptive homes that match the racial and/or cultural diversity of children entering foster care in that county. These targets help the county gain a better understanding of which populations to focus on to achieve an array of diverse foster homes within the county.

### **Licensing Standards and Process**

In Michigan, the MDHHS Division of Child Welfare Licensing (DCWL) monitors and enforces statewide licensing standards and ensures that they are consistently applied. Child-placing agencies, child caring institutions, foster family homes and foster family group homes are licensed through the division. Private child-placing agencies certify foster homes for licensure and send their recommendation to the division. The division reviews the documentation and decides whether to issue foster home licenses. Licensing variances are only granted for non-safety related rules. Follow-up visits to determine ongoing rule compliance and to complete renewals are done by child-placing agencies and sent to the Division of Child Welfare Licensing for processing.

Effective Jan. 1, 2008, an amendment to the Child Care Organizations Act, Public Act 116 of 1973, required fingerprinting of applicants for adoption and foster home licensure. Michigan must comply with the FBI Criminal Justice Information Services Security Policy. The following checks are completed on foster parent applicants and results are documented on the Licensing Record Clearance Request-Foster Home/Adoptive Home (CWL-1326) and in the Division of Child Welfare Licensing Bureau Information Tracking System:

- Fingerprint based criminal records checks.
- Public Sex Offender Registry.
- Central Registry.
- Secretary of State.
- CPS history.
- Previous licenses issued/closed.

Michigan law requires criminal history checks to be completed on all persons over 18 years residing in a licensed foster family home or foster family group home. The following record checks are completed on adult household members and documented on the License Record Clearance Request form and in the Bureau Information Tracking System:

- Law Enforcement Information Network.
- Internet Criminal History Access Tool.
- Central Registry.
- Public Sex Offender Registry.
- Secretary of State.
- CPS history.
- Previous licenses issued/closed.

When an agency completes the licensing evaluation, including the assessment of any conviction(s), and if the decision is made to recommend licensure despite conviction(s) for specified crimes as indicated in the Good Moral Character licensing rules, the agency completes the Administrative Review Team Summary and submits it with the initial licensing packet. Michigan's Good Moral Character Rule identifies criminal offenses that presume a lack of good moral character. Administrative Review is the process by which a licensee or applicant may rebut the Good Moral Character Rule's presumption by demonstrating detailed evidence of rehabilitation. If, in addition to a conviction for a specified crime, there are convictions for other crimes not specified in the Good Moral Character rule, all convictions must be addressed in the Administrative Review Summary. Decisions made by the Administrative Review Team are not subject to appeal. Subsequent disciplinary licensing actions are subject to appeal per MCL 722.121.

Once all record clearances are completed, the applicant is enrolled as a foster parent. Anytime a foster parent is fingerprinted by a police agency or has a new conviction in Michigan, the Michigan State Police sends an email to DCWL the next morning. Each week, DCWL receives a list of any names associated with a license that were placed on Central Registry. A new criminal history check is completed on all non-licensee adults in the household at each renewal.

### **Ensuring Proper Screening for all Foster and Adoptive Parents**

In Michigan, the following activities ensure that every foster and adoptive parent has a criminal history and Central Registry screening completed prior to licensure or home study approval:

- Every applicant is required to undergo fingerprinting, allowing accurate state and FBI criminal history clearance.
- Every applicant has a sexual offender registry clearance completed prior to licensure or home study approval.
- Every person has a central registry clearance completed prior to licensure or home study approval.
- Criminal history, sexual offender and central registry clearances are completed on every adult household member prior to licensure.

### **Foster and Adoptive Parent Training**

Foster and adoptive families are provided pre-service training prior to approval as a licensed foster family or pre-adoptive placement. Among other things, this training provides expectations and tools to assist families in caring for children from other cultural backgrounds and the LGBTQ community. Many MDHHS offices and private child-placing agencies provide training on this topic to current foster and adoptive parents.

### **Adoption Services**

Michigan executes contracts for adoption services with 61 private child-placing agencies. All adoption contracts are statewide and include expectations of conducting Interstate Compact Adoptive Home Studies, requesting Adoptive Home Studies through the Interstate Compact process for adoptive placements in other states and performing adoption services on assigned cases, including cross-county placements.

If a child's permanency plan is to be adopted by a family residing outside of the state of Michigan, the Interstate Compact on the Placement of Children (ICPC) must be used. Foster care and adoption staff must coordinate the referral process through the MDHHS Interstate Compact Office. A child cannot be placed out of state for relative placement, foster care placement or adoption without prior written approval from the receiving state through the ICPC process.

### **Child-Specific Recruitment Activities**

Child-specific recruitment is the most effective strategy to find an appropriate adoptive family for a child. If an adoptive family is not identified at the time of referral:

- A written, child-specific recruitment plan must be developed within 30 calendar days of the date of acceptance of the case transfer.
- The child must be registered for photo listing on the Michigan Adoption Resource Exchange (MARE) within 30 calendar days of termination of parental rights or the date of acceptance of the case transfer, whichever is later.
- An adoption case must be referred to an adoption resource consultant if an adoptive home has not been identified for the child within one year of the child being legally free with a goal of adoption.
  - Adoption resource consultants provide services until permanency is achieved through adoption or one of the other four federal permanency goals.
- Adoption navigators provide support and assistance to families pursuing adoption of children from Michigan's child welfare system.
- MARE produces recruitment brochures, videos and newsletters, maintains an informational website, hosts "meet and greet" events and maintains the Michigan Heart Gallery, a traveling exhibit featuring children for adoption.
- The MARE Match Support Program provides statewide services for families who have been matched with a child from the website and are moving forward with adoption. The Match Support Program provides up to 90 days of informational and referral services to families.

Progress in 2017 on licensing non-relative foster homes and homes for special populations:

Statewide	Goal for non-relative foster homes to be licensed	Number of non-relative foster homes licensed	Goal for non-relative homes to be licensed for adolescents	Number of non-relative foster homes licensed for adolescents	Goal for non-relative homes to be licensed for siblings	Number of non-relative foster homes licensed for siblings	Goal for non-relative homes to be licensed for children with disabilities	Number of non-relative foster homes licensed for children with disabilities
Statewide Totals	1150	1299	799	369	663	786	273	850

Data Source: MDHHS Child Welfare Licensing.

From Oct. 1, 2016 to Sept. 30, 2017, MDHHS and private child placing agencies licensed:

- Over 100 percent of the non-relative foster home goal.
- Forty-six percent of the non-relative foster home goal for adolescents.
- Over 100 percent of the non-relative foster home goal for sibling groups.
- Over 100 percent of the non-relative foster home goal for children with disabilities.

The following recruitment and licensing activities were carried out locally in Michigan to ensure foster and adoptive homes met the needs of children and families in their area:

- Outlined strategies to recruit and retain foster, adoptive and kinship families.
- Produced specialized dashboards that monitored the number of licensed homes, the number of closed homes, average length of time to achieve licensure, number of children placed in residential care and number of children placed with relatives.
- Provided tools and guidelines for analyzing demographic data for recruiting, licensing and retaining foster, adoptive and kinship parents.

Each local MDHHS office was expected to:

- Collaborate with private agency partners, local tribes, faith communities, service organizations and foster/adoptive/kinship parents in completing annual recruitment and retention plans.
- Provide specific strategies for reaching out to all parts of the community.
- Assure all prospective foster/adoptive/kinship parents have access to child-placing agencies that provide foster home certification.
- Increase public awareness of the need for adoptive and foster homes through general, targeted and child-specific recruitment activities within the counties.
- Provide strategies for dealing with linguistic barriers.

Counties determined local goals and action steps based on historical trends and data provided by the Office of Child Welfare Policy and Programs that include:

- Characteristics of children in care (i.e. age, gender, race and living arrangement).
- Characteristics of children entering and exiting foster care.

- Total number of homes licensed by the county at a point in time.
- Number of foster homes licensed by the county during specified periods.
- Foster home closure reasons.
- Demographic data on barriers to placements.

County performance:

- Seventy-nine percent of counties met at least 90 percent of their annual recruitment goal. This is an increase of 12 percent from 2016.
- Eighty-nine percent of counties met at least 70 percent of their annual recruitment goal.

### Progress in 2018

MDHHS began using the Foster Home Estimator developed by Wildfire Associates in Foundation. The Foster Home Estimator allowed each county to analyze data including:

- The number of children in care.
- Trends over the past two years of the number of children in care.
- The races of children in care.
- The number of children who are over age 13 or in a sibling group.
- The number of foster homes available.
- The average number of beds in a home.
- The percentage of beds in that county that are viable.
- The percentage of homes that were closed the previous year.

The needs identified by this tool were homes for specific age ranges, sibling groups and homes that match the race of children in the county. This information was valuable to local counties as they developed data driven recruitment plans to adequately serve their foster care population, within their own community.

The table below outlines the goals and progress for the six-month period from Oct. 1, 2017 through March 31, 2018, for licensing non-relative foster homes and homes for special populations.

	Goal for non-relative foster homes to be licensed	Number of non-relative foster homes licensed	Goal for non-relative homes to be licensed for adolescents	Number of non-relative foster homes licensed for adolescents	Goal for non-relative homes to be licensed for siblings	Number of non-relative foster homes licensed for siblings	Goal for non-relative homes to be licensed for children with disabilities	Number of non-relative foster homes licensed for children with disabilities
<b>Statewide</b>								
Statewide Totals	1129	524	702	126	737	304	300	356

In the span of six months, MDHHS and private child placing agencies licensed:

- Forty-six percent of the 12-month non-relative foster home goal.

- Eighteen percent of the 12-month non-relative foster home goal for adolescents.
- Forty-one percent of the 12-month non-relative foster home goal for sibling groups.
- Over 100 percent of the 12-month non-relative foster home goal for children with disabilities.

The enhanced non-relative licensing dashboard, released in 2017, continues to be used in 2018. The dashboard allows users to identify licensing progress at a statewide, BSC, county and agency level, and provides additional data not previously compiled and released. The following data is included:

- Four speedometers that show percentage of the licensure goal achieved (overall and for each special population).
- The number of foster homes opened compared to the number of foster homes closed. Graphs show this data by month and by fiscal year.
- Days to licensure.
- Number of enrollments.
- Number and percentage of residential placements by age group.
- Number and percentage of children placed with relatives.

MDHHS county offices and private agencies continue to collaborate on a local level to recruit, retain and train foster, adoptive and relative families, as outlined in each county Adoptive and Foster Parent Recruitment and Retention Plan. Targeted recruitment activities include:

- Back-to-school events.
- Community festivals, fairs and events.
- Flyers and presentations at local schools.
- Presentations at local hospitals and doctor offices.
- Foster care awareness and appreciation events.
- Adoption Day events.
- Presentations at congregations on the need for foster and adoptive parents.
- Collaboration with community and faith-based partners.
- Foster parent support groups.
- Flyers at sporting events.
- Local community presentations.
- Visiting library displays.
- Movie trailer ads.
- Billboards.

### **Regional Resource Teams (RRT)**

RRTs focus on recruiting, supporting and developing foster families to meet annual non-relative licensing goals, retain existing foster families, prepare families for the challenges associated with fostering and develop existing foster family skills to enable them to meet the needs of children with more challenging behaviors. RRT contracts went into effect in December 2017/January 2018.

### **Adoption and Legal Guardianship Incentive Payments**

Michigan received \$458,000 in Adoption and Legal Guardianship Incentive Funds in fiscal year 2016. The state will expend the Adoption and Legal Guardianship Incentive Payment from fiscal year 2016 in accordance with Sec. 473A of the Social Security Act, and will obligate the funds no later than Sept. 30, 2019. Michigan will liquidate any remaining funds no later than Dec. 21, 2019. Specific plans for fund expenditures have not been finalized.

### **Post Adoption Resource Centers**

Post Adoption Resource Centers are designed to support families who have finalized adoptions of children from the Michigan child welfare system, children who were adopted in Michigan through an international or a direct consent/direct placement adoption and children who have a Michigan subsidized guardianship agreement. Family participation is voluntary and free of charge. Adoption Resource Centers offer:

- Case management, including short-term and emergency in-home intervention.
- Coordination of community services.
- Information dissemination.
- Education.
- Training.
- Advocacy.
- Family recreational activities and support.
- Website and newsletter on topics relevant to adoptive families.

### **Adoption Resource Consultant services throughout the state:**

- Provide services to young people who have a permanency goal of adoption and have been legally free for adoption for one year or more without an identified family.
- Utilize a solution-focused model.
- Develop, review and amend the Individualized Adoption Plan with specific recruitment steps to place a child in an adoptive or pre-adoptive home.
- Assist with problem solving to eliminate barriers and enhance each Individualized Adoption Plan.

### **The statewide Parent-to-Parent Program:**

- Contracts with the Adoptive Family Support Network.
- Provides support, education, information and referral services to adoptive parents through:
  - Adoption support groups.
  - Adoptive parent seminars/trainings/workshops.
  - Adoptive family fun events.
  - Parent-to-parent hotline.

### **Foster and Adoptive Parent Recruitment, Licensing and Retention Assessment of Performance**

Michigan's performance in the Foster and Adoptive Parent Recruitment, Licensing and Retention systemic factor is measured through monitoring the percentage of counties that

meet their licensing goals. Performance is also reflected in the percentages of children who are placed in permanent homes in a timely manner and the number of relative caregivers that complete the licensing process.

**Goal:** MDHHS will implement an annual adoptive/foster parent recruitment and retention plan to ensure there are foster and adoptive homes that meet the diverse needs of the children who require out-of-home placement.

- **Objective 1:** MDHHS will ensure that state standards are applied to all licensed or approved foster family homes or child-caring institutions receiving Title IV-B or IV-E funds by:
  - Tracking demographic data of children in foster care.
  - Screening all applicants for foster and adoptive home licensing to meet minimum standards.
  - Developing a seclusion and corporal punishment protocol.
  - Developing a continuous quality improvement process for institutions.

**Measures:** Child welfare licensing data and other sources.

**Benchmarks 2015 – 2019:** Local licensing agencies will collaborate with the Division of Child Welfare Licensing to ensure all standards are applied equally.

- **2017 Performance:** Collaboration between local licensing agencies and the Division of Child Welfare Licensing continued to ensure standards were applied equally.

- **Objective 2:** MDHHS will ensure that the state complies with federal requirements for criminal background clearances for licensing foster and adoptive homes and has provisions for ensuring the safety of foster and adoptive placements.

**Measures:** Criminal history and central registry screening of foster or adoptive applicants.

**Benchmarks 2015 – 2019:** Collaboration between the Division of Child Welfare Licensing and local child-placing agencies to ensure each foster and adoptive home is screened and approved before children are placed.

- **2017 Performance:** One hundred percent of licensed foster homes had a completed criminal history and central registry screening prior to licensure.

- **Objective 3:** MDHHS will recruit and license an adequate and sufficient array of foster and adoptive homes to reflect the ethnic and racial diversity of children in the state for whom foster and adoptive homes are needed.

**Measure:** Percentage of annual recruitment, licensing and adoption plans that meet 90 percent of their goal, or better.

**Baseline:** Each county's 2015 licensing goal.

**Benchmarks: 2016 – 2019:** Eighty percent or more of annual plans will meet 90 percent of their goal.

**2016 Performance:**

- Sixty-seven percent of counties met at least 90 percent of their annual recruitment goal. This is an increase of 2 percent from 2015.

- Eighty-eight percent of counties met at least 70 percent of their annual recruitment goal. This is an increase of 9 percent from 2015.
- Foster Home Array results, for ISEP Commitment 6.5, met the goal.

**2017 Performance:**

- Seventy-nine percent of counties met at least 90 percent of their annual recruitment goal. This is an increase of 12 percent from 2016.
  - Eighty-nine percent of counties met at least 70 percent of their annual recruitment goal. This is an increase of 1 percent from 2016.
- **Objective 4:** MDHHS will support safe and timely placement across jurisdictions when such placement is in the best interest of the children.  
**Measure:** Interstate Compact data on percentage of out-of-state placements in Michigan with completed home studies within 60 days of the state’s request.  
**Baseline - 2013:** Sixty-two percent of home studies were completed with 60 days.
    - **2015 Performance:** Sixty-six percent of home studies were completed within 60 days.
    - **2016 Performance:** Seventy-one percent of home studies were completed within 60 days.
    - **2017 Performance:** Fifty-five percent of home studies were completed within 60 days.
  - **Objective 5:** MDHHS will ensure timely search for prospective parents for children needing adoptive placements, including the use of exchanges and other interagency efforts, if such procedures ensure that placement of a child in an appropriate household is not delayed by the search for a same race or ethnic placement.  
**Measure:** Number of children available for adoption without an identified family who are registered with MARE within required timeframes.  
**Baseline - 2014:**
    - Eighty percent of children available for adoption without an identified family were registered with MARE within required timeframes.
    - Eighty percent of children available for adoption without an identified family one year after termination of parental rights were referred to an Adoption Resource Consultant.**Benchmarks 2015 – 2019:** Demonstrate improvement each year.  
**2017 Performance:**
    - Twenty-two children were registered within the required timeframes; 39 percent compliance.
    - From Oct. 1, 2017 through March 31, 2018, 26 children were registered within the required timeframes; 41 percent compliance.
    - In 2017, 165 children were referred to the Adoption Resource Consultant Program.
    - From Oct. 1, 2017 through March 31, 2018, 89 children were referred to the Adoption Resource Consultant Program.

**Plan for Improvement - Activities for 2018 and 2019**

The following services will continue:

- Eight regional Post Adoption Resource Centers will provide services to support families who have finalized adoptions of children from the Michigan child welfare system or children who were adopted in Michigan through an international or a direct consent/direct placement adoption or children who have a Michigan subsidized guardianship agreement.
- Adoption resource consultant services.
- Adoption navigator services.
- MARE Match Support Program.
- The Adoption Oversight Committee will meet bi-monthly.
- Foster care navigator services.
- Six regional resource teams will continue to provide all pre-licensure and pre-adoptive parent training, provide parent support throughout the licensing process and provide recruitment and retention support to local MDHHS offices to enhance local recruitment and retention efforts.

### **Implementation Support**

- Collaboration and planning among MDHHS county offices, private agencies, federally recognized tribes, faith communities and key foster/adoptive/kinship parents occurs to determine the county's overall recruitment needs and goals and the actions steps required to achieve those goals.
- Public and private child placing agencies use the Foster Home Estimator to assess the need for foster homes in their respective communities.
- Eight regional Post Adoption Resource Centers provide services to support families who have finalized adoptions of children from the child welfare system.
- Foster care and adoption staff coordinate the referral process through the Interstate Compact Office.
- The Michigan Adoption Resource Exchange Match Support Program provides statewide services for families who have been matched with a child from the website and are moving forward with adoption.

### **Program Support**

- MDHHS utilizes the Placement sub-team to monitor the implementation plans for placement of children in unlicensed, relative homes and addresses practice in foster parent and relative licensing and placement exceptions.
- Adoption resource consultant services throughout the state provide services to young people who have a permanency goal of adoption and have been legally free for adoption for one year or more without an identified family.

### **Technical Assistance and Capacity Building**

- MDHHS will continue using the Foster Home Estimator developed by Wildfire Associates with support and funding from the Annie E. Casey Foundation.

### **Tribal Consultation and Coordination**

MDHHS delivers services to Michigan's 230,000 American Indian/Alaska Natives population through the office of Native American Affairs. Native American Affairs provides:

- Policy and program development.
- Resource coordination for tribal agencies.
- Advocacy to ensure access to necessary services.
- Training and technical assistance on serving Indian families and children.
- Implementation of state and federal laws pertaining to American Indians and tribal consultation.

Michigan engages in government-to-government relations with the state's federally recognized tribes prescribed by Presidential Memorandum 2009 (tribal consultation), Michigan Governor Rick Snyder's Executive Directive 2012-2, Title XX of the Social Security Act and the Children's Bureau guidance on tribal consultation.

### **Statewide APSR Tribal Consultation**

The Native American Affairs specialist interacted with tribal nations and organizations to discuss and enhance Indian Child Welfare Act (ICWA) implementation in MDHHS policies and services at onsite tribal consultation sessions and quarterly meetings in 2017.

Prior to the state submitting the 2018 APSR, MDHHS took the following steps to coordinate and collaborate with tribes in the implementation and assessment of the report:

- Convened the MDHHS-Tribal Forum, a tribal consultation meeting with the MDHHS director and deputy staff that included departmental updates, presentations and consultation between the MDHHS director and federally recognized tribes (Jan. 4, 2017).
- Facilitated Tribal-State Partnership meetings, a collaborative group of Tribal Social Services directors, state and private agencies and MDHHS staff that discusses Indian child welfare consultation and the implementation of the Indian Child Welfare Act of 1978 (Jan. 18-19, 2017, April 19-20, 2017, July 26-27, 2017 and Oct. 18-19, 2017).
- Facilitated the Urban Indian State Partnership meeting, an annual networking meeting comprised of urban Indian organizations, state agencies and MDHHS staff focusing on the challenges facing tribal at-large membership and point-of-entry for MDHHS services. The November 2017 meeting was cancelled due to meeting conflicts.
- Provided MDHHS updates at quarterly United Tribes of Michigan meetings in 2017, a forum for tribes to join, advance, protect, preserve and enhance the mutual interests, treaty rights, sovereignty and cultural way of life of Michigan tribes through the next seven generations (Feb. 22-23, 2017 and May 10-11, 2017).
- Convened Quarterly Regional Indian Outreach Worker meetings for service enhancements and professional development (April 19, 2017, July 11-12, 2017 and Nov. 7-8, 2017).
- Participated in Quarterly SCAO Court Improvement Program statewide task force

meetings to reform court processes to better meet the needs of Indian children (March 17, 2017, June 23, 2017, Sept. 15, 2017 and Dec. 8, 2017).

- Conducted NAA onsite tribal consultation sessions with seven of the 12 Michigan tribes between May 2017 and August 2017.
- Provided tribes with the state APSR in the July 2017 Tribal State Partnership meeting.
- Exchanged state and tribal APSRs annually through the coordinated efforts of Native American Affairs and tribes. In 2018, MDHHS will exchange the state APSR with tribes at the October 2018 Tribal State Partnership meeting.

### **Gathering Feedback from Tribes**

Since the submission of the 2018 APSR, the process that the state used to gather input from tribes, including the steps taken by the state to reach out to all federally recognized tribes in the state included:

- Involvement of tribal representatives on committees:
  - MDHHS Adoption/Foster/Kinship Care Committee.
  - Michigan Human Trafficking Task Force.
  - MDHHS CFSR steering committee and workgroup.
- Dissemination of federal, state and MDHHS child welfare policy, training, funding opportunities, ICWA law updates, and research publications to tribal social service directors and urban Indian organization directors in Michigan.
- Ongoing information sharing from MDHHS to tribal social service directors and urban Indian organizations. Information sharing provides notice to tribes and urban Indian organizations on various information sources that may initiate consultation or technical assistance requests through the tribal consultation process at Tribal-State Partnership Meetings, individual consultation, Urban Indian State Partnership, and the Tribal State Forum with Director Lyon.
- Local case management meetings held between tribes and county MDHHS office leadership as needed on an ongoing basis.

### **APSR 2019 Tribal Consultation Webinar and Survey Feedback**

- In March 2018, DCQI and Native American Affairs convened a webinar for representatives from Michigan's tribes to gather feedback on ICWA compliance. However, no tribal representatives attended the webinar.
- The APSR Tribal Consultation webinar materials and APSR Tribal Consultation Director's Survey were disseminated to the tribes after the webinar on March 28, 2018 to provide tribes with additional opportunities to provide feedback.
- The American Indian/Alaska Native Data Report, generated from MiSACWIS, was disseminated to the tribes on April 11, 2018.
- The Tribal Consultation Director's Survey was provided to MDHHS county and BSC directors, private agency foster care directors, and tribal representatives in April 2018. One tribal representative responded.

MDHHS continues to explore ways through the Tribal-State Partnership and Native American Affairs to improve engagement with tribes concerning ICWA compliance for reporting in the CFSP/APSR including workgroups and monthly Tribal Social Services Director Conference Calls. To date in 2018, tribes have declined participation in these opportunities.

### **County and Business Service Center Director Survey**

An additional survey was conducted in 2018 to identify local and regional efforts that were taken to improve compliance with ICWA and MIFPA and best practices that can be replicated in other areas of the state. Forty county directors, five BSC directors and 11 MDHHS private agency foster care directors responded. The complete survey results are contained in Attachment I, Native American Affairs Tribal Consultation Director's Survey

### **Ongoing Coordination and Collaboration with Tribes**

The state is taking the following steps to achieve ongoing coordination and collaboration with tribes in the implementation and implementation of the CFSP/APSR:

- MDHHS and tribes exchange CFSP/APSR upon Children's Bureau approval of plans/reports annually at the October Tribal-State Partnership Meeting.
- The 2017 Indian Child Case Review results will be published, presented, and reviewed upon completion in 2018.
- The American Indian/Alaska Native Data Report cleanup process between MDHHS and tribes is ongoing.
- Native American Affairs information sharing of federal, state, and MDHHS policy, training, funding opportunities, ICWA law, and research via email is ongoing.
- Annual Native American Affairs onsite tribal consultation will occur.
- Quarterly Regional Tribal State Partnership Meetings will occur.
- Additional Tribal Consultation with tribes pursuant to the State Tribal Accord with MDHHS and the Governor's Office will occur.
- The Annual Urban Indian Partnership Meeting will occur.
- The director of Native American Affairs will attend federal/state tribal consultation meetings.

### **Barriers Identified by Tribes**

While progress has been made over the past four years of the current five-year Child and Family Service Plan (CFSP) regarding tribal consultation, Michigan tribes expressed concerns in 2017 with four areas that affect Indian child welfare. This APSR describes the state's efforts to remove the identified barriers and improve outcomes for tribal children and families in Michigan. The four areas of priority concern identified by tribes in 2017 include:

1. Jurisdiction on tribal lands/tribal sovereignty;
2. American Indian/Alaska Native child ancestry verification; see Data on American Indian Children, below.
3. Notice of Indian child custody proceedings.
4. American Indian/Alaska Native data integrity.

## **Data on American Indian Children and Families**

Tribes expressed concerns with proper identification of an Indian child due to American Indian Alaska Native Data Report errors in 2017. To remedy this, Native American Affairs created a new form (MDHHS 5598) as a precursor to the ICWA notice form for Indian child custody proceedings (DHS-120) to assist staff and tribes with identification of an Indian child at the onset of any department interaction with a family. A MiSACWIS ICWA Job Aid was created in 2017 to assist the field with properly inputting ICWA details in the electronic case record.

Tribes expressed concerns with the MDHHS American Indian/Alaska Native Data Report integrity pertaining to: 1) children missing from the report and 2) children that tribes determined were not members or eligible for membership. Data reports are specific to foster care proceedings including placement in-home, adoption and juvenile justice. Three hundred nineteen Indian children were under the care and supervision of MDHHS in 2017.

The department initiated a review of Indian data report functionality and a clean-up and quality assurance process in 2017. The data cleanup process pinpointed two areas for remedy:

1. Information was not being added in the correct screens in MiSACWIS and, because of this, queries produced inaccurate data.
2. Training for caseworkers and supervisors on MiSACWIS ICWA screens.

The MiSACWIS team, in collaboration with NAA, developed an ICWA job aid located on the Learning Management System in 2017 and added it to its staff ICWA training.

Tribes and MDHHS have agreed that the American Indian/Alaska Native Data Report will always have a margin of error due to the report being a point-in-time report identifying children with Native American ancestry. Current information about a child's Indian ancestry may not be in MiSACWIS due to the timeline of a case opening and the ancestry verification process of each tribe. For example, if a child is presented as and entered in MiSACWIS as a member of a tribe, but upon tribal verification, it is found that the child is not a tribal member, correction in MiSACWIS can sometimes be delayed or missed. Since each tribe has its own ancestry verification process, timing of response to verification questions varies. To accurately measure ICWA compliance on ancestry identification, tribal notification and transfer, active efforts and placement preferences, Michigan relies on the Quality Assurance Compliance Review and the Indian Child Case Review, both of which review multiple factors to track compliance with ICWA.

## **ICWA Compliance Assessment of Performance**

MDHHS tribal consultation performance in 2017 was measured through:

- Tribal consultation on Michigan's APSRs at quarterly Tribal State Partnership meetings and the Tribal State Forum Meeting in 2017/2018.
- Mandatory ICWA training for new workers and new supervisors.
- Individual onsite tribal consultation sessions with Michigan tribes.
- Review of Michigan Court of Appeals ICWA/Michigan Indian Family Preservation Act (MIFPA) cases from February 2017 through February 2018.

- MiSACWIS reporting on Indian children in foster care.
- A statewide survey of tribal social service directors, county and Business Service Center directors and private agency foster care agency directors.
- An Indian Child Case Review.

A reduction in the number of ICWA court appeals occurred from 2016 – 2017. Contested Court of Appeals cases dropped from 13 to 6. The court indicated that there were six contested cases in total compared to 13 cases in 2016. Of the six cases, two lower-court decisions were upheld (regarding notice to tribes and active efforts); one was affirmed in part, vacated in part, and remanded (active efforts) and two were conditionally reversed and remanded (notice to tribes).

### **Tribal Feedback on ICWA Compliance**

Tribal perspectives on ICWA compliance were obtained at the quarterly Tribal-State Partnership meetings, individual Native American Affairs onsite tribal consultation meetings that were held May through August in 2017, the Tribal State Forum with MDHHS Director Nick Lyon, an APSR Tribal Consultation webinar and an APSR Tribal Consultation Director’s Survey. No specific data measuring ICWA or MIFPA compliance was presented or addressed in tribal feedback.

### **Data on Indian Child Welfare Act Compliance**

- **MiSACWIS:** Ongoing monthly quality assurance of Indian foster care data reports occurred in 2017.
- **Indian Child Case Review:** The Indian Child Case Review utilizes a standardized scoring tool and feedback forms to review 1) paper case files, 2) MiSACWIS case records and 3) conduct interviews with caseworkers, supervisors and care providers. The review assesses ICWA compliance and quality of services to Indian children and families. The review also provides MDHHS program offices with policy and practice recommendations for Indian child welfare programming. Native American Affairs is responsible for facilitating the Indian Child Care Review.

The Indian Child Case Review tools and data dictionaries for CPS and foster care were developed in collaboration with Michigan tribes, DCQI, SCAO and Native American Affairs between 2012 and 2013. In 2016 and 2017, DCQI and Native American Affairs tested the review tool in MiSACWIS case reviews of Indian children in Michigan’s foster care system. Native American Affairs piloted an initial review with the assistance of Indian Outreach Services staff in 2017. Due to the lack of fiscal resources and the small number of volunteer case reviewers available in 2017 to conduct the review, the report completion timeline was expanded. Additional budget and staff supporting Native American Affairs as well as internal workgroups will be explored in 2019.

Results reported in the APSR 2019 are based on preliminary tally of responses, which at the time of this report, had not yet been confirmed. A complete summary of the project and findings are expected in 2018.

**Goal:** MDHHS will ensure compliance with the Indian Child Welfare Act statewide.

- **Objective 1:** MDHHS will increase the number of children identified as American

Indian/Alaska Native (AIAN) at the onset of cases statewide.

**Measures:** MiSACWIS data on Indian heritage and the Quality Assurance Compliance Review (QACR).

**Benchmarks:**

- **2015 Performance:**
    - **2015 MiSACWIS:** data inconclusive.
    - **2015 QACR:** data not available.
  - **2016 Performance:**
    - **QACR:** 88 percent
    - **MiSACWIS:** Of 230 AIAN youth placed in foster care, 60 percent (138) indicated that tribes intervened in state court, and 40 percent (91) of tribes did not intervene, or no data was recorded for tribal intervention.
  - **2017 Performance:**
    - **MiSACWIS:** 69 percent
    - **Indian Child Case Review:** Initial findings demonstrate that the majority of cases include a proper notification of a preliminary Indian child custody proceeding. Proof of mailing and subsequent hearing notices were not found in the majority of paper case files.
- **Objective 2:** MDHHS will ensure the notification of Indian parents and tribes of state proceedings involving Indian children and will inform them of their right to intervene in the proceeding.

**Measures:** MiSACWIS data on Indian heritage and QACR.

- **2015 Performance:**
    - **MiSACWIS:** data inconclusive.
    - **QACR:** data not available.
    - **2016 Performance - QACR:** 100 percent
  - **2017 Performance:**
    - **MiSACWIS:** 76 percent
    - **Indian Child Case Review:** Initial findings demonstrate that the majority of cases included proper notification of a preliminary Indian child custody proceeding. Proof of mailing and subsequent hearing notices are not found in the majority of paper case files.
- **Objective 3:** MDHHS will ensure that placement preferences for Indian children in foster care, pre-adoptive and adoptive homes are followed.

**Measures:** MiSACWIS data on Indian heritage and QACR.

**Benchmarks:**

- **2015 Performance:**
  - **MiSACWIS:** data inconclusive.
  - **QACR:** data not available.
- **2016 Performance:**
  - **MiSACWIS:** 100 percent
  - **QACR:** 100 percent

- **2017 Performance:**
  - **MiSACWIS:** 97 percent
  - **Indian Child Case Review:** Initial findings of paper case file reviews demonstrate that the majority of youth are placed in parental or relative homes.
  
- **Objective 4:** MDHHS will ensure that active efforts are made to prevent the breakup of the Indian family when parties seek to place an Indian child in foster care or adoption.  
**Measures:** MiSACWIS data on Indian heritage and QACR.  
**Benchmarks:**
  - **2015 Performance:**
    - **MiSACWIS:** data inconclusive.
    - **QACR:** data not available.
  - **2016 Performance:**
    - **QACR:** 100 percent
    - **MiSACWIS:** 100 percent
  - **2017 Performance:**
    - **MiSACWIS:** 100 percent
    - **Indian Child Case Review:** Initial findings of paper case file reviews demonstrate active efforts were made. Furthermore, the overall quality of case documentation and teaming regarding active efforts is optimal when tribes are collaborating on cases.
  
- **Objective 5:** MDHHS will provide timely notification to the child’s tribe of its right to intervene in any state court proceedings seeking an involuntary placement or termination of parental rights of Indian children.  
**Measures:** MiSACWIS data on Indian heritage and QACR.
  - **2015 Performance:**
    - **MiSACWIS:** data inconclusive.
    - **QACR:** data not available.
  - **2016 Performance:**
    - **MiSACWIS:** Of the 230 AIAN youth placed in foster care, 60 percent (138) of cases indicated that tribes intervened in state court, and 40 percent (92) did not intervene in court, or no data was recorded for tribal notification.
    - **QACR:** 100 percent
  - **2017 Performance:**
    - **MiSACWIS:** 76 percent
      - In 12 of the 319 Indian child welfare cases in 2017, tribes requested transfer to tribal agency/court in state court.
  - **Indian Child Case Review:** Initial findings of the majority of paper case file reviews indicate proper notice of a child custody proceeding was mailed but proof of mailing was not found in the paper file.
    - The majority of cases reflect when a request was made to transfer the

case to tribal court. The DHS-120B form required per NAA policy regarding transfer to tribal agency is not found in the paper file.

MiSACWIS recorded the following placement types for Indian children in foster care in 2017:

<b>Placement Type</b>	<b>Number of Children</b>
Parental Home	68
Relative Foster Home	85
Licensed unrelated foster home	68
Adoptive home	37
Juvenile guardianship	18
Rental home	4
Residential home	21
Detention	2
Estates and Protected Individuals Code guardianship	0
Unrelated caregiver	3
MDHHS Training School	2
Absent without legal permission (AWOLP)	2
College	0
Unknown	9
<b>Total</b>	<b>319</b>

### **Consultation on Protecting Tribal Children and Providing Child Welfare Services**

There are 12 federally recognized tribes in Michigan, two of which do not have formal Indian child welfare code pertaining to child welfare services (Match-E-Be-Nash-She-Wish Band of Potawatomi and Nottawaseppi Band of Huron Potawatomi Indians). To see the locations of Michigan and U.S. tribes, please see Attachment J: Native American/Alaska Native Population Maps.

Where tribal government agencies do not have child welfare or tribal court services available, the state provides care and supervision of Indian child welfare cases and collaborates with tribal ICWA coordinators on case management. Child welfare case management is provided through 83 local MDHHS offices and private foster care providers. Michigan has individual consultation agreements with eight federally recognized tribes or communities:

- Bay Mills Indian Community.
- Hannahville Indian Community.
- Lac Vieux Desert Band of Lake Superior Chippewa Indians.
- Little River Band of Ottawa Indians.
- Little Traverse Bay Band of Odawa Indians.
- Nottawaseppi Huron Band of Potawatomi Indians.
- Pokagon Band of Potawatomi Indians.
- Sault Ste. Marie Tribe of Chippewa Indians.

- Michigan has an ICWA agreement with the Saginaw Chippewa Indian Tribe.
- Michigan negotiated a Title IV-E agreement with the Little Traverse Bay Band of Odawa Indians in 2012.

MDHHS established an agreement with the Little Traverse Bay Band for MDHHS to draw down Title IV-E funds for tribal cases under tribal court jurisdiction. Under this agreement, the tribe places tribal children under the care and supervision of MDHHS and the state makes the Title IV-E claim and payments for those tribal children and manages the Title IV-E requirements and reporting. The agreement specifies that the tribe maintains court jurisdiction and case monitoring, including ICWA/MIFPA recommendations for their Title IV-E child welfare cases.

MDHHS has an agreement with the Keweenaw Bay Indian Community that permits the state to pay the 50 percent Title IV-E maintenance match on behalf of tribal children under the tribal direct Title IV-E Plan for care and supervision. The state also provides services for tribal children that the plan does not provide such as Medicaid, licensing reviews, interstate compact and training and technical assistance for the tribe to implement their Title IV-E Plan effectively.

NAA began updating all 26 tribal agreements found in the NAA policy manual group under the Tribal Agreement Manual in 2017. Updates will align the agreements with the new MDHHS Memorandum of Understanding (MOU) template, update all system changes/requirements, add ICWA Final Rule 25 CFR 23 requirements and add new contact information for county and tribal utilization. Finalized agreements will be completed in 2018.

Tribes were consulted on new Child Protection Law language to include tribes as entities with whom MDHHS may release CPS information about an Indian child. Senate Bill 616 passed, and Governor Snyder signed the bill in March 2018. PA 56 took effect June 4, 2018.

### **Addressing Barriers in Assignment of Tribal CPS Cases**

During a quarterly Tribal-State Partnership meeting in 2017, tribes expressed concerns with the CPS centralized intake process for assigning tribal cases of child and adult abuse complaints. MDHHS centralized intake is responsible for assigning CPS complaints for investigation. Tribes expressed concerns that centralized intake might be assigning cases that are under tribal jurisdiction and authority to local offices for investigation. To address these concerns, the centralized intake tribal protocol was reviewed in 2017, which included complaint intake, collateral contacts, maps, tribal case transfers and local office assignments. In the future, to ensure accurate assignment of cases, the tribal collateral contact list will be reviewed quarterly rather than annually to assist in clarifying jurisdiction and tribal sovereignty matters (Tribal Priority Area Item 1).

The State Court Administrative Office does not track ICWA compliance due to courts maintaining separate client databases, which creates a structural barrier to statewide data collection. The Court Improvement Program collaborated with MDHHS on an ICWA compliance project, but the project ended due to confidentiality concerns. Court Improvement Program data reports reflect whether a child is an Indian child. An upgrade is underway to add the child's

membership in a specific tribe.

### **Chafee Tribal Consultation and Agreements**

The Keweenaw Bay Indian Community is the only tribe in Michigan that has developed a Title IV-E plan for child welfare maintenance and care and will administer those services independently, with the exception of Chafee services and the Education and Training Voucher program, which will continue to be provided through local MDHHS offices. In addition, the Keweenaw Bay Indian Community maintains a Title IV-D program for child support services within their tribe and five tribes have Youth in Transition Agreements for children under tribal court jurisdiction to access Youth in Transition funding:

- Hannahville Indian community.
- Pokagon Band of Potawatomi Indians.
- Bay Mills Indian Community.
- Saginaw Chippewa Indian Tribe.
- Sault Ste. Marie Tribe of Chippewa Indians.

Review of whether tribes would like to develop, administer, supervise or oversee Chafee, Education and Training Voucher and other child welfare services and receive a portion of the state's allotment for administration or supervision is conducted at least annually or at the request of a tribe at the quarterly Tribal State Partnership meetings. In 2017, the Youth in Transition and Education and Training Voucher discussion occurred at the July 2017 Tribal State Partnership Meeting, and the National Youth in Transition Database Survey was distributed to tribes through the distribution of weekly CSA Communication Issuances.

The Office of Workforce Development and Training provides Michigan tribes access to child welfare training through Title IV-E and Chafee funding. In addition, tribes have access to the Learning Management System to seek training schedules, track staff training, access computer-based training and register for training sessions. Access to the system is monitored through Native American Affairs. Tribes submit staff changes to Native American Affairs for Learning Management System access as needed.

### **Ensuring Culturally Appropriate Services**

MDHHS ensured culturally relevant services to Michigan's American Indian Alaska Native residents in 2017 through:

- Participation in regional and national tribal consultation through the following events:
  - Bureau of Indian Affairs Partners in Action Regional Tribal meetings and conferences.
  - United Tribes of Michigan meetings.
  - Child Welfare League of America Indian child welfare state manager calls.
  - Governor's Tribal Summit.
  - Child Welfare League of America State Indian Child Welfare Manager meetings.
  - Annual Department of Homeland Security Emergency Preparedness Conference.
  - Casey Family Programs ICWA Gold Standard Trainings.

- Annual U.S. Dept. of Health and Human Services and the Midwest Association of Sovereign Tribes Tribal Consultation meeting.
- MDHHS Diversity Committee meetings.
- Invitations to tribal representatives for participation and input on various MDHHS committees and workgroups, including the CFSR Workgroup.
- Development of grant and contract opportunities for tribal communities.
- Strengthening the MDHHS Indian Outreach Worker program through case reviews to target best practices and service barriers.
- Quarterly Tribal State Partnership meetings with representatives from Michigan's 12 federally recognized tribes, tribal organizations and local MDHHS and central office staff.
- Publishing culturally competent human service materials that reflect the unique status of tribal people and laws that protect their sovereignty.
- Reviewing and revising Indian child welfare policy to strengthen and achieve compliance with federal rules and regulations.
- The Office of Workforce Development and Training Indian child welfare training, mandatory for new caseworkers and supervisors.
- Strengthening the state courts' application of the ICWA through collaboration with tribal courts, attorneys and social services, state court administration, MDHHS Legal Division and NAA toward development and codification of MIFPA.
- Negotiating tribal-state Title IV-E and IV-D agreements. Michigan assists the tribe(s) to access Title IV-E administrative funding, Chafee Foster Care Independence Program, training and data collection resources.
- Developing Indian child welfare case review tools in collaboration with Michigan tribes and urban Indian organizations.
- Conducting stakeholder surveys for quality assurance.
- Maintaining a public MDHHS Native American Affairs website.
- Conducting public awareness events to sensitize consumers and vendors to issues of Native Americans in Michigan and improve cultural awareness and competence.

### **Contracting Culturally Appropriate Services**

Michigan ensured effective and culturally appropriate services in 2017 through the following contracted services:

- The Grand Traverse Bay Band maintains a contract for placement of juvenile girls and boys in a teaching family home environment. However, the home currently is not staffed and is not accepting placement of juveniles at this time.
- Keweenaw Bay Indian Community for direct tribal Title IV-E agreement and Title IV-D Memoranda of Understanding.
- Inter-Tribal Council of Michigan for Community Service Block Grant and Infant Safe Sleep initiatives.
- The Sault Ste. Marie Tribe of Chippewa Indians' Binogii Placement Agency for foster care and adoption services for tribal children.
- Sault Tribe Detention Center for juveniles for detention services.
- Michigan Indian Legal Services for Tribal Community Service Block Grant programming.

- Little River Band of Ottawa Indians for Tribal Community Service Block Grant programming.
- Families First of Michigan, serving seven of 10 reservation communities. Tribal representatives participate in bid ratings for new contracts.
- Annual Tribal Foster Care Recruitment and Retention Plans for Sault Ste. Marie Tribe of Chippewa Indians, Nottawaseppi Huron Band of Potawatomi Indians, Keweenaw Bay Indian Community and Bay Mills Indian Community foster parent recruitment events.

### **Progress in 2017 and 2018**

- The OWDT and NAA provides ICWA/MIFPA training in pre-service and new supervisor institutes, as well as a refresher course. In 2017 the following training sessions were held:
  - ICWA/MIFPA computer-based training: 1088 attended.
  - ICWA/MIFPA refresher training: 178 attended.
- Tribal participation in the following committees was invited through email, in-person presentations, and written Tribal State Partnership Meeting updates:
  - MDHHS Adoption/Foster/Kinship Care Committee.
  - Michigan Human Trafficking Task Force.
  - MDHHS CFSR Steering Committee and Workgroup.
- NAA conducted onsite consultations between May 2017 and August 2017 with seven of the 12 Michigan tribes: Saginaw Chippewa Indian Tribe, Nottawaseppi Huron Band of Potawatomi Indians, Little River Band of Ottawa Indians, Lac View Desert Band of Lake Superior Chippewa Indians, Hannahville Indian Community, Keweenaw Bay Indian Community and Bay Mills Indian Community. The Sault Ste. Marie Tribe of Chippewa Indians required a reschedule.
- Local case management meetings were held between tribes and county MDHHS office leadership on an ongoing basis.
- An Indian Outreach Services Business Information System Fit Analysis request was submitted for review of appropriate case management system to house IOS.
- Tribal indicators and tribally licensed homes were assessed for addition to the MDHHS Child Placing Network and ICWA foster home lists for MDHHS and tribes were posted on the NAA website.
- NAA policy and forms specific to ICWA/MIFPA compliance were updated.
- New OWDT ICWA Supervisors Training curriculum development occurred.
- Case management and collection of ICWA data in MISACWIS continued to be tracked.
- Verification and validation of ICWA data reports occurred.
- The MDHHS Tribal State Forum meeting was held on Jan. 4, 2017 to foster tribal consultation between Michigan tribes and Urban Indian Health Centers and the department for child welfare, Medicaid and mental health programming in Michigan.

### **Plan for Improvement - Activities for 2018 and 2019**

- Clean up of MiSACWIS data on identification, notification, placement and active efforts is an ongoing quality assurance process.

- Rollout of new ICWA Supervisor training will occur to strengthen compliance with identification of Native American heritage for children in foster care.
- MiSACWIS ICWA AFCARS enhancement development will be ongoing in 2018 and 2019.
- An Indian Outreach Services Business Information System Fit Analysis will be completed.
- Indian child welfare case reviews will occur in 2018 and 2019.
- The National Youth in Transition Database survey results will be reviewed through the Youth in Transition program, and tribal discussion and feedback are planned for 2018.
- Child Care Fund consultation will occur pertaining to Senate Bill 519 and 520.
- Tribes will continue to have access to the MDHHS child welfare training and Learning Management System through Title IV-E and Chafee funding.

### **Tribal CFSP and APSR Coordination 2018 and 2019**

Michigan tribes will continue to be involved in the implementation of the goals, objectives and interventions and in the monitoring and reporting of progress through:

- Quarterly Tribal State Partnership meetings.
- Annual MDHHS Tribal State Forum meeting (occurred Jan. 4, 2018).
- Urban Indian State Partnership meetings.
- Tribal APSR webinar and survey (occurred March 24, 2018).
- MDHHS CFSR Steering Committee and Workgroup participation.
- ICWA case reviews.
- ICWA 40<sup>th</sup> anniversary event planning.
- Individual tribal consultation.

For more information on child welfare services in tribal communities, please visit [www.michigan.gov/americanindians](http://www.michigan.gov/americanindians).

## **JOHN H. CHAFEE FOSTER CARE PROGRAM FOR SUCCESSFUL TRANSITION TO ADULTHOOD**

### **Service Description**

MDHHS administers, supervises and oversees the John H. Chafee Foster Care Program for Successful Transition to Adulthood, formerly the Chafee Foster Care Independence Program. Chafee goals are addressed through Michigan's Youth in Transition program. Youth in Transition provides support to young people in foster care and increases opportunities for those transitioning out of foster care through collaborative programming in local communities. Independent living preparation is required for all young people in foster care ages 14 and older, regardless of their permanency goal. MDHHS continues active collaboration with young people in planning and outreach.

MDHHS allocates funds to counties for independent living services for all young people aging out of foster care. Counties can contract with private agencies or provide funds for services. Payments can include:

- First month rent.
- Security deposit.
- Utilities.
- Car repair.
- Daycare.
- Preventive services.
- Mentoring.
- Securing identification cards.
- Participation in support groups and youth advisory boards.
- Vehicle insurance.
- Housing startup goods.
- Startup items and supplies for new infants.

### **Coordination with Other Federal and State Programs**

MDHHS continues to coordinate with other federal and state programs for youth, including transitional living programs funded under Part B of the Juvenile Justice and Delinquency Prevention Act of 1974, in accordance with Section 477(b)(3). The eligibility criteria for Chafee-funded services are documented in MDHHS foster care policy. Young people that meet the criteria for Chafee-funded services are eligible, regardless of race, gender or ethnic background. A youth who has or had an open juvenile justice case and is placed in an eligible placement under the supervision of MDHHS is eligible for Chafee funded goods and services. As foster care caseworkers, juvenile justice specialists are offered all training opportunities regarding services under the Chafee Foster Care Program.

MDHHS provides oversight to the programs and agencies providing direct services and support to children through the Education and Youth Services Unit, which is responsible for ensuring services meet federal requirements and are provided to all eligible young people. Education and Youth Services staff oversees contracting for Chafee services and ensure agencies comply with contractual obligations.

Michigan is committed to ensuring all allocated Chafee funds are provided to eligible youth and facilitating disbursements of funds to counties for goods and services. This budget line is reviewed at regular intervals to identify spending patterns and align funds with areas of need. Young people leaving foster care due to adoption or guardianship at 16 years and older are eligible for higher education financial aid (Education and Training Vouchers, Tuition Incentive Program, Pell Grant, Fostering Futures Scholarship); and at age 18, those young people are eligible for all Chafee-funded goods and services.

The Michigan Youth Opportunities Initiative (MYOI) is a partnership with the Jim Casey Foundation that was created to improve outcomes for young people transitioning from foster care to adulthood. It brings together community members, public and private agencies and resources critical to the success of young adults transitioning from the foster care system. Michigan Youth Opportunities Initiative programming is offered in 64 counties.

## **Family First Prevention Services Act**

The Family First Prevention Services Act was enacted through Public Law 115-123 on Feb. 9, 2018, which changed the name of the John H. Chafee Foster Care Independence Program to John H. Chafee Foster Care Program for Successful Transition to Adulthood. The act changes the program purpose and population of youth eligible to receive services through the Chafee and the Education and Training Voucher (ETV) programs. MDHHS will make necessary updates to policy and procedures once approved to do so through the counter-signed certification from the Children's Bureau. If approved for 2019, Michigan will expand supports and services to all youth who experienced foster care at age 14 or older and who are placed with the state child welfare agency in their transition to adulthood. Youth will be provided transitional services in financial, employment, education, vocational, health, mental health, housing and other needs as identified in collaboration with the youth as follows:

- Supports and services funded through the Chafee program will be made available until an eligible youth's 23<sup>rd</sup> birthday.
- Services provided through contracts funded through the Chafee program will be made available until an eligible youth's 23<sup>rd</sup> birthday.
- Education and Training Vouchers will be made available until an eligible youth reaches their 26<sup>th</sup> birthday.
- Services will be provided to youth who, after attaining 16 years of age, have left foster care for kinship care, guardianship or adoption.
- Services will ensure youth likely to remain in foster care until 18 have regular, ongoing opportunities to engage in age and/or developmentally appropriate activities.
- The limit on the amount of Chafee funds that may be used for room and board expenses for youth ages 18 and older remains unchanged, with no more than 30 percent of Chafee funds expended for room and board.

Changes to Michigan's Chafee Foster Care Program for Successful Transition to Adulthood will be included in policy manuals and contract amendments and messaged to youth, service providers and community partners in the following ways:

- Child welfare staff will receive instruction through statewide communication memos, monthly supervisory phone calls, technical assistance and training opportunities for child welfare staff working with youth, including MYOI coordinators, education planners and permanency resource managers.
- Service providers will be informed through outreach to the Federation of Foster Care and Adoption Agencies, Michigan Federation for Children and Families, contract amendments, statewide communication issuances, monthly supervisory phone calls, at Tribal-State Partnership meetings, and in meetings with education partners, Michigan's Children and other stakeholders.
- Youth will be informed through semi-annual transition planning meetings held at age 14 and older, 90-day discharge meetings, through service providers and outreach through other youth involved in MYOI.
- MDHHS initiated "Listening Sessions" on provisions of the Family First Prevention Services Act to inform partners and stakeholders statewide of the commitments and

opportunities provided by the act. This includes sessions with youth at the Michigan Teen Conference, SCAO, public and private child welfare agencies, contractors and service providers.

## **Justice for Victims of Trafficking Act of 2015 and the Trafficking Victims Protection Act**

The Michigan Legislature passed bills in 2014 to address child sex trafficking, many of which took effect in 2015 and resulted in the Safe Harbor Act.

### **Progress in 2017**

- Training was provided as requested by child welfare staff in local public and private agencies, and by community organizations and community partners.
- Updates to MiSACWIS were implemented to capture information on CPS complaints and investigations more accurately when human trafficking is identified.
- The revised Human Trafficking of Children Protocol was published, along with screening tools for assessing risk factors for human trafficking of youth in child welfare.
- Human trafficking policy was created in a policy manual referenced by all program areas and updated to include requirements for screening youth in both open and closed foster care cases who are at risk of being trafficked.
- The Education and Youth Services Unit requested the development of on-line training for children's services staff on human trafficking.
- Training was provided to child welfare caseworkers in Genesee, Monroe, Lenawee, Ingham, Kent, Macomb, Ottawa, Shiawassee and Wayne counties on accessing Youth in Transition funds, new contract opportunities and benefits for older youth in foster care.

### **Plan for Improvement - Activities for 2018 and 2019**

- The MDHHS Education and Youth Services Unit identifies training needs, establishes collaboration with other state agencies and interested organizations and identifies strategies for providing services to this population.
- MDHHS will continue to cross-train with community agencies on identification of human trafficking, the role of child welfare professionals in trafficking cases and resources for treating victims.
- Additional improvements in documenting incidents of trafficking were requested in MiSACWIS to improve the accuracy of information for federal reporting. Michigan will begin reporting data on the number of identified human trafficking victims in 2019.
- MDHHS is collaborating with private stakeholders to develop an assessment center for substance use and mental health assessments for trafficking victims. The goal is to reduce recidivism and assist victims to remain in treatment services after thorough assessment of their needs.
- The Education and Youth Services Unit is collaborating with the Office of Workforce Development and Training to develop online training for services staff on human trafficking of children.

## **Housing Resources**

Recognizing that runaways and homeless youth are especially vulnerable to becoming victims of crime, including assault, theft and human trafficking, MDHHS provides services to homeless young people and those at risk of homelessness. Services are provided to foster youth who have voluntarily remained in, or returned to, foster care after their 18<sup>th</sup> birthday that are homeless or at risk of becoming homeless. MDHHS developed contracts to provide an array of services through its Homeless Youth and Runaway programs. These contracts ensure:

- A minimum of 25 percent of those served are former foster children or homeless due to a dissolved adoption or guardianship.
- Approximately 27 percent of young people seeking homeless youth runaway services report a history of involvement with either the foster care or juvenile justice systems.
- Former foster youth comprise 33 percent of all youth receiving shelter in basic care centers.
- Of the youth reporting a history with child welfare (CPS, foster care and juvenile justice), 73 percent were placed with MDHHS through abuse and neglect wardship.

MDHHS has committed to reducing homelessness for foster alumni in the following ways:

- Collaborating with housing resource partners and local organizations to develop safe, stable and affordable housing for young people exiting foster care.
- Collaborating with the Detroit Housing Commission to provide Housing Choice Vouchers to young people ages 18 to 21.
- Participating in a new Housing and Urban Development demonstration grant to extend housing for youth eligible for the Family unification Program for five years. The Detroit Housing Commission committed to applying for the demonstration grant and included MDHHS as their child welfare agency partner.
- Developing partnerships with faith-based organizations and community partners to expand housing opportunities for young people.
- Collaborating with the Michigan State Housing Authority and Michigan Coalition Against Homelessness in these areas:
  - Increasing leadership, collaboration and civic engagement.
  - Increasing access to stable and affordable housing.
  - Providing 24-hour crisis services via 22 Homeless Youth/Runaway contracts.

## **Progress in 2017**

- The housing specialist in the Education and Youth Services Unit provided technical assistance to Homeless Youth and Runaway providers in serving young people who identify as lesbian, gay, bisexual, transgender and questioning (LGBTQ) and those identified as victims of human trafficking.
- The Homeless Youth and Runaway provider in Genesee County sponsored training for their staff and extended the invitation to other providers on providing safe and supportive services to young people who identify as LGBTQ. The training was provided by the Ruth Ellis Center, a residential program for LGBTQ youth in Wayne County.
- Participation in a new Housing and Urban Development demonstration grant to extend

housing for youth eligible for the Family unification Program for five years was approved. One hundred thirty-two young people were referred and, of these, 62 received Housing Choice Vouchers in 2016.

- Grand Traverse Continuum of Care organizations applied for and received a Homeless Youth Demonstration Program grant offered through Housing and Urban Development. The purpose of the grant is to identify strategies to meet the goal of preventing and ending homelessness for young people ages 14 to 24 by building comprehensive systems of care, rather than implementing individual or unconnected projects.
  - The MDHHS housing specialist provides technical assistance in the development of the innovative projects to serve rural communities through this grant.
- The housing specialist collaborated with Ruth Ellis Center, a community-based organization with a long-standing history of supporting contractors gain insight on how to better service youth who identify with diverse sexual orientation and gender identify expression.
- The Education and Youth Services Unit met with the Michigan Network for Youth and Families to share information on human trafficking and the unique needs they present.
- Participation in the Housing and Urban Development demonstration grant to extend housing for youth eligible for the Family unification Program was approved.
  - Eighty-six young people residing in Wayne, Oakland, Macomb, Lapeer and St. Clair counties received housing choice vouchers.
  - One hundred thirty-seven families residing in Wayne, Oakland, Macomb, Lapeer and St. Clair who were without adequate housing and were involved in a CPS investigation or who needed housing to support a reunification plan received a housing choice voucher.
- The housing specialist reached out to the local housing authorities in Saginaw, Wayne, Pontiac and Kent counties to create partnerships for Family unification Program vouchers. Only Wayne is currently providing vouchers in collaboration with their local MDHHS office.
- The demonstration grant work conducted by the Grand Traverse Continuum of Care organization collaborated with the City Housing Commission on a new Workforce Housing Redevelopment to set aside 12 to 15 one-bedroom units for youth ages 18-24 who are homeless or at risk of being homeless.

### **Plan for Improvement - Activities for 2018 and 2019**

- MDHHS will shift Homeless Youth and Runaway contracts to the new grant format, the Electronic Grants Administration and Management System in 2018.
- MDHHS will incorporate language in the grants awarded to Homeless Youth and Runaway providers requiring them trauma-informed service delivery and trained on the needs of young people who have been trafficked or who identify as LGBTQ.
- MDHHS will continue to collaborate with the Detroit Housing Commission to provide Housing Choice Vouchers to eligible young people and families who have inadequate housing or who need housing to achieve reunification.
- The department is collaborating with staff from Ruth Ellis Center to provide Homeless

Youth and Runaway services through an MDHHS grant.

- Homeless Youth and Runaway grants will incorporate the Service Prioritization Decision Assistance Tool. This screening tool will be used for youth in transitional living programs as a brief survey to quickly determine whether a youth has a high, moderate or low acuity, to guide case management and to improve housing stability outcomes.
- MDHHS will seek to engage in collaborative funding opportunities for youth housing through Housing and Urban Development, Michigan State Housing Development Authority and the Michigan Homeless Assistance Advisory Board.

## **Serving Youth across the State**

Independent living preparation is required for all young people in foster care ages 14 and older, regardless of their permanency goal. The goal of independent living preparation is to assist young people transitioning to self-sufficiency. MDHHS allocates funds to all 83 counties for independent living services.

Native American young people served by tribal child welfare services or MDHHS that meet eligibility criteria are eligible for Chafee and Education and Training Voucher services. Information about services is shared with tribes through quarterly Tribal-State Partnership meetings and technical assistance to individual tribes. MDHHS Indian Outreach Workers in counties with tribal populations provide information and assistance to tribal youth. To prepare for independent living, young people ages 14 and older are involved in the development of their case service plan and participate in quarterly case planning. The level of involvement in the plan and the services provided depend on the youth's developmental abilities. Beginning at age 14, young people in foster care participate in a semi-annual transition meeting to discuss their permanency goals, assess service needs and identify adults that will support them when the agency is no longer involved.

The transition plan covers all areas of a youth's needs, including housing, supportive relationships, independent living skills, education, employment, health, mental health, financial needs and the opportunity to extend foster care to age 21. Pregnancy prevention is among the topics that may be discussed in creating plans for transitioning to independent living. This document becomes the youth's transition plan and progress is evaluated during each meeting.

## **Opportunities to Engage in Age- or Developmentally-Appropriate Activities**

The discretionary allocation for each county provides funding for young people to participate in a range of activities that support their transition to self-sufficiency. Foster care licensing rules require foster parents to encourage young people to participate in recreational activities appropriate to their age and ability. The Michigan Youth Opportunities Initiative utilizes Chafee funds to support youth leadership and activities in local and statewide events.

## **Progress in 2017**

- Training was provided to child welfare caseworkers in Genesee, Monroe, Lenawee, Ingham, Kent, Macomb, Ottawa, Shiawassee and Wayne counties on accessing Youth in

- Transition funds, new contract opportunities and benefits to older youth in foster care.
- The Michigan Youth Opportunities Initiative provided advanced leadership and advocacy training to a group of 14 young people in a second Youth Leadership Institute.
- The Michigan Youth Opportunities Initiative provided participants with an array of employment and educational opportunities to engage in activities that support their interests and develop skills to successfully transition to adulthood.
- Young people from Michigan participated in the Daniel Memorial Independent Living conference, a national three-day conference focused on building independent living skills and self-sufficiency for young people in foster care.
- Chafee-eligible young people participated in the annual Teen Conference and attended sessions on independent living skills and topics of interest to youth in foster care.
- Local MDHHS offices and private agencies provided events that fostered learning and the development of daily living skills.
- Training was provided to Michigan Youth Opportunities Initiative Coordinators and Education Planners on engagement with young people who identify as LGBTQ.
- Young people are provided a range of opportunities to participate in activities and events that promote their learning and development of skills of daily living.
- Training was held for Michigan Youth Opportunities Initiative staff and youth board leaders regarding safe and strategic sharing and messaging.
- Strategies will be identified to publicize the services and opportunities available through the Chafee Foster Care Independence Program.

### **Plan for Improvement Activities for 2018 and 2019**

- The MDHHS Youth Advisory Board will be utilized for recommendations regarding improving youth engagement and access to available services and resources.
- The Quality Improvement Council Independent Living Well-Being subcommittee is updating the form used for the Semi-Annual Transition Planning Meeting and the 90-Day Discharge-Planning meeting to improve the identification of needs and services.
  - The Semi-Annual Transition Planning meeting form will be split into two options, a form for 14- and 15-year-olds, and one for youth ages 16 and older. This will result in each form being more relevant to the youth's age and ensure the discussions are age-appropriate.

### **Youth Participation in Improving Foster Care**

**Goal:** Young people will be actively involved in developing practices, policies and procedures to improve services for young people in foster care.

### **Progress in 2017**

- The Education and Youth Services Unit reached out to local youth boards to review the National Youth in Transition Database, older youth policy and service gaps.
- MDHHS provided a second group of 14 young people with advanced leadership and advocacy training through a second Youth Leadership Institute.

- MDHHS supported graduates of the Youth Leadership Institute through training.
- MDHHS utilized graduates of the Youth Leadership Institute to inform policy and practice improvements.
- Young people and child welfare staff participated in the Michigan Youth Leadership Advocacy Summit and provided opportunities to share their experience and recommendations in child welfare policy to legislatures and child welfare policymakers.
- Young people in foster care participated in workgroups and focus groups, including the LGBTQ and Residential Transformation committees.
- Young people from the Michigan Youth Opportunities Initiative participated on panels and individual presentations at conferences that focus on child welfare issues and improvement, including statewide conferences regarding education and psychotropic medication management.
- Young people in foster care participated in child welfare staff training and presentations, as well as foster home licensing training.
- Young people participated in the first meeting of the MDHHS Youth Advisory Board, which focused on an analysis of National Youth in Transition Database data to identify gaps in service areas or areas needing improvement.

Young people in foster care participated in advocacy and outreach through:

- Foster parent PRIDE training.
- Child Welfare Training Institute panels.
- Kids Speak events for legislators and policymakers.
- Community partnership meetings.
- Permanency Forum.
- Providing information related to education supports by serving as an Education Liaison with their local youth boards.
- Participating in MDHHS workgroups including:
  - Health Advisory and Resource Team.
  - Foster Care Bill of Rights.
  - Local QSR focus groups.

### **National Youth in Transition Database**

MDHHS will continue to cooperate in evaluation of the Chafee program through the National Youth in Transition Database. Since 2011, Michigan has gathered demographic and outcome information on young people receiving independent living services. Michigan will continue to collect service and outcome data and use the data to identify areas for improvement.

Michigan recognizes the importance of collecting accurate information regarding the services provided to youth who experienced foster care and the outcomes they experience. Michigan has remained in compliance with data collection standards every year since 2012. The state uses this data to improve understanding of the needs of young people and identify areas for improvement. The Education and Youth Services Unit engages in ongoing review of the data and meets with the data reporting team prior to each submission to ensure services are collected as completely and accurately as possible and to identify any updates or corrections

needed in the data collection process.

**Goal:** MDHHS will use data from National Youth in Transition Database submissions to assess services provided to young people and identify types and numbers of services provided.

- **Objectives:**
  - MDHHS will assess Chafee services provision for Native American youth.
  - By Sept. 1, 2015, MDHHS identified the number of young people receiving independent living services and types of services provided 2011 through 2014.
  - By Sept. 30, 2015, the Education and Youth Services Unit compiled services data that identifies the number of young people receiving independent living services by service domain for the years 2011 through 2013.
  - By Sept. 1, 2016, MDHHS examined youth characteristics, foster care history and educational level to identify trends and gaps.
  - By Sept. 30, 2016, the Education and Youth Services Unit examined three years of data to identify strengths and gaps in services.

### **Progress in 2017**

- The data query for identifying services provided to youth in foster care was strengthened to better capture services provided in career preparation and employment programs and vocational training.
- The Education and Youth Services Unit invited youth leaders from the Michigan Youth Opportunities Initiative and private agency partners to participate in a focus group to identify key questions in National Youth in Transition Database data and identify strengths and gaps in data and services.
- Data from the National Youth in Transition Database was shared at a youth board meeting that included the Michigan Youth Opportunities Initiative coordinator.
- Data and trends from the National Youth in Transition Database were shared during the Michigan Youth Leadership Advocacy Summit to an audience of young people who have experienced foster care, child welfare workers, staffs from Michigan's Children, the Michigan Department of Education, the Casey Youth Opportunities Initiative, Fostering Success Michigan and post-secondary institutions.
  - Participants were asked to provide input on priorities for using the data and ways to improve outcome survey collection.
- Young leaders participating in Michigan Youth Opportunities Initiative, child welfare staff, the director of Fostering Success Michigan and the Vice President of Programs for Michigan's Children met to form the MDHHS Youth Advisory Board.
  - The services and outcome data for the first and second cohorts of the National Youth in Transition Database were reviewed and discussed.
- Training on the importance of accurate and timely collection of survey and service information was provided to analysts assigned to the Business Service Centers and Child Welfare Supportive Services.
- Monthly supervisory phone conferences were used to provide updates and information to child welfare staff regarding the importance of accurate and timely collection of

- surveys and documentation of services provided to youth.
- Analysis of data from the National Youth in Transition Database will continue through the MDHHS Youth Advisory Board.
- Mapping data elements will be ongoing with the data team to ensure services provided are captured accurately.

### **Plan for Improvement - Activities for 2018 and 2019**

- The MDHHS Youth Advisory Board will meet as youth schedules allow to assess service delivery, policy development and National Youth in Transition data collection.
- NYTD reports will be reviewed with community stakeholders and partners to understand service strengths and gaps and outcomes of youth in cohorts.

**Goal:** During 2015 – 2019, MDHHS will develop a framework for analyzing National Youth in Transition data to inform service delivery.

- **Objectives:** During 2015-2019, MDHHS will:
  - Engage staff at all levels as well as youth and community partners.
  - Identify and select pertinent data.
  - Collaborate with the data team.
  - Develop an implementation plan that includes data monitoring.

**Measure:** Collaborative process for analyzing National Youth in Transition data.

**Benchmarks:**

- **2015:** MDHHS will establish a focus group that includes MDHHS staff, community partners, stakeholders and young people.
- **2016:** The focus group will identify the area(s) of focus including population and key questions to be asked. Appropriate data and measures needed to answer the key questions will be agreed upon by the focus group.
- **2017:** The MDHHS Youth Advisory Board was established, which included youth leaders from Michigan Youth Opportunities Initiative, community partners and child welfare staff.
- **2018 - 2019:** Strategies will be considered to address gaps and strengthen programming, and a monitoring process will be developed.

### **Progress in 2017**

- A focus group of youth leaders from the Michigan Youth Opportunities Initiative, public and private child welfare staff, Fostering Success Michigan and Michigan’s Children were invited to assess the outcomes and services information provided through the National Youth in Transition Database. It was decided that an MDHHS Youth Advisory Board would be a stronger approach to identifying the gaps in services and policy implementation.
- National Youth in Transition data and trends were shared during the Michigan Youth Leadership Advocacy Summit to an audience of young people who have experienced foster care, child welfare workers and staffs from Michigan’s Children, the Michigan Department of Education, the Casey Youth Opportunities Initiative, Fostering Success

Michigan and post-secondary institutions.

- Participants were asked for input on using the data and ways to improve outcome survey collection.
- Youth leaders from the Michigan Youth Opportunities Initiative, child welfare staff, the director of Fostering Success Michigan and the Vice President of Programs for Michigan's Children met to form the first MDHHS Youth Advisory Board.
  - The services and outcome data for the first and second cohorts of the National Youth in Transition Database were reviewed and discussed.
  - Youth engagement and transition planning were among the priority areas for future discussions.

### **Plan for Improvement - Activities for 2018 and 2019**

- MDHHS will review National Youth in Transition data with community partners with child welfare policy to provide recommendations to address older youth services.

### **Serving Youth of Various Ages and States of Achieving Independence**

Independent living preparation is required for all young people in foster care ages 14 and older, regardless of their permanency goal. The goal of independent living preparation is to assist young people transitioning to self-sufficiency. Independent living preparation for youth ages 12 and 13 is encouraged based on availability of services and need. Michigan provides age-appropriate independent living services to the following:

- Young people ages 14 through age 20 in foster care.
- Former foster children ages 18 through 20.
- Young people who, after age 16, have left foster care for kinship guardianship or adoption.

### **Progress in 2017**

- Michigan's Young Adult Voluntary Foster Care program was implemented in 2012 and allows youth who are in foster care at age 18 either to remain voluntarily in foster care when their abuse and neglect case is dismissed, or to return at a later date up to age 21. This program offers case management services and financial supports as long as the youth meets eligibility criteria.
- The first meeting of the MDHHS Youth Advisory Board analyzed National Youth in Transition data to assess barriers and strengths in service delivery, policy development and data collection.
- Chafee funds were allocated to each county to be used for discretionary goods and services to support eligible development of daily living skills.
- The Education and Youth Services Unit established contracts for mentoring services, Independent Living Skills Coaches, Independent Living Plus and Summer Youth Employment services to support youth becoming self-sufficient.
- Michigan Youth Opportunities Initiative assists youth ages 14 to 24 by providing independent living training and supports as well as financial capability training, participation stipends and match asset purchases.

## **Plan for Improvement - Activities for 2018 and 2019**

- The Michigan Youth Opportunities Initiative will expand statewide to eligible youth in every county.
- Contracts managed by Education and Youth Services staff will be assessed for utilization and outcomes.

### **Life Skills Assessment**

The Casey Life Skills Assessment is a free online tool that assesses the life skills of youth in foster care as they navigate high school, post-secondary education, employment and other milestones. The assessment is completed with young people annually starting at age 14. Young people ages 14 and older are involved in the development of their service plans and participate in quarterly case planning. Beginning at age 14, young people participate in semi-annual meetings to discuss their permanency goal, identify needs, resources and adults to support them when the agency is no longer involved. Transition plans cover all areas, including housing, relationship skills, independent living skills, education and employment.

### **Assistance with Startup Living Expenses**

Young people 18 and older are eligible for independent living support that includes first month rent, security deposit and startup goods, with a lifetime limit of \$1,500. Room and board funds are available to young people who were in foster care at the age of 18 and have not yet reached their 21<sup>st</sup> birthday. If the youth is a parent or expecting a baby, there is an additional allowance for goods to be used specifically for the newborn.

### **Progress in 2017**

- Training was provided to public and private child welfare staff regarding the availability of startup living expenses for eligible youth.
- Technical assistance was provided to public and private child welfare staff to support timely access and documentation of startup living expenses for eligible youth.
- Training was provided to Michigan Youth Opportunities Initiative and child welfare staff regarding eligible expenses, opportunities available to youth and documentation of Chafee fund expenditures.

### **Educational Assistance**

MDHHS education planners work with foster youth ages 14 and older. They work one-on-one to assist young people with financial aid applications and arrange college tours. With the youth, education planners address other barriers to educational success through assisting with:

- Education transportation and payment.
- Records transfer.
- Education placement determinations.
- Advocacy to remain in the school of origin.
- Resolving special education issues.
- Resolving disciplinary issues.
- Post-secondary preparation and attendance.

Education planners also assist young people to complete their financial aid applications and provide training and technical assistance to caseworkers in their counties. Currently, 16 education planners serve young people in 51 counties.

### **Progress in 2017**

- The education analyst co-presented six webinars with the Michigan Department of Education. The webinars were offered to all education planners, MDHHS education points-of-contact and school district foster care liaisons. The webinars provided guidance and instruction in the provisions of Every Student Succeeds Act of 2015.
- A communication memo was released to child welfare staff statewide with education policy updates, including changes to school transportation responsibilities and payment.
- The education analyst presented information on the new education requirements on monthly child welfare supervisor phone calls.
- In summer 2017, the Michigan Department of Education hired a state foster care consultant, as required by the Every Student Succeeds Act, with whom the MDHHS education analyst collaborated to continue training child welfare and education staff across the state.

### **Plan for Improvement - Activities for 2018 and 2019**

- As a requirement of the Every Student Succeeds Act, state education agencies must report on students who are in foster care. The Education and Youth Services Unit will work with the Michigan Department of Education and the Center for Education Performance and Information as needed to ensure this requirement is met.
- Strategies to improve data collection on education outcomes will be identified in collaboration with the Michigan Department of Education.
- The education analyst will continue to provide technical assistance and training to child welfare staff, Education planners and the education points-of-contact on education policy and school transportation procedures.
- Education policy will be updated to reflect the newest changes to education transportation process and procedure.

### **Personal and Emotional Support for Youth Aging out of Foster Care**

- Independent Living Plus provides youth in foster care needing services to develop skills for independent living with case management, weekly training and referrals to meet their education, employment, health and mental health needs as identified in their individualized treatment plan.
- In 2016, two additional contracts were awarded for mentoring youth who are currently or previously were in foster care, expanding services to five counties.
- Opportunities to provide emotional support to young people transitioning to independence will be identified and strategies developed to address this need.

## **Employment Assistance**

- Local MDHHS offices collaborate with businesses and agencies in their communities to refer older youth in foster care for job training and employment opportunities. The discretionary allocation provided to county offices is used to cover the costs of a training program and provide employment services through a contract. Additionally, young people ages 14 and older are referred to the local Michigan Works! Agency for employment support.

## **Progress in 2017**

- For several years, the Education and Youth Services Unit has collaborated with Michigan Works! to offer the Summer Youth Employment Program. The Summer Youth Employment Program provides job readiness training and summer employment linked to academic and occupational learning for up to 350 young people per year.
  - In 2016, 373 young people received services in nine Summer Youth Employment sites. Of these, 326 successfully completed the program.
  - In 2016, the minimum amount of time spent on job readiness training was increased to two weeks.
  - In 2017, 270 young people received services in eight Summer Youth Employment sites. Of these, 197 successfully completed the program.

## **Program Support**

- Education planners provide resource information to public and private child welfare staff and refer young people to employment and educational programs in their area.

The Education and Youth Services Unit and the Michigan Youth Opportunities Initiative collaborated with Jobs for Michigan's Graduates to improve education and employment outcomes for young people in foster care in Berrien, Wayne and Genesee counties, including juvenile justice cases. Jobs for Michigan's Graduates received a grant from the Annie E. Casey Foundation to work with young people over the next three years.

## **Plan for Improvement - Activities for 2018 and 2019**

- Strategies for collaboration with school districts will be developed to refer eligible young people to services available through the Workforce Innovation and Opportunity Act.
- The 2018 Summer Youth Employment Program will be offered in nine sites.

## **Michigan Youth Opportunities Initiative (MYOI)**

MDHHS expanded programming through the Michigan Youth Opportunities Initiative. Programming results in positive outcomes in permanency, education, employment, housing, health, financial management and relationships. Encouraging young people to share their insights and experiences enables MDHHS to receive critical input on current policy and practice.

- Michigan Youth Opportunities Initiative programming is being expanded and will be offered in all 83 counties.

- Eight hundred ninety-four youth were enrolled in the Michigan Youth Opportunities Initiative program at the end of 2017.
- The Michigan Youth Opportunities Initiative is available to eligible youth with abuse and neglect or juvenile justice cases.

**Goal:** During 2015 - 2019, MDHHS will use the Michigan Youth Opportunities Initiative self-evaluation to identify strategies for engagement with foster youth about gender and race disparity.

- **Objectives:**

- MDHHS will review data collected through self-evaluation to identify disparities in participation and service delivery related to gender and race.
- MDHHS will include state and national data and current research to increase engagement of foster youth by gender.
- MDHHS will collaborate with MiTEAM Specialists to include training and communication for youth engagement and outreach.

**Measure:** Demographic information on Michigan Youth Opportunities Initiative enrollment.

**Benchmarks 2015 – 2019:**

- Enrollment of males in Michigan Youth Opportunities Initiative will increase annually.
- Enrollment in Michigan Youth Opportunities Initiative by race will more closely match the population of young people in their county of care.

## **Progress in 2017**

- All Michigan Youth Opportunities Initiative sites are provided with demographic data of enrolled youth to assist development of programming.
- Staff from Wayne and Genesee counties attended a Race Equity Design Lab sponsored by the Annie E. Casey Foundation to begin assessment of young people enrolled in Michigan Youth Opportunities Initiative about disparities in race and gender.
- Technical assistance was offered to Wayne and Genesee counties from the Annie E. Casey Foundation in preparation for the training.
- Michigan Youth Opportunities Initiative staff received training on the needs of young people identifying as LGBTQ to support their understanding of diversity and inclusion.
- Technical support and training is offered to Michigan Youth Opportunities Initiative sites to increase participation and service delivery with equitable opportunities for all young people.

## **Pregnancy Prevention**

- Young people participating in Michigan Youth Opportunities Initiative are offered monthly training regarding development of age-appropriate independent living skills in employment, education, financial competency and health. Many Michigan Youth Opportunities Initiative programs include pregnancy prevention and reproductive health as frequent training topics to all participants.

- The Michigan Youth Opportunities Initiative utilizes local experts, including Planned Parenthood, to educate young people about safe sex, pregnancy prevention and healthy relationships.

### **Plan for Improvement - Activities for 2018 and 2019**

- Michigan will seek guidance and technical assistance from national resources, such as the Family and Youth Services Bureau to identify gaps in policy, best practices or program opportunities for pregnancy prevention.
- Michigan Youth Opportunities Initiative staff will identify pregnant and parenting enrolled youth to offer targeted supports in partnership with the Annie E. Casey Foundation.

### **LGBTQ Youth**

Michigan’s non-discrimination policy states “MDHHS will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identity or expression, sexual orientation, political beliefs or disability.” This statement applies to all licensed and unlicensed caregivers, families and/or relatives that potentially could provide care or are currently providing care for MDHHS supervised children, including children assigned to contract agencies.

To assist caseworkers and others to provide culturally sensitive services to young people that identify as LGBTQ, community stakeholders and youth joined MDHHS beginning in 2014 to discuss best practice recommendations for increasing awareness and support for young people who are LGBTQ. MDHHS is committed to developing a child welfare workforce that is knowledgeable and competent to support all children in care.

### **Progress in 2017**

- MDHHS collaborates with universities to provide training in specific topics. Addressing the needs of LGBTQ youth is included in this curriculum.
- The Foster Care and Licensing Worker Summit offered a session in which participants learned about evidence-based practices to increase health and safety for young people in care who identify as LGBTQ.
- The LGBTQ workgroup is developing recommendations for policy and best practice, licensing rules and placement decisions, community resources and training needs.
- MDHHS was awarded a grant to be a local implementation site for the National Quality Improvement Center on Tailored Services, Placement Stability and Permanency for Lesbian, Gay, Bisexual, Transgender, Questioning and Two Spirit Children and Youth in Foster Care. The grant will be administered in Wayne, Macomb and Oakland counties to address the needs of youth with diverse sexual orientations and gender identities in foster care to improve placement stability and promote well-being and permanency.
- Changes were requested to MiSACWIS to capture information related to youth sexual orientation and gender identity expression.

## **Plan for Improvement - Activities for 2018 and 2019**

- The practice guide for child welfare workers will be made available once final approval is obtained.
- Online training for child welfare workers will be updated.

## **Young Adult Voluntary Foster Care**

Michigan passed the Young Adult Voluntary Foster Care Act in 2011, allowing young people to remain in foster care until age 21 and receive services and financial support. Services include mental health, medical, dental, substance abuse, educational and employment support. Homeless youth residing with a Homeless and Runaway Youth contractor are eligible until their extension of foster care case is opened and they have begun receiving a stipend.

To be eligible, participants must maintain employment of at least 80 hours per month or participate in an educational program. In Michigan, youth participating youth can reside in a number of placement types, including:

- Independent living, including attending a college or university.
- Living with a licensed or unlicensed relative.
- Residential care.
- Guardianship or adoption.

Participants living with a biological parent, regardless of the status of that parent's legal rights or incarceration, become ineligible for Young Adult Voluntary Foster Care. Participation in Young Adult Voluntary Foster Care is voluntary and participants may choose to exit the program at any time. Participants also become ineligible when they fail to meet educational, employment, or disability-related requirements. Michigan allows unlimited exits and re-entries into Young Adult Voluntary Foster Care.

## **Progress in 2017**

- The Education and Youth Services analyst collaborated with the Federal Compliance and Child Welfare Funding Unit to providing training to local caseworkers on policy and payment for the Young Adult Voluntary Foster Care program.
- Technical assistance was offered to local child welfare offices to resolve barriers to timely enrollment and processing payments to youth in the Young Adult Voluntary Foster Care program.
- Policy was updated to clarify implementation of Youth Adult Voluntary Foster Care.
- Policy was updated to expand eligibility to young people who participate in volunteering in local organizations.
- Training was provided to staff from two Business Service Centers, as well as several individual counties.
- Technical assistance to field staff was enhanced through the development of a mailbox specific to Youth Adult Voluntary Foster Care policy and implementation questions.
- The MDHHS Youth Advisory Board reviewed the policy for the extension of foster care to make recommendations to MDHHS.

## **Plan for Improvement - Activities for 2018 and 2019**

- Strategies will be identified for additional methods to communicate this opportunity to young people transitioning from the child welfare system.
- Forms used for documenting the Semi-Annual Transition Plan Meeting and the 90-Day Discharge Meeting will be revised to highlight the opportunity for extending foster care and document that youth were informed of this program.

## **Support for Foster Children in Higher Education**

- The Michigan legislature appropriates funding for Fostering Futures Scholarships for eligible young people to attend higher education in Michigan.
  - MDHHS collaborates with the Michigan Department of Treasury, Office of Scholarships and Grants, to process applications and award scholarship funds.
  - The Education and Youth Services Unit verifies eligibility for the Office of Scholarships and Grants.
- MDHHS supports 13 post-secondary institutions with campus-based supports for young people in foster care who are attending college.
- Of these, 10 institutions have contracts with MDHHS to provide independent living skills coaches to participating youth.
- In the remaining three colleges, MDHHS provides an employee on campus to be a liaison and support person to enrolled students in foster care.
- The Education and Youth Services Unit collaborates with the Education and Training Vouchers contractor and with Fostering Success Michigan to provide regional trainings on higher education supports for foster youth in universities statewide.

## **Campus Coaches**

Campus coaches assist students who are currently or were formerly in foster care acclimate to campus life and reaching their education goals. In addition to campus coaches, Western Michigan University, Northwestern Michigan College and the University of Michigan utilize MDHHS employees as liaisons. The liaisons work with students from foster care to ensure they receive all services for which they are eligible, including:

- Young Adult Voluntary Foster Care.
- Education and Training Vouchers.
- Youth in Transition funds.
- Medicaid.
- Daycare.
- Supplemental Nutrition Assistance Program.

## **Progress in 2017**

- One hundred ninety-five young people were served through independent living skills coach contracts.
- A new contract was awarded to Grand Valley State University.
- Seven of the independent living skills coach contracts expired. A new Request for Proposal was posted in April 2017.

- Six of the seven independent living skills coach contractor re-applied for a new three-year contract. All six were awarded contracts.
- As of March 2018, there are 10 colleges with independent living skills coach contracts.

### **Plan for Improvement - Activities for 2018 and 2019**

- Messaging will continue to inform all eligible youth in foster care of opportunities to attend higher education.
- The MDHHS education analyst will continue statewide training and technical support regarding education opportunities and resources.
- The MDHHS education analyst will provide technical assistance to the independent living skills coach contractors to ensure they are serving all eligible youth on campus.

### **Collaboration with Other Private and Public Agencies**

MDHHS collaborates with private and public agencies to assist youth in the following ways:

- MDHHS provides Medicaid coverage to foster youth who leave MDHHS supervision and care to age 26 under the Patient Protection and Affordable Care Act.
- The Michigan Youth Opportunities Initiative is a partnership with the Jim Casey Youth Opportunities Initiative in its 15th year of assisting older youth in foster care through training, advocacy, leadership development and financial competency.
- MDHHS provides an array of supports to young people enrolled in the Michigan Youth Opportunities Initiative. Each site collaborates with community partners and stakeholders to develop opportunities for employment, education and social activities for young people in foster care, including banks, housing developers, employers, the faith-based community and mentors.
- MDHHS awarded mentor contracts to private agencies in five counties to provide one-to-one mentoring for older youth.

### **Program Support**

- Training was provided as requested by child welfare staff in local public and private agencies, and by community organizations and community partners.
- The MDHHS human trafficking analyst identifies training needs, establishes collaboration with other state agencies and interested organizations and identifies strategies for providing services to this population.
- MDHHS will continue to cross-train with community agencies on identification of human trafficking, the role of child welfare professionals in trafficking cases and resources for treating victims.
- The housing specialist in the Education and Youth Services Unit provided technical assistance to Homeless Youth and Runaway providers in serving young people who identify as lesbian, gay, bisexual, transgender and questioning (LGBTQ) and those identified as victims of human trafficking.
- The housing specialist collaborated with Ruth Ellis Center, a community-based organization with a long-standing history of supporting contractors gain insight on how

to better service youth who identify with diverse sexual orientation and gender identify expression.

- The human trafficking analyst met with the Michigan Network for Youth and Families to share information on human trafficking and the unique needs they present.
- The housing specialist reached out to the local housing authorities in Saginaw, Wayne, Pontiac and Kent counties to create partnerships for Family unification Program vouchers. Only Wayne is currently providing vouchers in collaboration with their local MDHHS office.
- Training on the importance of accurate and timely collection of survey and service information was provided to analysts assigned to the Business Service Centers and Child Welfare Supportive Services.
- Monthly supervisory phone conferences were used to provide updates and information to child welfare staff regarding the importance of accurate and timely collection of surveys and documentation of services provided to youth.
- Training was provided to public and private child welfare staff regarding the availability of startup living expenses for eligible youth.
- Technical assistance was provided to public and private child welfare staff to support timely access and documentation of startup living expenses for eligible youth.
- Training was provided to Michigan Youth Opportunities Initiative and child welfare staff regarding eligible expenses, opportunities available to youth and documentation of Chafee fund expenditures.

### **John H. Chafee Foster Care Program Consultation with Tribes**

All Chafee services including Education and Training Vouchers are available to eligible tribal youth without exception. MDHHS includes information about Chafee services and the Education and Training Voucher program at each quarterly Tribal State Partnership meeting. Tribal leaders have an opportunity to ask questions and request presentations. Technical assistance is provided to individual tribes as requested.

### **Program Support**

- MDHHS provides Indian Outreach Workers in each local office with a tribal population who provide individual services and assistance with applications to ensure all tribal youth are aware of the available services and how to access them.
- The Office of Workforce Development and Training provides ICWA training monthly for new child welfare and supervisory staff through new worker online training and facilitator-led supervisor training.
- The SCAO Court Improvement Program statewide task force holds meetings quarterly to advocate on behalf of tribal families.
- Review of whether tribes would like to develop, supervise or oversee Chafee, Education and Training Voucher and other child welfare services and receive a portion of the state's allotment for administration is conducted annually, or at the tribe's request.

MDHHS is in the process of updating prior Memoranda of Understanding for Michigan's

federally recognized tribes to ensure Youth in Transition funds are available to tribal youth in foster care. The Education and Youth Unit presented at the quarterly Tribal-State Partnership meetings, provided outreach and conducted follow-up. Technical assistance is offered at each quarterly meeting and as requested. The Keweenaw Bay Indian Community has requested a Title IV-E tribal/state agreement that will be effective when their federal plan is approved.

### **Training in Support of the Goals and Objectives of the Chafee Program**

To support Chafee policy and procedures, Child Welfare Specialists are trained on Youth in Transition policy in the Office of Workforce Development and Training Pre-Service Institute and Program-Specific Transfer Training. Technical assistance is provided as requested. As new issues are identified, information is shared with child welfare management and staff through communication issuances and monthly supervisory phone calls. Michigan provides the following training on the needs of young people preparing for independent living:

- Education - College Scholarships and Resources, in which information is shared on educational needs of children and youth and the associated federal and state laws and policy. The training includes how to access post-secondary resources for youth.
- Training is provided to the 16 Education Planners with policy and program updates, changes in law and topics of interest.
- Education Requirements for Youth in Foster Care; education policy and the educational needs of young people are trained.
- Monthly technical assistance phone calls are held with education planners and Michigan Youth Opportunities Initiative coordinators on policy updates.
- Regional and county office trainings are held on the policy, procedures and benefits of accessing Youth in Transition funding for older foster youth.
- Youth panels are presented, in which foster and adoptive youth share their experiences.
- MDHHS local offices and private foster care agencies offer training to foster and adoptive caregivers on topics identified in their communities. Training includes how to assist youth preparing for independent living and providing culturally sensitive services, including services to LGBTQ youth.
- The training “Working with LGBTQ Youth” addresses the special needs that may occur regarding sexual orientation and sexual identification.

## **EDUCATION AND TRAINING VOUCHER PROGRAM**

### **Service Description**

The Education and Training Vouchers Program is a state-administered program implemented through a contract with Samaritas of Michigan since 2006. Samaritas maintains an online database and website that streamlines the application process. Education and Training Vouchers staff complete 50 outreach activities each year, including training, webinars and mass mailings. Samaritas tracks utilization of vouchers on each youth’s award and education history. This database ensures a youth is never awarded more than \$5,000 in one fiscal year, per policy.

### Education and Training Vouchers for Unaccompanied Minors

In 2013, MDHHS began including unaccompanied refugee minors in the Education and Training Vouchers Program. The Education and Training Vouchers staff works closely with the Office of Refugee Services to ensure that young people are aware of the program and application process.

- In 2015, 67 unaccompanied refugee minors were awarded Education and Training Vouchers.
- In 2016, 56 unaccompanied refugee minors were awarded vouchers.
- In 2017, 38 unaccompanied refugee minors were awarded vouchers.

### Education and Training Vouchers for Tribal Youth

All tribal human services directors are sent Education and Training Voucher materials and provided technical assistance if needed or requested. MDHHS participates in quarterly Tribal State Partnership meetings that include tribal human services directors to discuss availability and access of tribal youth to Education and Training Vouchers.

### Education and Training Vouchers Awarded

	Total ETVs Awarded	New ETVs
2015-2016 School Year (July 1, 2015 to June 30, 2016)	519	192
2016-2017 School Year (July 1, 2016 to June 30, 2017)	436	166
2017-2018 School Year (July 1, 2017 to March 31, 2018)	408	165
2017-2018 School Year, estimated (July 1, 2017 to June 30, 2018)	460	190

## SERVICE DESCRIPTION - TITLE IV-B(1) AND (2) FUNDS

### Title IV-B(1) Service Description - Stephanie Tubbs Jones Child Welfare Services

Michigan's Title IV-B(1) funding is used for child welfare services, including:

- Children's Protective Services, described in Michigan's Child Abuse Prevention and Treatment Act (CAPTA) 2018 Annual Update.
- Crisis Intervention – Family Preservation Services, in addition to Title IV-B(2) funds.
- Prevention and Support Services, in addition to Title IV-B(2) funds.
- Time-Limited Family Reunification Services, in addition to Title IV-B(2) funds.
- Foster Family and Relative Care Maintenance (foster care payment) services, in addition to Title IV-E and state, local and donated funds.

### Locally Allocated Funds

MDHHS' commitment to providing accessible services to families that can be individualized

includes community-based programs. Allocation of funds to local county offices ensures that the services offered to families are appropriate to the needs of each geographical region and local needs. Funds allocated to MDHHS local offices may be consolidated to allow counties with low populations to combine funds in contracts that serve a broader population or geographic area.

### **Child Protection Community Partners**

Funding is provided to MDHHS local offices for preventive services to children of families at low to moderate risk of child abuse or neglect. The purpose of the funding is to:

- Reduce the number of re-referrals for substantiated abuse and/or neglect.
- Improve the safety and well-being of children and family functioning.

Services contracted with these funds include:

- Parenting education.
- Parent aide services.
- Wraparound coordination.
- Counseling.
- Prevention case management.
- Flexible funds for individual needs.

### **Child Safety and Permanency Plan**

Funding is provided to MDHHS local offices to contract for services to families with children at high risk of removal for abuse and/or neglect, or families with children in out-of-home placement. The purpose of the funding is to:

- Keep children safe in their homes and prevent the unnecessary separation of families.
- Return children in care to their families in a safe and timely manner.
- Provide safe, permanent alternatives for children when reunification is not possible.

Purchased services include:

- Counseling.
- Parenting education.
- Parent aide services.
- Wraparound coordination.
- Families Together Building Solutions services.
- Flexible funds to meet individual needs.

### **Family Preservation Services**

Each of Michigan's family preservation models is based on collaboration with the family to assess their strengths and needs and providing individualized services focused on the family's particular needs and circumstances.

- Families Together Building Solutions.
- Families First of Michigan.
- Family Reunification Program.

## **Title IV-B(2) Service Description**

Community-based programs are key components of the MDHHS services continuum and are recommended by local stakeholders to address needs identified in their communities. Funding allocated to Michigan's 83 counties enables local MDHHS offices to contract for services to keep children safely in their homes including:

1. Strong Families/Safe Children, Michigan's Title IV-B(2) program.
2. Child Protection Community Partners program.
3. Child Safety and Permanency Plan program.

Local MDHHS decision-making on expenditures through the above funding is one of the ways Michigan ensures that diverse local and regional services are available that meet the needs of specific communities and regions.

### **Strong Families/Safe Children**

Strong Families/Safe Children requires collaborative planning among local human services and other child welfare stakeholders. Community groups, in partnership with MDHHS local offices, assess local resources and gaps in services, develop annual service plans and recommend contracts for local service delivery. The program is statewide.

### **Family First Prevention Services Act**

Resulting from the passage of the Family First Prevention Services Act of 2018, Michigan amended eligibility for services in two categories served by Title IV-B(2) funds: Family Support and Time-Limited Family Reunification services. Changes to program eligibility and services and how they will be communicated to local offices and private agencies are described in the Family Support Services and Time-Limited Family Reunification Services sections below.

### **Title IV-B(2) Family Preservation - Placement Prevention Services**

These include services to help families at-risk or in crisis, including:

- Alleviating concerns that may lead to the out-of-home placement of children.
- Maintaining the safety of children in their own homes when appropriate.
- Providing support to families to whom a child has been returned from placement.
- Supporting families preparing to reunite or adopt.
- Assisting families in obtaining culturally sensitive services and supports.

Services are targeted to parents or primary caregivers with minor children who have an open foster care, juvenile justice or CPS Category I, II or III case. Services in 2016 and 2017 include:

- Parent aide services.
- Parenting education.
- Wraparound coordination.
- Families Together Building Solutions.
- Crisis counseling.
- Flexible funds for individual needs.

## **Title IV-B(2) Family Support Services**

### **Family First Prevention Services Act**

In Michigan, Family Support Services are provided to children and families through service contracts administered through MDHHS central office and local MDHHS offices. In response to the Family First Prevention Services Act, MDHHS will modify service descriptions and eligibility criteria to include services and support to foster families to enhance their skills and ability to serve the needs of children in their care. This includes modifying contract requirements for Families Together Building Solutions, home-based and home visiting services, parenting education, parent aides, Wraparound, counseling, in-home services, family support workers, mentoring services and supportive visitation, among others.

Expanding service eligibility to foster families will enhance their ability to mentor and coach birth families, facilitate transition of children from foster care and encourage the development of long-term supportive relationships among families. The increased support to foster families may also enhance their retention. Broader service eligibility and provision is expected to eliminate barriers to services experienced by families and thereby assist in change, which in turn, will lead to improved outcomes.

Expanded eligibility requirements will be communicated to the field through CSA Communication Issuances, Listening Sessions held in various locations (described in the Agency Responsiveness section), monthly supervisory telephone conferences, BSC and Child Welfare Supportive Services technical assistance, Tribal-State Partnership meetings, associations of private agency foster care providers and the MDHHS Behavioral Health Services Division.

Family support services promote the safety and well-being of children and families and:

- Increase family stability.
- Increase parenting confidence, resilience and supportive connections.
- Provide a safe, stable and supportive family environment.
- Strengthen relationships and promote healthy marriages.
- Enhance child development.

Family support services are provided to primary caregivers who meet one or more of the following eligibility criteria:

- An open foster care, juvenile justice or CPS category I, II or III case.
- A MDHHS child welfare case that has closed in the past 18 months.
- A CPS investigation in the past 18 months.
- Three or more rejected CPS complaints.
- Serve as relative and non-relative foster caregivers.

The services provided in 2017 include:

- Home-based family strengthening and support services.
- Parenting education/life skills.
- Parent aide services.
- Families Together Building Solutions.

- Mentoring programs for young people and their families.

## **Title IV-B(2) Time-Limited Reunification Services**

### **Family First Prevention Services Act**

Services are provided to children in foster care and their primary caregivers to facilitate reunification from foster care. The Family First Prevention Services Act expanded time limits to 15 months after the child has returned from foster care or residential placement. Services provided under this category include:

- Individual, group and family counseling.
- Substance abuse treatment.
- Mental health services.
- Services to address domestic violence.
- Therapeutic services for families.
- Transportation to and from services.
- Wraparound coordination.
- Supportive visitation/parenting time support services.
- Parent Partners peer mentoring.
- Flexible funds for individual needs.

Expanding eligibility and time limits for Family Reunification services will enhance the availability of long-term assistance to families and allow realistic time frames for readjustment and transition of children back into the care of their families. Expanded time frames will increase support to birth families and help address long-term effects of trauma and foster care placement, leading to improved outcomes and child and family well-being.

Expanded eligibility and time limits to Family Reunification services will be communicated to the field through CSA Communication Issuances, Listening Sessions described in the Agency Responsiveness section, monthly supervisory telephone conferences, BSC and CWSS technical assistance, Tribal-State Partnership meetings, association of private child placing agencies and the MDHHS Behavioral Health Services Division.

## **Title IV-B(2) Adoption Promotion and Support Services**

Services that encourage adoption from the foster care system include pre- and post-adoptive services that expedite the adoption process and support adoptive families. Services are targeted to adoptive and potential adoptive parents of minor children adopted through Michigan's foster care system. Services provided in 2016 and 2017 include:

- Adoptive family counseling and post-adoption services.
- Relative caregiver support services.
- Wraparound coordination.
- Foster and adoptive parent recruitment and support services.

## **Title IV-B(2) Percentages for 2016**

Actual expenditure percentages of total Title IV-B(2) funds in 2016 are below.

- Family Preservation, Placement Prevention: 29 percent.
- Family Support: 33 percent.
- Time-Limited Reunification: 19 percent.
- Adoption Promotion and Support: 5 percent; estimate: 15 percent.
- Administrative costs: 4 percent.

The above percentages reflect 2016 expenditures for the total Title IV-B(2) grant and include other allowable expenditures in addition to Strong Families/Safe Children services. Some Title IV-B(2) funds were used to augment state resources for post-adoption counseling services and for preventive services to families.

## **Rationale for Percentage Variances in 2016**

In Michigan, Title IV-B(2) funds are allocated to county MDHHS offices for spending in the areas of need identified by those counties. Allocation of Title IV-B(2) funds to county offices allows service expenditures in the four service categories to match the needs of each county, which maximizes available resources for the areas of greatest need.

Direct adoption services in Michigan are provided by private agencies, which receive adoption incentive payments through a cost pool that does not include Title IV-B(2) funds, but instead utilizes other federal, state and local dollars. Further, there is a reduced cost for post-adoption counseling services because children receiving adoption assistance are eligible for Medicaid coverage, including counseling services.

The percentage variation in the service category does not affect the accessibility of resources for adoption promotion and support because Michigan also has centrally administered initiatives and adoption support services funded through Title IV-B(1), as well as state, local and donated funds. Adoptive families may also receive services categorized as family support or family preservation. The reduced need for Adoption Promotion and Support services and for administrative costs allows Michigan to utilize additional funds in the categories of Family Preservation, Family Support and Time-Limited Reunification services.

## **Title IV-B(2) Estimated Percentages for 2019**

The Title IV-B(2) estimates for fiscal year 2019 submitted with this plan indicate that Michigan expects to spend the following percentages of Title IV-B(2) funds for the four service categories and administrative costs:

- Family Preservation: 30 percent.
- Family Support: 20 percent.
- Time-Limited Family Reunification: 20 percent.
- Adoption Promotion and Support: 20 percent.
- Administrative costs: 10 percent.

## Rationale for Percentage Variances in 2019

The rationale for the variance from 20 percent to 30 percent in Family Preservation services in 2019 is that costs for administration of funds will be charged to other accounts and the allowable 10 percent for administration will be allotted to Family Preservation services, which continue to be in high demand.

## SERVICE DECISION-MAKING PROCESS FOR FAMILY SUPPORT SERVICES

Michigan allocates Title IV-B(2) funds annually to all 83 counties for community-based collaborative planning and delivery of family preservation, family support, time-limited reunification and adoption promotion and support services. Michigan's program includes local groups in service planning to ensure that services fit the needs of the community and can be individualized. Stakeholder groups include representatives from:

- Michigan Department of Education.
- Local and regional schools.
- Public and private service organizations.
- The medical community.
- Mental and behavioral health service providers.
- Courts.
- Parents.
- Consumers.

The program design maintains community-based assessment, selection and delivery of Title IV-B(2) services. Service planning and delivery reflect the service principles identified in federal regulations at 45 CFR 1355.25. There are no changes planned to Michigan's Title IV-B(2) program design for 2019.

## JUVENILE JUSTICE PROGRAMS

In 2017, MDHHS Juvenile Justice Programs continued its administration of state and federal grants. Juvenile Justice Programs continues to write policy for State of Michigan juvenile justice case managers and public and private, contracted juvenile justice residential treatment facilities. Juvenile Justice Programs also continued to manage:

- Regional detention support services.
- An assignment unit for all juvenile justice residential placements.
- Two state-run residential juvenile justice facilities.
- Prison Rape Elimination Act compliance audits for all public and private, contracted juvenile justice residential facilities.

The two state-run juvenile justice residential facilities provide secure treatment and detention services for delinquent youth 12- to 20-years-old, placed either directly by the county court or

by an MDHHS juvenile justice specialist through the Juvenile Justice Assignment Unit. Juveniles include males and females who are delinquent for whom community-based treatment is determined inappropriate. Services include secure short-term detention, general residential, treatment of youth who are sexually reactive and substance use disorder treatment. The residential facilities operate at the secure level and include 24-hour, seven days per week staff supervision.

Juvenile Justice Programs continues to hold as a top priority improving data collection and integration that supports juvenile justice and child welfare services. Data will be used to develop a continuous quality improvement process.

### **Michigan Youth Reentry Initiative**

Juvenile Justice Programs implements the Michigan Youth Reentry Initiative that operates through a contract for care coordination, with an emphasis on assisting young people with medical, mental health or other functional life impairments that may impede success when re-entering the community. Juvenile Justice Programs also provides re-entry services to youth with disabilities who are adjudicated through an Interagency Agreement with Michigan Rehabilitation Services. The program delivers evidence-based and/or promising practices resulting in lower rates of recidivism, increased employment and education outcomes and permanency for youth with disabilities when re-entering the community.

To address the needs of dual wards, or “crossover youth,” MDHHS collaborated with Casey Family Programs to support a pilot project of the Georgetown University Center for Juvenile Justice Reform Crossover Youth Practice Model in Wayne County. This contract ended in May 2017.

**Goal:** MDHHS will establish data reports to evaluate juvenile justice programming and services.

- **Status:** With the implementation of MiSACWIS, MDHHS has begun the process of creating reports to assist with the oversight and understanding of juvenile justice programs.

**Goal:** To ensure a universal statewide tool is utilized across the state for courts to administer and assess young people as they enter the juvenile justice system.

- **Status:** Juvenile Justice Programs continues to work with the Mental Health Diversion Council to implement a statewide risk assessment tool, the Michigan Juvenile Justice Assessment, with access to the online tool for local courts. All MDHHS juvenile justice caseworkers and public and private contracted residential workers utilize the risk assessment tools and document the results in MiSACWIS.

### **Plan for Improvement - Activities for 2018 and 2019**

Planning is ongoing for the enhancement of programs and services for young adults including:

- Continuing to enhance re-entry services to disabled youth who can work and/or be rehabilitated to ensure supports are available to help them return to the community.

- Enhancing the MDHHS website to ensure easy access to tools and resources for youth and service providers.
- Continuing regular communication and collaboration with training staff, residential providers and juvenile justice specialists and supervisors to enhance program integrity. This includes local office expert and residential liaison conference calls and web demonstrations, Juvenile Justice Programs and Child Welfare Training Institute collaborative meetings and quarterly Juvenile Justice Field and Residential Policy Advisory Committees.
- Juvenile justice activities through work on the Mental Health Diversion Council including the implementation of a curriculum and training for juvenile competency forensic mental health examiners and restoration providers. It also includes the implementation of two pilot county community-based programs to deliver juvenile urgent response teams that respond 24/7 to divert or lessen penetration of youth into the juvenile justice system.
- Increase the use of in-home care and community-based services for young people who are delinquent as a means of reducing out-of-home placements.
- Incorporation of the Prison Rape Elimination Act screening tool, residential youth orientation checklist and collection of sexual orientation, gender identity and gender expression information in MiSACWIS to assist with ensuring appropriate and safe placement and services.

## JUVENILE JUSTICE TRANSFERS

One hundred sixteen young people in Michigan’s abuse/neglect foster care system were adjudicated as delinquent in FY 2017. This data was derived from the wardship coding in MiSACWIS that counted those children and youth whose type of wardship changed from abuse/neglect to juvenile justice, or became dual abuse/neglect-juvenile justice wards in FY 2016. As of Feb. 5, 2018, there were 179 dual abuse/neglect-juvenile justice wards in Michigan.

The juvenile justice system in Michigan is decentralized, with each county responsible for its juvenile delinquent population. County courts may refer a youth to MDHHS for delinquency care and supervision as a temporary delinquent court ward under the Social Welfare Act, 1939 PA 280 or commit the youth as a public ward under the Youth Rehabilitation Services Act, 1974 PA 150 as dispositional options under the Probate Code, 1939 PA 288.

### Juvenile Supervision in Michigan

In Michigan, most youth in the juvenile justice system remain the responsibility of the local court. Some youth who have had open foster care cases enter the juvenile justice system and remain under court supervision. The state does not have access to the case management systems used by court programs; therefore, determining the number of dual wards is challenging.

**Goal:** MDHHS will work collaboratively with the county courts to improve data collection.

- **Status:** Juvenile Justice Programs continues participation in a statewide work group formed by county family courts called Juvenile Justice Vision 20/20.

## SERVICES FOR CHILDREN ADOPTED FROM OTHER COUNTRIES

In 2017, following a review of the 11 MiSACWIS case records of dissolved adoptions in the state, there were no known children who were previously adopted internationally.

In Michigan, the provision of services to facilitate inter-country adoptions falls exclusively within the purview of licensed private adoption agencies. Adoption agencies licensed in Michigan to provide inter-country adoption services have an agreement with the foreign country that specifies the responsibilities of the agency in completing adoptions. Michigan has oversight of children adopted from other countries once they enter into Michigan's custody due to a disrupted or dissolved adoption. Michigan tracks disrupted and dissolved adoptions through MiSACWIS.

Children adopted from other countries are entitled to the full range of services as are all children in Michigan. These include family preservation and family reunification services and local services for pre- and post-adoptive families experiencing a risk of adoption disruption or dissolution.

### **Supporting the Families of Children Adopted from Other Countries**

Private agencies that provide services for international adoptions are licensed as child-placing agencies and held to Michigan's licensing rules for adoption. The Division of Child Welfare Licensing performs on-site reviews and investigations of alleged rule violations.

Adoption assistance programs provide permanency for children with special needs who are adopted from foster care. As a result, the statutory requirements for eligibility reflect the needs of children in the child welfare system and are difficult to apply to children adopted from other countries. The statute does not categorically exclude these children from participation in adoption assistance programs; however, it is highly improbable that children adopted abroad by U.S. citizens or brought into the United States from another country for adoption will meet the eligibility criteria in federal and state law.

### **Planned Activities to Support Children Adopted from Other Countries**

MDHHS provides post adoption services through eight regional Post-Adoption Resource Centers. Participation is voluntary and free of charge. The Post Adoption Resource Centers are designed to support families who have finalized adoptions of:

- Children from the Michigan child welfare system.
- Children adopted in Michigan through an international or a direct consent/direct placement adoption.

- Children who have a Michigan subsidized guardianship agreement.

The Post Adoption Resource Centers offer the following services:

- Case management, including short-term and emergency in-home intervention.
- Coordination of community services.
- Information dissemination.
- Education.
- Training.
- Advocacy.
- Family recreational activities and support.
- A website and newsletter about topics relevant to adoptive families, community resources and a calendar of events and training.

## MONTHLY CASEWORKER VISIT DATA AND FORMULA GRANT

Michigan continues to improve the rate of children in foster care visited by their caseworker every month, exceeding the federal goal. Michigan used the federally approved sampling methodology on monthly caseworker visits. The target and Michigan’s performance for the percentage of children visited each month by fiscal year is:

- 2014 requirement: 90 percent - Michigan achieved 96.3 percent.
- 2015 requirement: 95 percent - Michigan achieved 96.7 percent.
- 2016 requirement: 95 percent – Michigan achieved 97.1 percent.
- 2017 requirement: 95 percent – Michigan achieved 96.4 percent.

Michigan continues to exceed the federal goal of achieving at least 50 percent of the number of monthly visits made by caseworkers to children in foster care occurring in the child’s residence. The percentage of children visited in their residence in Michigan is:

- 2014: 83.8 percent.
- 2015: 73.4 percent.
- 2016: 97.9 percent.
- 2017: 98.0 percent.

### **Maintaining Progress on Monthly Caseworker Visits**

Michigan’s standard for the frequency of caseworker visits of children in foster care exceeds federal standards. Current foster care policy for caseworker contacts with children in out-of-home placement is as follows:

- The caseworker must have at least two face-to-face contacts per month with the child for the first two months following an initial placement or placement move. The first contact must take place within five business days from the date the case is assigned or within five business days of the placement move. At least one contact each month must take place at the child’s placement.
- The caseworker must have at least one face-to-face contact with the child each calendar

month in subsequent months. At least one contact each calendar month must take place at the child's placement.

- The caseworker must have weekly face-to-face contacts with the parent(s) and the child in the home for the first month after the child returns home. This period may be extended to 90 days if necessary.
- The caseworker must two have face-to-face contacts with the parent(s) and the child each calendar month in the home for subsequent months after the child has returned home until case closure, unless the family is receiving Family Reunification or Families First services.
- Each contact must include a private meeting between the child and the caseworker.

The topics listed below must be discussed with the child at each visit:

- The child's feelings and observations about the placement.
- Education.
- Parenting time.
- Sibling and relative visitation plans.
- Extracurricular and cultural activities and hobbies since the last visit.
- The child's permanency plan.
- Medical, dental and mental health.
- Any issues or concerns expressed by the child.

### **Monthly Caseworker Visit Formula Grant**

In 2017, Michigan used the Monthly Caseworker Visit Formula Grant for the following activities:

#### **Center for the Support of Families Contract**

- Design of the last training modules for the statewide Enhanced MiTEAM implementation.
- Design of the Parallel Steps for management and supervisors on the four MiTEAM competencies: 1) Case Planning, 2) Case Plan Implementation, 3) Placement Planning and 4) Mentoring.
- Addition of modules, application exercises and resources to the MiTEAM Virtual Learning Website.

#### **MiTEAM Support Calls**

Prior to each training cycle of the statewide implementation of the enhanced MiTEAM Practice Model, calls were conducted with management to prepare them for supporting staff during implementation. Support calls were conducted in March and April of 2017 to prepare for the Case Planning and Case Plan Implementation training cycle and in July and August 2017 to prepare for the Placement Planning and Mentoring training cycle. The enhanced MiTEAM Practice Model was implemented statewide in 2017. Directors, second line managers and supervisors were prepared to lead the process, track implementation (modules, application exercises and fidelity), exhibit behaviors consistent with the model (parallel process) and begin local CQI planning. This support led to increased engagement of staff and supported retention.

### **Safety Conference**

The 2017 MDHHS Child Welfare Safety Conference had nearly 350 registered participants. Attendees participated in a variety of breakout sessions designed to enhance their knowledge of various topics regarding the child welfare system. Breakout sessions of all programs, home visitation programs and Native American Tribal services were designed to help increase worker knowledge, improve the safety of children and help child welfare staff connect with resources across the state. This training assists with retention and support.

### **MiTEAM/Domestic Violence**

Funding allowed online modules to be provided to staff from two BSC regions. The training model's approach is based on tracking perpetrator patterns, and promoting survivor strengths working with domestic violence in a child centered way. The training promotes effective case practice when working with families experiencing domestic violence.

### **Strength-based Supervisory Training**

The Wayne Together Collaborative Workforce Change Initiative Committee facilitated a countywide training and support activities for all Wayne County MDHHS supervisors in May through August 2017. Sixty-nine supervisors completed both the training and coaching calls. Supervisors' skills are enhanced and focused on less crisis-oriented supervision to improve retention.

### **Employee Engagement**

To address staff turnover and employee morale in Wayne County, in August 2017, Wayne District offices participated in multiple employee engagement activities.

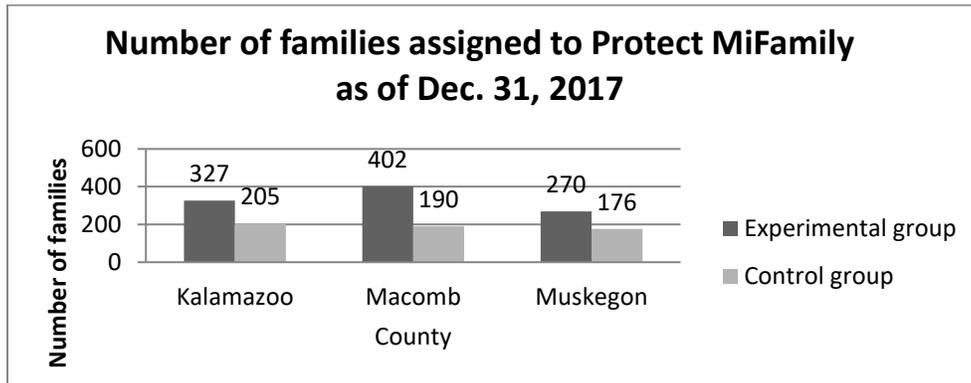
### **Wayne County home aides**

In April 2017, Wayne County home aides began providing assistance to Wayne County District offices to provide worker relief in child welfare. Home aides schedule and plan family visits, in coordination with the primary caretaker, foster parents and assigned specialist. Home aides make contact with foster parents to provide case forms, clothing, materials and other necessary items for foster youth. They also schedule and transport foster youth to/from medical, dental appointments and court hearings, and perform clerical support to specialists. With the assistance from home aides, key performance indicators improved for foster care, related to visits and medical and dental exams.

## **PROTECT MIFAMILY - CHILD WELFARE WAIVER DEMONSTRATION PROJECT**

In 2012, MDHHS was granted a waiver under Section 1130 of the Social Security Act to implement a five-year child welfare demonstration project. MDHHS implemented the project, Protect MiFamily, in August 2013 in Kalamazoo, Macomb and Muskegon counties. The target population includes families with children from birth through age 5 that reside in a participating county determined to be at high or intensive risk for maltreatment. Both Title IV-E-eligible and non-eligible children may participate.

Protect MiFamily seeks to reduce out-of-home placement and repeat maltreatment, while improving parental capacity and child well-being. Contracts were awarded to engage families in an enhanced screening, assessment and in-home case management model for 15 months, coupled with access to an array of support services. The chart below outlines the number of families assigned to the project from the time of implementation through March 31, 2017.



Protect MiFamily uses an experimental research design in which families are referred to treatment and control groups. The experimental group is provided with Protect MiFamily case management and assistance, while services funded through Title IV-B, such as Families Together Building Solutions, Wraparound, parent support groups and parenting skills training are provided to families selected for the control group. Title IV-B funds are used to maximize the use of flexible Title IV-E dollars in the following ways:

- Participating counties use Title IV-E flexibility to expand secondary and tertiary prevention services to improve outcomes for children and families.
- Michigan’s Title IV-E waiver uses an experimental research design in which families are referred to treatment and control groups. Services funded through Title IV-B are provided to families selected for the control group, such as Families Together Building Solutions, Wraparound, parent support groups and parenting skills training.
- Title IV-B funded services may also be employed as step-down services, should a family require ongoing support.

The Protect MiFamily project integrates the goals and objectives of the Child and Family Services Plan by:

- Providing evidence-based services.
- Engaging families as partners.
- Improving family functioning.
- Reducing abuse and neglect.
- Keeping children safely in their own homes.
- Improving the well-being of children.
- Implementing continuous quality improvement practices.
- Evaluating program effectiveness on established outcomes.

## **Project Evaluation**

MDHHS contracted with an independent evaluation team to determine the effectiveness of the demonstration. The final evaluation report will include process, outcome and cost/benefit analyses. The number of cases enrolled in the evaluation as of December 31, 2017 is 1,570; of these, 999 cases are in the experimental group and 571 in the control group. Findings include:

- In Category II cases, families that completed the 15-month program were significantly less likely to have a child removed from the home, compared with families in the control group.
- Preliminary outcomes reported in 2016 showed that families who completed the Protect MiFamily program showed statistically significant improvement on three of the four Protective Factors Survey subscales and on three of the five Knowledge of Parenting/Child Development items.
- Family Satisfaction Survey results across all three phases continue to suggest that satisfaction with the program services is positive:
  - Almost 91 percent of respondents either agreeing or strongly agreeing that the project helped them and their families reach their goals.
  - Exactly 98 percent of respondents agreed or strongly agreed that their Protect MiFamily worker asked for their family's opinions.
  - Over 98 percent agreed or strongly agreed that their Protect MiFamily worker included their comments, ideas and opinions into their service plans.
  - Almost 94 percent of respondents either agreed or strongly agreed that their family was getting the services they need.
  - Over 94 percent of respondents agreed or strongly agreed that they knew how to contact other agencies to get their needs met.

## **Michigan's Plan to Sustain Successful Waiver Interventions**

Under its Terms and Conditions, Michigan's Child Welfare Demonstration Project, Protect MiFamily, was to be terminated on June 30, 2018. On March 29, 2018, Michigan submitted a request to the Children's Bureau to extend the state's project through Sept. 30, 2019, the last day of waiver authority under the law.

In reviewing the state's extension request and Title IV-E claiming history for the demonstration project, the Children's Bureau identified areas of financial reporting needing correction and/or clarification to ensure that the project has properly determined and demonstrated cost neutrality. As of June 2018, additional time is needed to thoroughly analyze and address the issues. The Associate Commissioner of the Children's Bureau provided Michigan a short-term extension of the waiver for one quarter through Sept. 30, 2018. By the conclusion of this period, a final decision will be provided as to whether to extend the project for an additional year through Sept. 30, 2019, or to terminate the project. Decisions on sustaining successful waiver interventions will be made following the decision on whether the project is to be extended.

**Michigan 2019 Annual Progress and Services Report  
Goals and Objectives Matrix**

	A	B	C	D	E	F
1	<b>Safety</b>					
2	<b>Outcome:</b>		<b>Children are, first and foremost, protected from abuse and neglect.</b>			
3	<b>Goal:</b>	<b>MDHHS will reduce maltreatment of children in foster care.</b>		<b>Year</b>	<b>Data Measure/Time Period</b>	<b>APSR 2019 Reference</b>
4	<b>Objective 1.1:</b> MDHHS will decrease maltreatment of children in foster care.			2015-2019	NCANDS Data Profile	p. 23
5	<b>Benchmarks:</b>			Baseline	13.56/FY 2013	
6	2015	Demonstrate improvement each year.		2015	20.42/FY 2013	
7	2016-2019	Demonstrate improvement each year.		2016	16.64/FY 2014	
8				2017	14.68/FY 2015	
9	<b>Objective 1.2:</b> MDHHS will reduce the number of victims having recurrence of maltreatment.			2015-2019	NCANDS Data Profile	p. 23
10	<b>Benchmarks:</b>			Baseline	16%/FY 12b	
11	2015	Demonstrate improvement each year.		2015	14.9%/FY 13b	
12	2016-2019	Demonstrate improvement each year.		2016	13.3%/FY 14b	
13				2017	13.6%/FY15b	
14	<b>Permanency</b>					
15	<b>Outcome:</b>		<b>Children will have permanency and stability in their living situations.</b>			
16	<b>Goal:</b>	<b>MDHHS will increase permanency and stability for children in foster care.</b>		<b>Year</b>	<b>Data Measure/Time Period</b>	<b>APSR Reference Section</b>
17	<b>Objective 1.1:</b> MDHHS will increase the percentage of children discharged to permanency within 12 months of entering care.			2015-2019	Adoption and Foster Care Analysis Reporting System (AFCARS) Data Profile	p. 34
18	<b>Benchmarks:</b>			Baseline	34.6% FY 2012	
19	2015	Increase by .5%		2015	34.5%/FY 2013	
20	2016-2019	Increase by .5%		2016	31.1%/FY 2014	
21				2017	32.3%/FY 2015	
22						
23	<b>Objective 1.2:</b> MDHHS will increase the percentage of children in care for 12 to 23 months discharged from foster care to permanency within 12 months.			2015-2019	AFCARS Data Profile/U-M Data Lab (2015)	p. 35
24	<b>Benchmarks:</b>			Baseline	49.3% FY 2014	
25	2015	43.7% or more		2015	50.3%/FY 2015	
26	2016-2019	43.7% or more		2016	48.1% FY 2016	
27						
28				2017	47.4%/FY 2017	

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	A	B	C	D	E	F
29	<b>Objective 1.3:</b> MDHHS will increase the percentage of children in care for 24 months or more			2015-2019	AFCARS	p. 35
30	discharged to permanency within 12 months.			Baseline	32.8% FY 2014	
31	2015	Establish a baseline.		2015	35.8% FY 2015	
32	2016 - 2019	Demonstrate improvement each year.		2016	41.3% FY 2016	
33				2017	36.6% FY 2017	
34	<b>Objective 1.4:</b> MDHHS will decrease the percentage of children who re-enter foster care within 12 months of discharge to relative care or guardianship.			2015-2019	AFCARS Data Profile	p. 35
35	<b>Benchmarks:</b>			Baseline	3.7% FY 2012	
36	2015	Achieve the National Standard of 43.6% or more.		2015	4.3% FY 2013	
37	2016-2019	Achieve the National Standard of 43.6% or more.		2016	3.9% FY 2014	
38				2017	7% FY 2015	
39	<b>Objective 1.5:</b> MDHHS will decrease the rate of placement moves per day of foster care.				AFCARS Data Profile	p. 35
40	<b>Benchmarks:</b>			2015-2019		
				Baseline	3.45 FY 2014	
41	2015	Achieve the National Standard of 4.12 moves or less.		2015	3.58 moves FY 2015	
42	2016-2019	Achieve the National Standard of 4.12 moves or less.		2016	3.51 moves FY 2016	
43	2016-2019	Achieve the rate of 4.12 or less.		2017	3.64 moves FY 2017	
44	<b>Outcome P.2:</b>		<b>The continuity of family relationships and connections will be preserved for children.</b>			
45	<b>Goal:</b>	<b>MDHHS will maintain and preserve family relationships and the child's connections.</b>		<b>Year</b>	<b>Data Measure/Time Period</b>	<b>APSR Reference</b>
46	<b>Objective 2.1:</b> Children will have visits of sufficient frequency with their mother and father to promote parent-child relationships.			2015-2019	Quality Assurance (QA) Compliance Review	p. 38
47	<b>Benchmarks:</b>			Baseline	77.00%	
48	2015	Establish a baseline.		2015	65.50%	
49	2016-2019	Demonstrate improvement each year.		2016 YTD	76.00%	
50				2017	97.00%	
51	<b>Objective 2.2:</b> MDHHS will track the number of children in foster care who are placed with relatives.			2015-2019	MDHHS Monthly Fact Sheet	p. 39
52	<b>Benchmarks:</b>			Baseline		
53	2015	Establish a baseline.		2015	34.00%	
54	2016-2019	Demonstrate improvement each year.		2016 YTD	36.00%	
55				2017	56.00%	
56	<b>Objective 2.3:</b> Children will have visits of sufficient frequency with siblings to maintain and promote			2015-2019	QA Compliance Review	

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	A	B	C	D	E	F
57	sibling relationships. <b>Benchmarks:</b>			Baseline	88%/2014	
58	2015	Establish a baseline.		2015	57.00%	
59	2016-2019	Demonstrate improvement each year.		2016	63.00%	
60				2017	83.00%	
61	<b>Well-being</b>					
62	<b>Outcome:</b>		<b>Families have enhanced capacity to provide for their children's needs.</b>			
63	<b>Goal:</b>	<b>Families will have enhanced capacity to provide for their children's needs.</b>		<b>Year</b>	<b>Data Measure/Time Period</b>	<b>APSR Reference</b>
64	<b>Objective 1.1:</b> Caseworkers will visit with parents at a frequency sufficient to address issues pertaining to the safety, permanency and well-being of the child and promote achievement of case goals. Benchmarks:			2015-2019	QA Compliance Review	p. 46
65				Baseline	69%/2014	
66	2015	Establish a baseline.		2015	56.50%	
67	2016-2019	Demonstrate improvement each year.		2016	89% - Mothers, 69% - Fathers	-
68				2017	96.4% - Mothers, 89% - Fathers	
69	<b>Objective 1.2:</b> Caseworkers will assess the needs of parents initially and on an ongoing basis to identify the services necessary to achieve case goals.			2015-2019	QA Compliance Review	p. 47
70	<b>Benchmarks:</b>			Baseline	80% -parents, 89% -childrens, 74% -caregivers	
71	2015	Establish a baseline.		2015	85% - parents	
72	2016-2019	Demonstrate improvement each year.		2016	86% Parents, 95% children's, 89% caregivers	
73				2017	96% Mothers, 95% Fathers, 100% Children's, 98% Caregivers	
74	<b>Objective 1.3:</b> Caseworkers will involve the child and family in case planning. <b>Benchmarks:</b>			2015-2019	QA Compliance Review and Quality Services Review	p. 47
76	2015	Establish a baseline.		2015	Parents: 26%, Youth: 35%; QSR Voice & Choice: 44.2%	
77	2016-2019	Demonstrate improvement each year.		2016	Fathers, 91% Children, QSR Voice & Choice, M,F,C avg: 56.9%	

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	A	B	C	D	E	F
78				2017	QACR: 100% Mothers, 90% Fathers, 95% Children QSR Voice & Choice: M,F,C avg: 51.6%	
79	<b>Objective 1.4:</b> Caseworkers will visit with children in foster care a minimum of once each calendar month.			2015-2019	MISACWIS FY Federal Reporting	Page 46
80	<b>Benchmarks:</b>			Baseline	96.3%/FY 2014	
81	2015	Achieve 90 percent or more.		2015	96.00%	
82	2016-2019	Achieve 95 percent or more.		2016	97.00%	
83				2017	96.40%	
84	<b>Outcome:</b>		<b>Children will receive appropriate services to meet their educational needs.</b>			
85	<b>Goal:</b>	<b>Children will receive appropriate services to meet their educational needs.</b>		<b>Year</b>	<b>Data Measure/Time Period</b>	<b>APSR Reference</b>
86	<b>Objective 2.1:</b> School-aged children will be registered and attending school within five days of initial placement or any placement change.			2015-2019	QA Compliance Review	p. 51
87	<b>Benchmarks:</b>			Baseline	89%/2014	
88	2015	Establish a baseline.		2015	Initial: 88% Change: 79% Change	
89	2016-2019	Demonstrate improvement each year.		2016	Initial: 86%, Change: 83%	
90				2017	Initial: 83% Change: 83%	
91	<b>Objective 2.2:</b> Children entering foster care or experiencing a placement change will remain in their school of origin whenever possible and if it is in the child's best interest.			2015-2019	QA Compliance Review	p. 52
92	<b>Benchmarks:</b>			Baseline	77.3%/2014	
93	2015	Establish a baseline.		2015	Initial: 79% Change: 72%	
94	2016-2019	Demonstrate improvement each year.		2016	Initial: 72%, Change: 63%	
95				2017	93% documentation showed caseworkers made efforts	
96	<b>Objective 2.3:</b> MDHHS will ensure a children's educational needs are assessed and appropriate services are provided.			2015-2019	QA Compliance Review	p. 52
97	<b>Benchmarks:</b>			Baseline	93.94%/2014	
98	2015	Establish a baseline.		2015	89.00%	
99	2016-2019	Demonstrate improvement each year.		2016	88.00%	
100				2017	97% needs assessed; 40% need identified; of these 100% needs were met	

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101	<b>Outcome:</b>		<b>Children will receive adequate services to meet their physical and mental health needs.</b>			
102	<b>Goal:</b>	<b>Children will receive timely physical and mental health services that are documented in the case record.</b>		<b>Year</b>	<b>Data Measure/Time Period</b>	<b>APSR Reference</b>
103	<b>Objective 3.1:</b> Children entering foster care will receive an initial physical examination within 30 days of entry.			2015-2019	QA Compliance Review	p. 56
104	<b>Benchmarks:</b>			Baseline	75.40%	
105	2015	95%		2015	69.71%	
106	2016-2019	95% or higher		2016	75.00%	
107				2017	83.00%	
108				2018 YTD	Medical: 85%, Dental: 83%	
109	<b>Objective 3.2:</b> Children entering foster care will receive a mental health screening within 30 days of entry.			2015-2019	QA Compliance Review	p. 56
110	<b>Benchmarks:</b>			Baseline	53.80%	
111	2015	95%		2015	50.70%	
112	2016-2019	95% or higher		2016	73.00%	
113				2017	83.00%	
114				2018 YTD	85.00%	
115	<b>Objective 3.3:</b> Parents, caseworkers and children will engage in an informed consent process with physicians prescribing psychotropic medication.			2015-2019	Access Database	p. 57
116	<b>Benchmarks:</b>			Baseline	55.00%	
117	2015	Increase by 5%		2015	18.00%	
118	2016-2019	Increase by 5%		2016	84.00%	

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	A	B	C	D	E	F
1	<b>A. Information System</b>			<b>MiSACWIS Sub-Team</b>		
2	<b>Goal:</b>	<b>MiSACWIS will be compliant with federal requirements for statewide automated child welfare information systems.</b>		<b>Year</b>	<b>Data Measure/Time Period</b>	<b>APSR Reference</b>
3	<b>Objective 1.1:</b> MDHHS will submit the Adoption and Foster Care Analysis Reporting System (AFCARS) file to the Children’s Bureau semi-annually and ensure the file contains less than 10 percent errors for each data element.			2015-2019	File Error Rate <10%	p. 65
4	<b>Benchmarks:</b>			Baseline		
5	2015	Submit file with less than 10% error rate.		2015	File was submitted timely; one timeliness area.	
6	2016-2019	Submit file with less than 10% error rate.		2016	Submitted timely; one timeliness error in	
7				2017	Submitted timely; one timeliness error in	
8	<b>Objective 1.2:</b> MDHHS will submit the National Child Abuse and Neglect Data System (NCANDS) file to the Children’s Bureau annually and ensure the file contains less than 10 percent errors for each data element.			2015-2019	MiSACWIS	p. 65
9	<b>Benchmarks:</b>			Baseline		
10	2015	Submit file.		2015	File was submitted timely.	
11	2016-2019	Submit file.		2016	File was submitted timely.	
12				2017	File was submitted timely.	
13	<b>B. Case Review System</b>			<b>MiTEAM and CQI Sub-Team</b>		
14	<b>Goal:</b>	<b>MDHHS’ child welfare case review system will ensure each child has a case plan that promotes permanency.</b>		<b>Year</b>	<b>Data Measure/Time Period</b>	<b>APSR Reference</b>
15	<b>Objective 1.1:</b> A written case plan will be developed jointly with the child's parents for each child in care.			2015-2019	QA Compliance Review	Well-Being 1.3, p. 43

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	A	B	C	D	E	F
16	<b>Benchmarks:</b>			Baseline	Mother: 27.2% Father: 22.3%/2014	
17	2015	Establish a baseline.		2015	Mother: 79%, Father: 62%, Child: 67%	
18	2016 - 2019	Demonstrate improvement each year.		2016	Mother: 84%, Father: 66%, Child: 70%	
19	Reported in Well-Being 1, objective 3			2017	Mother: 100%, Father 90%, Child 95%	
20	<b>Objective 1.2:</b> For children in foster care, periodic court review hearings will occur in a timely manner.			2015-2019	QA Compliance Review	p. 76
21	<b>Benchmarks:</b>			Baseline	91.70%	
22	2015	Establish a baseline.		2015	95%	
23	2016 - 2019	Demonstrate improvement each year.		2016	82%	
24				2017	86%	
25	<b>Objective 1.3:</b> For children in foster care, a permanency hearing will occur no later than 12 months from the date the child entered foster care and no less frequently than every 12 months thereafter.			2015-2019	QA Compliance Review (QACR)	p. 77
26	<b>Benchmarks:</b>			Baseline	QACR: 49.5%, PIR: 97%	
27	2015	Establish a baseline.		2015	QACR: 92%, PIR 98%	
28	2016 - 2019	Demonstrate improvement each year.		2016	97%	
29				2017	97%	
30	<b>Objective 1.4:</b> For each child that has been in foster care 15 of the last 22 months, termination of parental rights petitions will be filed or compelling reasons will be documented.			2015-2019	QA Compliance Review	p. 79
31	<b>Benchmarks:</b>			Baseline	38.2%/2014	
32	2015	Establish a baseline.		2015	67%	
33	2016 - 2019	Demonstrate improvement each year.		2016		
34				2017	100%	
35	<b>Objective 1.5:</b> Caregivers will be notified of court hearings and the notification will include how they may exercise their right to be heard.			2015-2019	QA Compliance Review	p. 80
36	<b>Benchmarks:</b>			Baseline	42.7%/2014	
37	2015	Establish a baseline.		2015	18%	

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38	2016 - 2019		Demonstrate improvement each year.	2016	58%	
39				2017	61%	
40	<b>C. Quality Assurance System</b>			<b>MiTEAM and CQI Sub-Team</b>		
41	<b>Goal:</b>	<b>MDHHS will operate an identifiable quality assurance system.</b>		<b>Year</b>	<b>Data Measure/Time Period</b>	<b>APSR Reference</b>
42	<b>Objective 1.1:</b> The quality assurance system will operate in jurisdictions where services in the Child and Family Services Plan are provided.			2015-2019	Quality Service Review (QSR) Child and Family	p. 97
43	<b>Benchmarks:</b>			Baseline		
44	2015	Implement 8 Quality Service Reviews.		2015	8 Quality Service Reviews held	
45	2016	Implement 6 Quality Service Reviews and two CFSR test sites.		2016	6 QSRs, 2 CFSR practice	
46	2017	Complete the CFSR statewide assessment.		2017	7 QSRs, Statewide	
47	2018	Complete the CFSR on-site review.		2018		
48	2019	Implement the CFSR program improvement plan.				
49	<b>Objective 1.2:</b> The quality assurance system will include standards to evaluate the quality of services, including standards to ensure children in foster care are provided services that protect their health and safety.			2015-2019	QSR and CFSR Protocols	p. 97
50	<b>Benchmarks:</b>			Baseline	Piloted QSR protocol	
51	2015	Completed revisions of the Quality Service Review (QSR) protocol.		2015	Revision completed	
52	2016-2019	Review QSR protocol and revise as necessary.		2016	Established PIP process for counties.	
53				2017	Changed process for identifying counties for review.	
54	<b>Objective 1.3</b> The quality assurance system will identify strengths and needs of the service delivery system.			2015-2019	QSR and CFSR	p. 98
55	<b>Benchmarks:</b>			Baseline		
56	2015	Roll-up of county reports and annual report of the QSR.		2015	County rollup reports and annual QSR reports completed	
57	2016	Roll-up of county reports and annual report of the QSR.		2016	County rollup reports and annual QSR reports completed	

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	A	B	C	D	E	F
58	2017		Complete the CFSR statewide assessment.	2017	County rollup reports and annual QSR reports	
59	2018		Compile the CFSR results.			
60	2019		Develop the CFSR program improvement plan.			
61	<b>Objective 1.4:</b> The quality assurance system will provide relevant reports.			2015 - 2019	QSR and CFSR	p. 98
62	<b>Benchmarks:</b>			Baseline		
63	2015		Roll-up of county reports and annual report of the QSR.	2015	County rollup reports and annual QSR reports completed	
64	2016		Roll-up of county reports and annual report of the QSR.	2016	County rollup reports and annual QSR reports completed	
65	2017		Complete the CFSR statewide assessment.	2017	County rollup reports and annual QSR reports	
66	2018		Compile CFSR results.	2018		
67	2019		Provide CFSR program improvement plan progress reports.	2019		
68	<b>Objective 1.5:</b> The quality assurance system will evaluate implemented program improvement measures.			2015-2019	Development of a feedback process.	p. 98
69	<b>Benchmarks:</b>			Baseline		
70	2015		Development and utilization of a comprehensive feedback process.	2015	Feedback process implemented	
71	2016-2019		Demonstrate improvement each year.	2016	Developed PIP process	
72				2017	Changed process for Identifying counties for review.	
73	<b>D. Staff and Provider Training</b>			<b>Training Sub-Team</b>		
74	<b>Goal:</b>	<b>MDHHS will ensure training is provided to all staff who deliver services.</b>		<b>Year</b>	<b>Data Measure/Time Period</b>	<b>APSR Reference</b>

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	A	B	C	D	E	F
75	<b>Objective 1.1:</b> MDHHS will ensure initial training is provided to all new staff who deliver services that includes the basic skills and knowledge required for their positions.			2015-2019	Learning Management System (LMS)	p. 104
76	<b>Benchmarks:</b>			Baseline	Caseworkers: 97.5% Supervisors: 98.5%	
77	2015	Establish baseline.		2015	Caseworkers: 98% Supervisors: 98%	
78	2016-2019			2016	Caseworkers 98% Supervisors: 85%	
79				2017	Caseworkers 98% Supervisors: 96%	
80	2016-2019	A. 98% of new caseworkers will complete initial training within 16 weeks of hire. B. 98% of new supervisors will complete initial training within 12 weeks of hire.		FY 2016-2018		
81	<b>Objective 1.2:</b> MDHHS will ensure ongoing training is provided to all staff who deliver services that includes the basic skills and knowledge required for their position.			2015-2019	LMS	p. 109
82	<b>Benchmarks:</b>			Baseline	Caseworkers: 99.4% Supervisors: no FY 2014 requirement	
83	2015	Establish baseline.		2015	Caseworkers: 99% Supervisors: 99%	
84	2016	Caseworkers: 99% will complete 32 hours of in-service training per year. Supervisors: 90% will complete 16 hours of in-service training per year.		2016	Caseworkers: 98%, Supervisors: 99%	
85	2017-2019	Caseworkers: 99% will complete 32 hours of in-service training per year. Supervisors: 95% will complete 16 hours of in-service training per year.		2017	Caseworkers: 98% Supervisors: 99%	
86	<b>Goal:</b>	MDHHS will expand training for foster and adoptive parents.		<b>Year</b>		<b>APSR Reference</b>
87	<b>Objective 2.1:</b> MDHHS will explore centralizing training for foster and adoptive parents.			2015-2019	LMS	p. 110
88	<b>Benchmarks:</b>			Baseline		
89	2015	Submit a proposal to SOFAC for consideration of centralizing foster and adoptive parent training options.		2015	Proposal submitted to the SOFAC.	
90	2016	Determine funding sources for implementing centralized foster and adoptive parent		2016	Budget proposal not	

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91	2017	Assess progress and determine benchmarks.		2017	Exploring alternative approaches for expanding training	
92	2018-2019	Demonstrate improvement each year.		2018		
93	<b>E. Service Array and Resource Development</b>			<b>Resource Development Sub-Team</b>		
94	<b>Goal:</b>	<b>MDHHS' service array and resource development system will function to ensure an array of services is accessible and individualized to meet the needs of children and families served by the agency.</b>		<b>Year</b>	<b>Data Measure/Time Period</b>	<b>APSR Reference</b>
95	<b>Objective 1.1:</b> MDHHS will provide a service array and resource development system to ensure that accessible services are provided to: <ul style="list-style-type: none"> <li>Assess the strengths and needs of children and families and determine other service needs.</li> <li>Address the needs of families in addition to children in order to create a safe home environment.</li> </ul>			2015-2019	Demonstrate improvement each year.	p. 124
96	<ul style="list-style-type: none"> <li>Enable children to remain safely with their parents when reasonable.</li> <li>Help children in foster and adoptive placements achieve permanency.</li> </ul> <b>Benchmarks:</b>			Baseline		
97	2015	Identify available services and gaps in services statewide.		2015	Service gaps identified	
98	2016	Establish a plan to expand effective services and supports.		2016	Expanded FRP and	
99	2017 - 2019	Develop or expand supports.		2017	Tech. assistance in Teaming for the field.	
100						
101	<b>Objective 1.2:</b> MDHHS' service array and resource development system will ensure services can be individualized to meet the unique needs of children and families served.			2015-2019	To be determined.	p. 124
102	<b>Benchmarks:</b>			Baseline		
103	2015	Identify available services and gaps in services statewide.		2015	Service gaps identified	
104	2016	Establish a plan to expand effective services and supports.		2016	Trauma-informed services	
105	2017 - 2019	Develop or expand supports.		2017	Trauma-informed assessment training for the field	
106	<b>F. Agency Responsiveness to the Community</b>			<b>Communications Sub-Team</b>		

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107	<b>Goal:</b>	<b>MDHHS will be responsive to the community statewide through engagement with stakeholders.</b>		<b>Year</b>	<b>Data Measure/Time Period</b>	<b>APSR Reference</b>
108	<b>Objective 1.1:</b> MDHHS will engage in ongoing consultation with tribal representatives, consumers, services providers, the juvenile court and other public and private service agencies to ensure collaboration addresses the major concerns in implementing the CFSP and annual updates.			2015-2019	Annual SOFAC Report	p. 136
109	Benchmarks:			Baseline		
110	2015	Utilize the council and sub-teams for ongoing collaboration.		2015	Ongoing internal and external collaboration	
111	2016-2019	Utilize the council and sub-teams for ongoing collaboration.		2016	Ongoing internal and external collaboration occurred	
112				2017	Ongoing internal and external collaboration occurred	
113	<b>Objective 1.2:</b> MDHHS will utilize the Strengthening Our Focus Advisory Council (SOFAC) and sub-team structure to operationalize a continuous quality improvement plan that includes engaging internal and external stakeholders in assessment and development of effective strategies.			2015-2019	Annual SOFAC Report	p. 136
114	Benchmarks:			Baseline		
115	2015	Utilize the council and sub-teams for ongoing collaboration.		2015	Ongoing internal and external collaboration occurred	
116	2016-2019	Utilize the council and sub-teams for ongoing collaboration.		2016	Ongoing internal and external collaboration	
117				2017	Ongoing internal and external collaboration	
118	<b>Objective 1.3:</b> MDHHS will ensure that the state's services are coordinated with services or benefits of other federal or federally assisted programs serving the same population.			2015-2019	Annual SOFAC Report	
119	Benchmarks:			Baseline		
120	2015	Utilize the council and sub-teams for ongoing service coordination.		2015	Ongoing service coordination occurred	

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121	2016-2019	Utilize the council and sub-teams for ongoing service coordination.		2016	Ongoing service coordination occurred	
122				2017	Ongoing service coordination occurred	
123	<b>G. Foster and Adoptive Parent Licensing, Recruitment, and Retention</b>			<b>Placement Sub-Team</b>		
124	<b>Goal:</b>	<b>MDHHS will implement an annual adoptive/foster parent retention and recruitment plan that ensures there are foster and adoptive homes that meet the diverse needs of the children and youth that require out-of-home placement.</b>		<b>Year</b>	<b>Data Measure/Time Period</b>	<b>APSR Reference</b>
125	<b>Objective 1.1:</b> MDHHS will ensure that state standards are applied to all licensed or approved foster family homes or child care institutions receiving Title IV-B or IV-E funds.			2015-2019	Child Welfare Licensing data and other sources.	p. 151
126	<b>Benchmarks:</b>			Baseline		
127	2015			2015	State standards were applied equally	
128	2016-2019			2016	Collaboration occurred between local licensing agencies and the DCWL to ensure standards	
129				2017	Collaboration occurred between local licensing agencies and the DCWL to ensure standards were applied equally.	
130	<b>Objective 1.2:</b> MDHHS will ensure the state complies with federal requirements for criminal background clearances related to licensing or approving foster care and adoptive placements and has a case planning process that includes provisions for addressing the safety of placements for children.			2015-2019	Criminal and central registry screening of all applicants.	p. 152
131	<b>Benchmarks:</b>			Baseline		

**2019 Annual Progress and Services Report  
Goals and Objectives Matrix**

	A	B	C	D	E	F
132	2015			2015	Criminal and central registry screening of all applicants occurred prior to licensure.	
133	2016-2019			2016	Collaboration occurred between local licensing agencies and the DCWL to ensure each foster and adoptive home is screened and approved before children are placed.	
134				2017	100% of licensed foster care placements had criminal history and central registry screening prior to licensure.	
135	<b>Objective 1.3:</b> MDHHS will recruit and license an adequate and sufficient array of foster and adoptive homes that reflect the ethnic and racial diversity of children in the state for whom foster and adoptive homes are needed.			2015-2019	Percentage of annual plans that meet 90% of their goals or better.	p. 152
136	<b>Benchmarks:</b>			Baseline		
137	2015	September: approved plans returned to counties for implementation.		2015	65%	
138	2016-2019	September: approved plans returned to counties for implementation.		2016		
139				2017		
140	<b>Objective 1.4:</b> MDHHS will ensure the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placement for children is occurring statewide.			2015-2019	Interstate Compact Office	p. 152
141	<b>Benchmarks:</b>	Incoming home study requests will be completed within 45 days.		Baseline	62%	
142	2015			2015	66%	
143	2016-2019	Demonstrate improvement each year.		2016	71%	

**2019 Annual Progress and Services Report  
Goals and Objectives Matrix**

	A	B	C	D	E	F
144				2017	55%	
145						
146	<b>Goal:</b>	<b>The Office of Child Welfare Policy and Programs and the placement sub-team will ensure best practices for recruitment and retention are used and barriers addressed as needed.</b>		<b>Year</b>	<b>Data Measure/Time Period</b>	<b>APSR Reference</b>
147	<b>Objective 2.1:</b> MDHHS will ensure procedures for timely search for prospective parents for a child needing an adoptive placement, including the use of exchanges and other interagency efforts, if such procedures ensure that placement of a child in an appropriate household is not delayed by the search for a same race or ethnic placement. <b>Benchmarks:</b>			2015-2019	MI Adoption Resource Exchange and Adoption Resource Consultant referrals.	p. 153
148	<b>Benchmarks:</b>			Baseline	80% of youths available for adoption were registered with the MARE within required timeframes.	
149	2015	80% of youth available for adoption were registered with the MARE within required timeframes.		2015	22%	
150	2016-2019	80% of youth available for adoption were registered with the MARE within required timeframes.		2016	80%	

**2016 Annual Progress and Services Report  
Goals and Objectives Matrix**

Indian Child Welfare Act Compliance		Native American Affairs		
Goal 1:	MDHHS will ensure compliance with the Indian Child Welfare Act statewide.	Year	Data Measure	APSR Reference
<b>Objective 1.1:</b> MDHHS will increase the number of cases statewide where children are identified as American Indian/Alaska Native at the onset.		2015-2019	MiSACWIS QACR	p. 157
<b>Benchmarks:</b>				
<b>2015</b>	Establish a baseline.	2015		
<b>2016 - 2019</b>	Demonstrate improvement each year.	2016 - 2019		
		2016	88%	
		2017	Not available	
<b>Objective 1.2:</b> MDHHS will ensure the notification of Indian parents and tribes of state proceedings involving Indian children and inform them of their right to intervene or transfer proceedings to the jurisdiction of the tribe.		2015-2019	MiSACWIS QACR	p. 158
<b>Benchmarks:</b>		Baseline		
<b>2015</b>	Establish a baseline.	2015	Data not available.	
<b>2016 - 2019</b>	Demonstrate improvement each year.	2016 - 2019		
		2016	100%	
		2017	76%	
<b>Objective 1.3:</b> MDHHS will ensure that placement preferences for Indian children in foster care, pre-adoptive and adoptive homes are followed.		2015-2019	MiSACWIS QACR	p. 158
<b>Benchmarks:</b>		Baseline		
<b>2015</b>	Establish a baseline.	2015	Data not available.	
<b>2016 - 2019</b>	Demonstrate improvement each year.	2016 - 2019		
		2016	100%	
		2017	97%	
<b>Objective 1.4:</b> MDHHS will ensure that active efforts are made to prevent the breakup of the Indian family when parties seek to place a child in foster care or for adoption.		2015-2019	MiSACWIS QACR	p. 159
<b>Benchmarks:</b>		Baseline		
<b>2015</b>	Establish a baseline.	2015	Data not available.	
		2016	100%	
		2017	100%	

**2016 Annual Progress and Services Report  
Goals and Objectives Matrix**

<b>Objective 1.5:</b> MDHHS will provide timely notification to the child's tribe of its right to intervene in any state court proceedings seeking involuntary placement or termination of parental rights of Indian children.		Baseline	MiSACWIS	p. 159
<b>Benchmarks:</b>		2015	Data not available.	
<b>2015</b>	Establish a baseline.	2016	100%	
<b>2016 - 2019</b>	Demonstrate improvement each year.	2017	76%	
<b>2016 - 2019</b>	Demonstrate improvement each year.	2016 - 2019		
<b>Goal 2</b>	<b>MDHHS will increase cultural connections of Indian children in care statewide.</b>	<b>Year</b>	<b>Data Measure</b>	<b>APSR Reference</b>
<b>Objective 2.1:</b> Children will be placed in the least restrictive culturally appropriate setting to meet their safety, permanency and well-being needs.		2015-2019		Goal discontinued
<b>Benchmarks:</b>		Baseline		
<b>2015</b>	Establish a baseline.	2015		
<b>2016 - 2019</b>	Demonstrate improvement each year.	2016		
		2017		
<b>Objective 2.2:</b> American Indian/native foster and adoptive homes will be prepared, supported and available for the placement of Native American children statewide.		2015-2019		Goal discontinued
<b>Benchmarks:</b>				
<b>2015</b>	Establish a baseline.	Baseline		
<b>2016 - 2019</b>	Demonstrate improvement each year.	2015		

**CFS-101, Part I: Annual Budget Request for Title IV-B, Subpart 1 & 2 Funds, CAPTA, CFCIP, and ETV and Reallotment for Current Federal Fiscal Year Funding**

For Federal Fiscal Year 2019: October 1, 2018 through September 30, 2019

<b>1. Name of State or Indian Tribal Organization:</b> Michigan		<b>2. EIN</b>	38-60000134-C4	
<b>3. Address:</b> (insert mailing address for grant award notices in the two rows below)		<b>4. Submission Type:</b> (select one)		
235 S Grand Ave		<input checked="" type="checkbox"/> NEW		
Lansing, MI 48909		<input type="checkbox"/> REALLOTMENT		
a) Email address for grant award notices:		<input type="checkbox"/> REVISION		
<b>REQUEST FOR FUNDING for FFY 2019:</b> Hardcode all numbers; no formulas or linked cells.				
<b>5. Requested title IV-B Subpart 1, Child Welfare Services (CWS) funds:</b>				\$8,693,051
a) Total administrative costs (not to exceed 10% of the CWS request)		ok		\$86,930
<b>6. Requested title IV-B Subpart 2, Promoting Safe and Stable Families (PSSF) funds and estimated expenditures:</b>		<b>% of Total</b>		<b>\$8,574,942</b>
a) Family Preservation Services		30%		\$2,572,484
b) Family Support Services		20%		\$1,714,988
c) Time-Limited Family Reunification Services		20%		\$1,714,988
d) Adoption Promotion and Support Services		20%		\$1,714,988
e) Other Service Related Activities (e.g. planning)		0%		\$0
f) Administrative costs (APPLICABLE TO STATES ONLY: not to exceed 10% of the PSSF request)		10.0%		\$857,494
g) Total itemized request for title IV-B Subpart 2 funds: <i>NO ENTRY: Displays the sum of lines 6a-6f.</i>		100%		\$8,574,942
<b>7. Requested Monthly Caseworker Visit (MCV) funds: (For STATES ONLY)</b>				\$591,533
a) Total administrative costs (FOR STATES ONLY: not to exceed 10% of MCV request)		ok		\$59,153
<b>8. Requested Child Abuse Prevention and Treatment Act (CAPTA) State Grant: (STATES ONLY)</b>				\$720,257
<b>9. Requested Chafee Foster Care Independence Program (CFCIP) funds:</b>				\$4,171,796
a) Indicate the amount to be spent on room and board for eligible youth (not to exceed 30% of CFCIP request).		ok		\$200,000
<b>10. Requested Education and Training Voucher (ETV) funds:</b>				\$1,219,566
<b>REALLOTMENT:</b>				
Complete this section for adjustments to current year (FFY 2018) awarded funding levels.				
<b>11. Identification of Surplus for Reallotment:</b>				
a) Indicate the amount of the State's/Tribe's FFY18 allotment that will not be utilized for the following programs:				
CWS	PSSF	MCV (States only)	CFCIP Program	ETV Program
\$0	\$0	\$0	\$0	\$0
<b>12. Request for additional funds in the current fiscal year, should they become available for re-allotment:</b>				
CWS	PSSF	MCV (States only)	CFCIP Program	ETV Program
\$0	\$0	\$0	\$0	\$525,000
<b>13. Certification by State Agency and/or Indian Tribal Organization:</b>				
The State agency or Indian Tribal Organization submits the above estimates and request for funds under title IV-B, subpart 1 and/or 2, of the Social Security Act, CAPTA State Grant, CFCIP and ETV programs, and agrees that expenditures will be made in accordance with the Child and Family Services Plan, which has been jointly developed with, and approved by, the Children's Bureau.				
<i>Signature of State/Tribal Agency Official</i>		<i>Signature of Federal Children's Bureau Official</i>		
				
<i>Title</i>		<i>Title</i>		
EXEC DIRECTION CSA				
<i>Date</i>		<i>Date</i>		
6/25/18				

CRS-101 Part II: Annual Estimated Expenditure Summary of Child and Family Services

Name of State or Indian Tribal Organization: Michigan

For FY 2019: OCTOBER 1, 2018 TO SEPTEMBER 30, 2019

SERVICES/ACTIVITIES	(A) IV-B Subpart I- CWS	(B) IV-B Subpart II- PSSF	(C) IV-B Subpart II- MCV	(D) CAPTA	(E) CFCIP	(F) ETV	(G) TITLE IV-E *	(H) STATE, LOCAL & DONATED FUNDS	(I) Number Individuals To Be Served	(J) Number Families To Be Served	(K) Population To Be Served	(L) Geog. Area To Be Served
1.) PROTECTIVE SERVICES	\$ 275,000			\$ 709,750								Statewide
2.) CRISIS INTERVENTION (FAMILY PRESERVATION)	\$ 2,092,836	\$ 2,572,484								25,709	Eligible families	Statewide
3.) PREVENTION & SUPPORT SERVICES (FAMILY SUPPORT)	\$ 3,904,300	\$ 1,714,988					\$ 160,000	\$ 2,500,000		4,779	Eligible families	Statewide
4.) TIME-LIMITED FAMILY REUNIFICATION SERVICES	\$ 165,000	\$ 1,714,988								4,779	Eligible families	Statewide
5.) ADOPTION PROMOTION AND SUPPORT SERVICES									961		Eligible children	Statewide
6.) OTHER SERVICE RELATED ACTIVITIES (e.g. planning)											NA	NA
7.) FOSTER CARE MAINTENANCE:												
(a) FOSTER FAMILY & RELATIVE FOSTER CARE	\$ 2,169,185						\$ 25,000,000	\$ 94,200,000	13,298		Eligible children	Statewide
(b) GROUP/INST CARE							\$ 21,250,000	\$ 246,500,000	976		Eligible children	Statewide
8.) ADOPTION SUBSIDY PYMTS.							\$ 92,057,500	\$ 62,828,500	24,526		Eligible children	Statewide
9.) GUARDIANSHIP ASSISTANCE PAYMENTS							\$ 3,436,000	\$ 6,694,700	1,003		Eligible children	Statewide
10.) INDEPENDENT LIVING SERVICES					\$ 4,171,546				2,934		Eligible youth	Statewide
11.) EDUCATION AND TRAINING VOUCHERS						\$ 1,219,566		\$ 304,892	460		Eligible youth	Statewide
12.) ADMINISTRATIVE COSTS	\$ 86,930	\$ 857,494	\$ 59,153				\$ 87,650,000	\$ 111,000,000				
13.) FOSTER PARENT RECRUITMENT & TRAINING							\$ 1,638,200	\$ 3,500,000				
14.) ADOPTIVE PARENT RECRUITMENT & TRAINING							\$ 1,368,000	\$ 2,000,000				
15.) CHILD CARE RELATED TO EMPLOYMENT/TRAINING												
16.) STAFF & EXTERNAL PARTNERS TRAINING				\$ 10,507	\$ 250		\$ 2,635,000	\$ 6,000,000				
17.) CASEWORKER RETENTION, RECRUITMENT & TRAINING			\$ 532,380									
18.) TOTAL	\$ 8,693,051	\$ 8,574,942	\$ 591,533	\$ 720,257	\$ 4,171,796	\$ 1,219,566	\$ 235,194,700	\$ 536,569,592				
19.) TOTALS FROM PART I	\$8,693,051	\$8,574,942	\$591,533	\$720,257	\$4,171,796	\$1,219,566						
20.) Difference (Part I - Part II)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00						

(If there is an amount other than \$0.00 in Row 20, adjust amounts on either Part I or Part II. A red value means Part II exceeds request)

21.) Population data are included in the APSR/CFSR narrative, rather than above in columns I - L.  YES  NO

\* Only states or tribes operating an approved title IV-E waiver demonstration may enter information for rows 1-6 in column (9), indicating planned use of title IV-E funds for these purposes.

**CFS-101, PART III: Annual Expenditures for Title IV-B, Subparts 1 and 2, Chafee Foster Care Independence and Education And Training Voucher Reporting For Federal Fiscal Year 2016 Grants: October 1, 2015 through September 30, 2017**

1. Name of State or Indian Tribal Organization: Michigan		2. EIN: 38-60000134-C4	3. Address: 235 S Grand Ave Lansing, MI 48909			
4. Submission Type: (select one) <input checked="" type="checkbox"/> NEW <input type="checkbox"/> REVISION						
Description of Funds	(A) Estimated Expenditures for FFY 16 Grants	(B) Actual Expenditures for FFY 16 Grants	(C) Number Individuals served	(D) Number Families served	(E) Population served	(F) Geographic area served
5. Total title IV-B, subpart 1 (CWS) funds a) Administrative Costs (not to exceed 10% of CWS allotment)	\$ 8,931,618	\$ 6,690,842	12,656	-	Eligible children	Statewide
6. Total title IV-B, subpart 2 (PSSF) funds Tribes enter amounts for Estimated and Actuals, or complete 6a-f.						
a) Family Preservation Services	\$ 9,776,927	\$ 9,804,281		9,558	Eligible families	Statewide
b) Family Support Services	\$ 2,933,080	\$ 2,826,389				
c) Time-limited Family Reunification Services	\$ 1,955,385	\$ 3,264,185				
d) Adoption Promotion and Support Services	\$ 1,955,385	\$ 1,897,561				
e) Other Service Related Activities (e.g. planning)	\$ 1,955,385	\$ 1,453,695				
f) Administrative Costs (FOR STATES: not to exceed 10% of PSSF allotment)	\$ -	\$ -				
g) Total title IV-B, subpart 2 funds NO ENTRY: This line displays the sum of lines a-f.	\$ 9,776,927	\$ 9,804,281				
7. Total Monthly Caseworker Visit funds (STATES ONLY)	\$ 615,243	\$ 563,317				
a) Administrative Costs (not to exceed 10% of MCV allotment)	\$ 61,524	\$ -				
8. Total Chafee Foster Care Independence Program (CFCIP) funds	\$ 4,791,837	\$ 3,954,309				
a) Indicate the amount of allotment spent on room and board for eligible youth (not to exceed 30% of CFCIP allotment)	\$ 1,437,551	\$ 179,807	2,934	-	Eligible youth	Statewide
9. Total Education and Training Voucher (ETV) funds	\$ 1,548,387	\$ 1,512,315	519	-	Eligible youth	Statewide
10. Certification by State Agency or Indian Tribal Organization: The State agency or Indian Tribal Organization agrees that expenditures were made in accordance with the Child and Family Services Plan, which was jointly developed with, and approved by, the Children's Bureau.						
Signature of State Tribal Agency Official 		Signature of Federal Children's Bureau Official				
Title Executive Director CSM	Date 9/25/16	Title	Date			



**Children's Services Agency  
Division of Continuous Quality Improvement**

**Child Abuse Prevention and Treatment Act  
State Plan**

**2019 Annual Update**

**June 2018**

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### Attachments

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### Michigan’s Child Abuse Prevention and Treatment Act Coordinator

Colin Parks, Manager, Children’s Protective Services Policy and Program Office  
Michigan Department of Health and Human Services  
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## CHILD ABUSE PREVENTION AND TREATMENT ACT 2019 ANNUAL UPDATE

Michigan’s Child Abuse Prevention and Treatment Act (CAPTA) state plan aligns with the state’s Child and Family Services Review (CFSR) goals of improving the safety, permanency and well-being of children and families. Michigan’s Child Protection Law and child protection policies and procedures are applicable to all jurisdictions in the state. Activities to address CFSR outcomes are noted in this 2019 update. Information on ward transfers from the abuse/neglect system to the juvenile justice system can be found at the end of this report. Michigan uses the 2008 baseline and continues to coordinate Children’s Protective Services (CPS) goals with the Child and Family Services Plan.

### CPS Outcome Measures and Results

Measure	2012	2013	2014	2015	2016	2017
Number of complaints received	141,338	148,392	151,185	157,417	160,065	167,160
Percent of complaints accepted for investigation	65%	59%	55%	59%	56%	56%
Percent of investigations resulting in substantiation of abuse or neglect	27%	26%	25%	25%	28%	28%
Maltreatment in foster care <sup>1</sup>	12.17	13.56	12.84	10.65	9.84	12.58
Recurrence of maltreatment <sup>2</sup>	12.42%	11.68%	9.98%	8.38%	13.6%	10.92%

### CAPTA STATE GRANT FUNDS

CAPTA state grant funds are used for activities and contracts to reduce child abuse and neglect and improve practice. Currently these activities include:

- Providing “birth match” investigative services, which identify when a parent(s) who have had their parental rights terminated give birth to a new child. These complaints result in an automatic complaint and investigation.
- An annual child abuse and neglect conference.
- A paternity testing contract for children in the child welfare system.
- Safe sleep programming and services support.
- Support for the CPS Advisory Committee (made up of frontline CPS supervisors) and

<sup>1</sup> The rate of victimization per 100,000 days of foster care of all children in foster care.

<sup>2</sup> Of all children who were victims of a substantiated or indicated report of maltreatment during a 12-month target period, what percent were victims of another substantiated or indicated maltreatment allegation within 12 months of their initial report?

- annual conference.
- Support for the statewide child death review contract. This contract supports:
  - Coordination of local child death review teams.
  - Coordination of the State Child Death Review Team.
  - An annual child death review conference.
- Support for the annual Medical Advisory Conference.
- CPS program office travel costs.
- Assessments of revisions to the states Structured Decision Making (SDM) Tool, which assesses risk and safety in CPS investigations.
- Safety assessment and planning training.

## CHILD ABUSE AND NEGLECT LAWS

There were no substantive changes to Michigan law during the report period (July 1, 2016 – June 30, 2017) that will affect the state’s continued eligibility for CAPTA State Grant Funds.

Legislation was proposed but not enacted in 2017 that would incorporate aspects of the CAPTA Comprehensive Abuse and Recovery Act (CARA) in the Michigan Child Protection Law. These changes only incorporated the CARA language into Michigan law, but also corresponded with the CPS policy changes made in 2017 to align with CARA. Although sponsors helped to develop the proposed changes, they have not yet been reintroduced this session.

Department changes adopted in 2017 that incorporate CAPTA/CARA requirements and its impact CPS policy and practice are described below.

### **Needs of Infants Born Affected by Substance Abuse**

Michigan developed policies and procedures to address the needs of infants born with and identified as affected by illegal substance abuse or withdrawal symptoms. These include:

- Mandated reporters who have reasonable cause to suspect that a newborn infant has alcohol, a controlled substance, or a metabolite of a controlled substance in his or her body that are not the result of medical treatment are required to make a complaint of suspected child abuse to CPS (MCL 722.623a Sec. 3a).
- Mandated reporters include the following medical professionals:
  - Physicians and physician’s assistants.
  - Dentists and registered dental hygienists.
  - Medical examiners.
  - Nurses.
  - Persons licensed to provide emergency medical care.
  - Medical social workers.
- In 2017, MDHHS initiated a statewide effort to enhance mandated reporter training for

medical providers. This training provides mandated reporters:

- A reminder of their legal requirements to report these concerns.
- Guidance for how to identify safety concerns in situations when substance use/abuse is suspected.
- Suggested approaches to work with parents and providers to develop plans of safe care for infants suspected of being affected by substance abuse or withdrawal symptoms or Fetal Alcohol Spectrum Disorder.
- CPS must investigate complaints alleging that a newborn has been exposed to alcohol or drugs before birth. Policy requires CPS investigators to:
  - Contact the reporting source.
  - Contact medical professionals to confirm exposure and/or to identify appropriate medical treatment.
  - Review the criminal and CPS history of the family.
  - Interview the mother to assess the need for substance abuse assessment/treatment.
  - Determine the parents' capacity to provide adequate care of the newborn and other children in the home.

## SAFE CARE FOR INFANTS AFFECTED BY SUBSTANCE USE

MDHHS worked with public health providers to develop definitions and requirements in Michigan's Child Protection Law to define a "Plan of Safe Care" and require that these plans be established for infants and families when the criteria are met.

Michigan's policies and procedures for developing a Plan of Safe Care for infants identified as affected by substance use include the following:

- Mandated reporters are required to report suspected child abuse or neglect if the reporters knows or suspects that a newborn infant has any amount of alcohol, a controlled substance or a metabolite of a controlled substance (whether legal or illegal) in his or her body.
- Mandated reporter training was revised to include this guidance and a statewide effort was made to train medical professionals about these changes. The Mandated Reporter Training Committee reached out to liaisons in all of Michigan's birthing hospitals and offered this revised training and guidance to medical professionals for addressing how to respond to and provide services for substance exposed newborns and their families.
- Confirmed complaints of drug- or alcohol-exposed infants must be classified as physical abuse, Category I, II or III, based on the risk assessment.
- In 2017, policy changes include the definition of a safe care plan to be included in an investigation involving an infant identified as affected by substance use of their parent and/or withdrawal symptoms, or as a victim of Fetal Alcohol Spectrum Disorder. In

these cases, the worker must develop a safe care plan which will:

- Address the health and substance use treatment needs of the mother and infant and other affected family members.
  - Ensure that appropriate referrals and safety and treatment plans are developed to address the needs of the infant and family.
  - Take steps to ensure services provided to the infant and family are monitored either through continued MDHHS involvement or another service provider.
  - Addressing concerns through appropriate referrals is required. The referral and monitoring of these services must be documented by the worker in the Social Work Contacts and the Case Disposition narrative in MiSACWIS. This allows for better documentation of these case-types and conforms to federal reporting requirements.
- MDHHS has added requirements in all family preservation contracts for a Plan of Safe Care for all cases involving an infant identified as affected by substance use of their parent and/or withdrawal symptoms or as a victim of Fetal Alcohol Spectrum Disorder.
  - In confirmed complaints in which the infant requires medical treatment to address symptoms resulting from the drug/alcohol exposure and medical personnel indicate that the exposure seriously impairs the infant's health or physical well-being, a petition for court jurisdiction is required within 24 hours.
  - The state does not exclude complaints when a child is withdrawing from drugs legally prescribed to the mother. The state assesses whether those legally prescribed drugs were taken in accordance with a doctor's treatment requirements. If the drug use was not following treatment guidance or if the parent's substance use/abuse affects the ability to care for their child safely, a CPS case is opened and a Plan of Safe Care established.
  - Services must be coordinated with medical personnel, maternal infant health programs, substance abuse assessment and treatment providers.
  - Infants who are victims of confirmed prenatal substance exposure must be referred to Early On for an assessment and treatment of developmental delays.
  - Safe care plans also utilize the state's myriad of home visitation programs. These programs network with local MDHHS offices and birthing hospitals to ensure that contact is occurring and referrals to families are being made whenever appropriate. MDHHS has provided training and support to Michigan Home Visitation Programs to ensure their understanding and utilization of Plans of Safe Care.
  - In Michigan, mandated reporters include the following medical personnel:
    - Physicians, dentists, physician assistants, registered dental hygienists, medical examiners, nurses, persons licensed to provide emergency medical care, audiologists and psychologists.

MDHHS is participating in the following workgroups to address the needs of substance-affected newborns:

- **2017 Policy Academy - MDHHS Recovery Oriented Systems of Care**

Michigan was one of 10 states selected to participate in the “2017 Policy Academy: Improving Outcomes for Pregnant and Postpartum Women with Opioid Use Disorders and their Infants, Families and Caregivers.” Michigan is working with multiple partners on the public health and child welfare offices of MDHHS to develop a cross-system plan to evaluate systems, policies and statute, to address the needs of infants affected by opioids and their caregivers and to assess services needs and gaps in service provision.

- **Comprehensive Addiction and Recovery Act (CARA) workgroup**

The workgroup is developing a work plan to ensure Michigan is meeting the requirements of the 2016 federal CARA and the provisions of the Child Abuse Prevention and Treatment Act. Participants include internal and external child welfare and public health systems. The focus of the work is on:

- Creating uniform definitions of substance affected newborns and Infant Plans of Safe Care.
- Aligning MDHHS policies, programs and contracts with CARA.
- Identifying and implementing cross-system responses to support substance affected newborns and their families.
- Training and education on Infant Plans of Safe Care for birthing hospital staff, home visitation programs, infant mental health programs, family preservation services, CPS and foster care programs.
- Establishing a plan for tracking and monitoring all infants born affected by substances, and implementation of infant Plans of Safe Care.

- **Michigan Collaborative Quality Initiative of Birthing Hospitals**

In partnership with the initiative, the MDHHS Division of Maternal and Infant Health continues to provide education and training for birthing hospitals to screen infants for the signs and symptoms of Neonatal Abstinence Syndrome (NAS) and linking families to evidence-based home visiting to assist with the development Infant Plans of Safe Care.

Technical assistance to improve practice for caring for infants affected by substance abuse includes:

- Ongoing collaboration with Early On to ensure that infants who are exposed to a parent’s prenatal substance use should undergo an assessment of possible developmental delay and treatment if needed.
- Changes to MiSACWIS to implement a statewide monitoring system to determine whether child welfare staff and other public health providers are providing appropriate substance use/abuse treatment services for the infant and affected family or caregiver. These changes were finalized in October 2017.

### **CAPTA State Grant Enhancement**

Michigan was awarded additional CAPTA State Grant funds resulting from the federal Consolidated Appropriations Act of 2018, effective March 23, 2018. Beginning in 2019, the department will utilize this increased federal appropriation with a priority on addressing the development, implementation and monitoring of Plans of Safe Care for infants born and

identified as being affected by substance use or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder. The department will begin the work by:

- Ensuring effective coordination of efforts for Plans of Safe Care with birthing hospitals, public health and family preservation partners and others to ensure awareness of how to develop and implement these plans and how to report to the department on their development and outcome.
- Providing statewide training and technical assistance for child welfare and public health partners on implementation and monitoring of these plans.
- Ensuring department reporting is consistent with CAPTA reporting requirements.
- Working with local partners, including law enforcement, prosecutors, child assessment centers and others to develop and maintain local child abuse and neglect investigation protocols. These protocols will address substance use investigations, system approaches designed to improve child and family outcomes and the development and reporting of Plans of Safe Care.
- Assessing service provision gaps for children and families identified through birthing hospitals, public health or child welfare and addressing those needs through the development of local and/or statewide services to provide Plans of Safe Care for families as needed.

## **Justice for Victims of Trafficking Act and the Trafficking Victims Protection Act Safe Harbor**

Safe Harbor was one of the key reforms in the 2014 Michigan human trafficking legislative package. Specific changes included:

- Stronger protection for victims.
- Stronger tools to hold traffickers accountable.
- Victim health and welfare provisions.
- Establishment of commissions and boards.

## **Preventing Sex Trafficking**

In response to the growing problem of child trafficking, and in recognition of the vulnerability of foster youth to being targeted, MDHHS created a protocol for child welfare professionals, court personnel, law enforcement officials and schools. The protocol addresses the following goals:

- To provide a coordinated investigative approach while minimizing trauma to victims.
- To provide protection and specialized services to victims and family members.
- To provide cross-professional training to promote a better understanding of the unique nature and challenges of cases involving child sex trafficking and labor trafficking.
- To provide alternatives for handling the case after a child or youth has been identified as a victim of human trafficking.

## **Progress in 2017**

- Training for human trafficking awareness, assessment and prevention was provided as

requested to child welfare staff in public and private agencies and to community organizations and community partners.

- The Human Trafficking of Children Protocol-revised was published, along with screening tools for assessing risk factors for human trafficking of youth in child welfare.
- The Human Trafficking analyst worked to identify training needs, established collaboration with other state agencies and interested organizations and identified strategies for providing services to this population.
- MDHHS continues to cross-train with community agencies to educate them on identification of trafficking and resources for treating victims.
- MDHHS updated the public website with resources.
- Improvements in MiSACWIS have enhanced the capture of trafficking elements at intake and case disposition in order to ensure compliance with federal reporting requirements and the provision of services as needed.
- To reduce recidivism and assist victims to remain in treatment after thorough assessment of their needs, MDHHS has provided referrals to services with a variety of providers to assist with substance use and mental health assessments for trafficking victims.
- Human Trafficking policy was created in a policy manual referenced by all services program areas and updated to include a requirement to screen youth receiving foster care services who are at risk of human trafficking and all closed foster care cases receiving services.
- The CPS program office began coordination with Office of Workforce Development and Training for online training to be available to child welfare staff on Human Trafficking.

MDHHS has provisions and procedures to identify and assess all reports of known or suspected victims of child sex trafficking. Specifically:

- The MDHHS mandated reporter training includes the definition of child sex trafficking and mandated reporters' responsibility for reporting suspected child sex trafficking.
- MiSACWIS was updated and enhanced to collect information on child victims of sex trafficking in a manner that allows for better tracking.
- Any child or youth identified as a sex trafficking victim must be referred to specialized services aligned to their needs. MDHHS service provision includes a contract with Vista Maria (<https://www.vistamaria.org/>), which provides supportive services and housing for sex trafficking victims.

### **Training CPS Workers about Sex Trafficking**

- Child welfare caseworkers are provided training on child sex trafficking and labor trafficking. An overview of sex trafficking investigation is included in CPS Pre-Service Institute.
- Human Trafficking training is available to all child welfare staff on an ongoing basis.

### **The Infant Safe Sleep Act**

Enacted In 2014, Michigan House Bill 4962, the Infant Safe Sleep Act, requires hospitals and health professionals to provide readily understandable information and educational and instructional materials regarding infant safe sleep practices. Hospitals and other professionals working with families are provided free educational materials to use in their work with families; 368,905 educational items were distributed by MDHHS in FY 2017. MDHHS also provides a website for ongoing education that includes testimonials from parents who have lost a child due to unsafe sleep practices, access to materials and other resources. The Infant Safe Sleep website can be accessed at [www.michigan.gov/safesleep](http://www.michigan.gov/safesleep).

During 2017, MDHHS had contact with at least 17,970 children under the age of 1-year-old at the time of the CPS complaint. MDHHS continued to require investigators to discuss the dangers of unsafe sleep with parents of children under 12 months through CPS policy. Workers are required to ask the parent whether:

- The infant sleeps alone.
- The infant has a bed, bassinet or portable crib.
- There is anything in the infant's bed.
- The infant's mattress is firm with tight-fitting sheets.

The worker must inform the parent of safe sleep and the dangers of not providing a safe sleep environment. When discussing this with parents, the worker should:

- Utilize safe sleep educational materials.
- Educate family members about how to provide a safe sleep environment for their child.

If the infant is not provided with a safe sleep environment, the worker must document efforts to assist the family in creating one. The worker can utilize friends and family, community resources or local funds to assist the family.

MDHHS continues to provide training on the basic information of infant safe sleep for all child welfare workers and now includes any interested community partners. In 2018, MDHHS Infant Safe Sleep Program will release the "Safe Sleep 201" training for home visitors and child welfare workers that will be available in person and online. The objective of this training is to go beyond the American Academy of Pediatrics recommendations and address how child welfare workers can have effective conversations with families about safe sleep while addressing the challenges families face in following the guidelines.

Each year, Michigan reports deaths attributed to unsafe sleep environments to the federal Centers for Disease Control. Obtaining accurate numbers of child deaths can be a lengthy process, and is dependent on assessments by medical examiners and reviews by local child death review teams. Michigan reported to the Centers for Disease Control and Prevention that 142 infants died due to unsafe sleep environments in 2016 (the most recent year data is available). MDHHS recently completed the report "[Infant Safe Sleep in Michigan: A Comprehensive Look at Sleep-Related Deaths](#)." This marks the first time Michigan has compiled

data, research and information regarding local and statewide safe sleep initiatives into one comprehensive document.

MDHHS works to improve public awareness of the dangers of placing infants to sleep in an unsafe sleep environment. MDHHS will continue to participate in the Safe Sleep Advisory Committee, a multi-agency collaborative group that advocates for education of the public.

MDHHS is improving the quality of CPS investigations through initiatives including:

- **CPS Child Death Alert and Report.** This software enhancement collects child death information and notifies key MDHHS personnel when a death has occurred. The information collected in an investigation is stored in a secure database.
- **Foster Care, Adoption and Juvenile Justice Child Death Alert and Report.** Programming helps MDHHS collect accurate death information for children under the care and supervision of MDHHS. The information is stored in a secure database.

MDHHS sponsored a safe child/safe sleep campaign for the prevention of child deaths. Risk factors in child deaths include:

- Lack of smoke detectors.
- Poor prenatal care.
- Drug or alcohol use during pregnancy.
- Unsafe sleep environments.
- Poor supervision.
- Inappropriate selection of babysitters.

The MDHHS prevention campaign educates customers on home safety, shaken baby syndrome and creating safe sleep environments. The local offices have brochures, videos and resources available to clients and providers. MDHHS distributed Safe Sleep Kits statewide that include posters, brochures, toy cribs and dolls, reminder door hangers and an informational DVD.

The CPS program office will continue coordination with the Michigan Department of Education, community providers and the state Child Death Review Team to create and maintain a statewide plan to provide the video to the public in a variety of settings, including:

- Health care settings.
- Public health offices.
- MDHHS county offices.

## CPS POLICY UPDATES IN 2017

MDHHS updates CPS policy throughout the year in a continuing effort to improve case management and enhance child safety. Significant policy changes in 2017 include:

- A link to the MDHHS Human Trafficking Protocol was added to the online policy manual,

as was a high-level overview of the protocol. Contact information was added to allow CPS supervisors access to a CPS policy expert for policy questions including guidance for all human trafficking related cases. Policy also includes guidance for notifying law enforcement of any investigation alleging human trafficking.

- Policy was amended to include direction for investigators to contact non-custodial parents at the earliest point possible in the investigation. Additionally, language was added to reflect that MDHHS should not maintain recorded interviews conducted by Children's Assessment Centers.
- Policy regarding Law Enforcement Information Network (LEIN) usage by MDHHS employees is now located under SRM 700.
- Policy was updated to include additional reasons for allowances for investigation extensions. Policy also allows for approval of extension requests for reasons not included in policy, if approved by the director of field operations or their designee.
- To reflect legal clarification, licensed foster parents, owners, operators, volunteers or employees of licensed or registered child care organizations must be listed on Central Registry in any case in which there is a preponderance of evidence of child abuse and/or neglect when the victim is not their own child.
- Policy was updated to inform staff that CPS retains responsibility of a case if the child(ren) are not expected to be out of the home for seven days or less. If the child(ren) are expected to be outside the home for eight or more days, the responsibility of the case will be transferred to foster care. Previous policy indicated CPS would retain the responsibility of the case if the children were expected to return home within twenty-one days.
- Requirements for Plans of Safe Care were added to policy, as were requirements of what must be included in such plans. Regardless of the disposition of the case, workers must make a referral to community-based services when an infant is affected by substance use.
- Policy was updated to indicate mandated reporters were no longer required to contact Centralized Intake regarding controlled substance exposure of a newborn if the reporter confirmed the exposure was due to medication-assisted treatment.
- Policy was updated to include criteria for assignment of substance positive infants to be based on positive urine screen, positive meconium screen or positive umbilical cord tissue testing. Mandated reporters are informed of their responsibility to make a report once a positive screen was obtained, or if the infant begins exhibiting symptoms of exposure to a controlled substance.
- Workers must now coordinate with law enforcement regarding complaints involving allegations of manufacturing, selling, distribution or use of methamphetamine and Carfentanyl, or production or extraction of marijuana butane hash oil.

MDHHS revises policy throughout the year to incorporate updated legislation or programming and provide staff with direction to carry out responsibilities effectively. The CPS program office, the QIC Safety sub-team and Business Service Centers determine the actions necessary to

improve the performance of staff on CFSR safety measures.

## CHILD ABUSE PREVENTION AND TREATMENT ACT PROGRAM AREAS

### **CAPTA Section 106(a)1. To improve the intake, assessment, screening and investigation of reports of abuse and neglect.**

To ensure consistency in response to CPS complaints across the state, MDHHS established a statewide 24-hour Centralized Intake hotline for abuse and neglect reporting in 2012. CPS Centralized Intake ensures consistency in complaint disposition through the following activities:

- Monthly staff meetings to ensure clear communication and understanding of policy.
- Monthly meetings of Centralized Intake supervisors to ensure consistency.
- Updating Centralized Intake procedures and practices as necessary and communicating those updates to all Centralized Intake staff and the field.
- Updating the Centralized Intake manual “Procedures and Best Practices – Michigan’s Centralized Intake” and maintaining that document on a SharePoint site available to all MDHHS employees statewide.
- Monthly meetings with Centralized Intake Director/Managers and CPS program office to ensure that policy is correctly interpreted and communicated.
- Ongoing communication with MDHHS field staff to discuss disputed complaints.

### **Criminal Background Clearances**

Michigan complies with federal requirements for background clearances for prospective licensed foster care, relative providers and adoptive parents by completing central registry and criminal history clearances for all foster care, relative and adoptive placements. Michigan Licensing Rules for Foster Family Homes and Foster Family Group Homes for Children (R. 400.9205) require a criminal background check and a CPS central registry check for all licensed foster and adoptive parents and other adult household members. Licensing Rules for Child Placing Agencies (R. 400.12309) also require child-placing agencies to conduct these checks. No changes in this process have occurred over the last year.

Licensing consultants complete an annual on-site inspection of every child-caring institution. During annual reviews, personnel files are reviewed, in addition to a sample of files for current staff. The licensing consultant checks the central registry clearance, training records, criminal history information and other documentation.

The Michigan Child Protection Law was amended to allow MDHHS to verify that an employee, potential employee, volunteer or potential volunteer of an agency in which the person will have access to children is not on the central registry. There have been no substantive changes to the law affecting the state’s eligibility for the state grant (Section 106 (b)(C)(1)).

- In 2017, the CPS program office reviewed and responded to over 5,409 central registry

requests.

CPS program office has modified policy to address after-hours placement in unlicensed out-of-home care. This change required CPS workers to contact CPS Centralized Intake to receive central registry and criminal history background checks prior to the child's placement.

### **MDHHS Birth Match Process**

The MDHHS birth match process matches Michigan childbirths to a list of parents whose parental rights were terminated in Michigan because of neglect or abuse. It allows MDHHS to identify cases that may require a court petition documenting the likelihood of threatened harm based on previous termination of parental rights or a history of severe physical abuse. The process results in investigation and assessment of risk to the infant. The birth match system was identified as a best practice and was endorsed by the Commission to Eliminate Child Abuse and Neglect Fatalities in their "Within Our Reach" federal report. Michigan was asked to discuss the work of the birth match and the findings of the report at Harvard Law School in February 2017.

### **CAPTA Section 106(a) 2. Creating and improving the use of multidisciplinary teams and interagency protocols to enhance investigations and improve legal preparation and representation**

MDHHS works with the Governor's Task Force on Child Abuse and Neglect (GTF), Office of Workforce Development and Training, Prosecuting Attorneys Association of Michigan and the State Court Administrative Office Child Welfare Services Division (SCAO-CWS) to train public and private child welfare staff to use investigative protocols. To improve practice, MDHHS utilizes the following:

- **A Model Child Abuse Protocol** - To coordinate handling of child abuse and neglect cases between MDHHS, law enforcement and prosecuting attorneys, the Governor's Task Force updated "[A Model Child Abuse and Neglect Protocol with an Approach Using a Coordinated Investigative Team](#)" in 2013.
  - The Prosecuting Attorneys Association of Michigan continues to provide training to increase collaboration between prosecutors, child protective services and law enforcement on multi-disciplinary team (MDT) investigations.
  - In 2017, the department worked with the Prosecuting Attorneys Association of Michigan to gather local child abuse protocols to ensure collaboration between prosecutors, child protective services and law enforcement. Of Michigan's 83 counties, 36 have local MDT protocols.
- **Forensic Interviewing Protocol** - MDHHS assists investigative professionals to use best practices when interviewing children. MDHHS worked in collaboration with the GTF, statewide child welfare partners and staff at Central Michigan University to develop (and in 2017, revise) the [Forensic Interviewing Protocol](#). This protocol allows investigators to conduct an interview with a child in a developmentally sensitive,

unbiased and truth-seeking manner that supports accurate and fair decision-making. The protocol is trained in law enforcement and child welfare programs throughout the state and is the primary protocol for training new child abuse and neglect investigators.

- **Medical Child Abuse Protocol** - To address cases which may involve complex medical and psychological issues, the Governor’s Task Force revised the investigative protocol “Munchausen Syndrome by Proxy: A Collaborative Approach to Investigation, Assessment and Treatment,” and created the [Medical Child Abuse Protocol](#). This protocol defines and helps workers to identify and address medical child abuse. It also establishes guidelines for each discipline involved in an investigation. This update places the focus of the investigation on the abuse inflicted on the child, instead of the potential mental health concerns of the alleged perpetrator (Children’s Justice Act grant funded via the Governor’s Task Force).
- **Human Trafficking Protocol** - MDHHS has created and updated a protocol that aligns with federal and state legislation regarding human trafficking victims. This protocol was created to define best practice for determining whether a child is a victim of human trafficking, and how to move forward once a child has been identified as a victim.
- **Methamphetamine Protocol** - MDHHS addresses the immediate health and safety needs of children exposed to methamphetamine lab settings, establish best practices and provide guidelines for coordinated efforts between MDHHS workers, law enforcement and medical services. A multi-disciplinary work group developed the [Methamphetamine Protocol](#).

### **CAPTA Section 106(a) 3. Case management, including ongoing case monitoring and delivery of services and treatment provided to children and their families**

MDHHS will continue to improve case management and services by decreasing the number of children in out-of-home placement and enhancing the role of parents and families throughout the case planning process. MDHHS is using the following strategies:

- In 2017, MDHHS completed statewide implementation of the enhanced MiTEAM practice model.
- MDHHS’ CPS policy requires additional supervisory oversight and pre-removal family team meetings for all investigations including cases involving children in out-of-home placement. CPS workers are required to consult with their supervisors prior to disposition.

### **Progress in 2017**

- MDHHS completed statewide implementation of the enhanced MiTEAM practice model. Implementation included virtual learning, structured activities, practice support, resources and feedback for improving teaming and engagement with families, assessment (includes case planning, case plan implementation and placement planning) and mentoring skills for child welfare workers.

#### **CAPTA Section 106(a) 4. Enhancing the general child protective system by developing, improving and implementing risk and safety assessment tools and protocols.**

MDHHS addressed safety through changes in CPS policy through the following activities:

- The department created the Quality Improvement Council (QIC) Safety sub-team, which meets monthly. The following initiatives received committee support:
  - Providing statewide safety planning training (Safety by Design) and threatened harm training for all child welfare staff.
  - Safe sleep initiatives, including mandatory safe sleep training for all MDHHS and private agency staff.
  - Suicide prevention initiatives, including a conference co-sponsored by MDHHS.
  - A child welfare centered safety conference held in December 2017.

#### **Progress in 2017**

- MDHHS provided training on policy in multiple sessions offered by the State Court Administrative Office.
- MDHHS is working with the National Council for Crime and Delinquency to discuss updates to Michigan's structured decision-making tools regarding the risk and safety assessments. Validations of the assessments will be completed by the end of 2019.
- MDHHS presented a Safety Conference in December 2017.

#### **CAPTA Section 106(a) 5. Developing and updating systems of technology that support the program and tracking reports of child abuse and neglect**

**Goal:** CPS program office continues to work with the Division of Continuous Quality Improvement Data Management Unit and the MiSACWIS team to create reports for local managers to track outcomes and ensure that local managers are able to access and understand these reports. These reports include:

- Monthly Management Reports which provide data on standards of promptness for CPS commencement and CPS reporting requirements by county and agency.
- InfoView database, which provides data on CPS requirements at the agency, unit and caseworker level, allowing for their use as a supervisory tool.

**Status:** Development of enhanced reports is ongoing, as MiSACWIS is refined and users trained in case documentation. Data reports are published in the Infoview system and county managers are trained on how to use them to monitor case management activities. During 2017, new supervisor training included training opportunities for interpreting the data reports.

#### **CAPTA Section 106(a) 6. Developing, strengthening and facilitating training, including research-based strategies to promote collaboration, the legal duties of such individuals and personal safety training for caseworkers**

**Goal:** MDHHS will provide training statewide in collaboration with stakeholders.

**Status:** MDHHS will continue to provide training for child welfare professionals, including:

- Michigan’s annual Child Abuse and Neglect Prevention Conference.
- Yearly summit conferences on current issues in the investigation and judicial handling of child abuse, neglect and sexual abuse cases for legislators and other policymakers.
- In partnership with the universities, the Office of Workforce Development and Training will continue to provide in-service training to enhance caseworker skills.

### **CAPTA Section 106(a) 7. Improving the skills, qualifications and availability of individuals providing services to children and families**

MDHHS provides training statewide in collaboration with stakeholders, including:

- Michigan’s annual Child Abuse and Neglect Prevention Conference.
- CPS oversees the CPS Advisory Committee, a group of local CPS supervisors who meet quarterly to discuss CPS policy, practice and implementation. The group provides an opportunity for supervisors to connect with their peers, to participate in policy development and develop a network to enhance child welfare awareness and strengthen leadership skills.
- Yearly summit conferences on current issues in the investigation and judicial handling of child abuse, neglect and sexual abuse cases for legislators and other policy-makers.
- In partnership with the universities, the Office of Workforce Development and Training continues to provide in-service training to enhance caseworker skills. (Children’s Justice Act funded via the Governor’s Task Force).

**There were 1,568 CPS workers allocated in Michigan in 2017.** MDHHS continues to collaborate with Michigan State University and other schools of social work and the Michigan Department of Civil Service to identify and hire qualified candidates and develop internship programs.

**Retaining staff.** Experienced managers continue to provide targeted training to reduce attrition. The department continues recruitment efforts to fill existing children’s services manager positions. Efforts include use of national posting services, college/university career offices and changes to the current civil service system to increase benefits for managers.

**Collaboration with universities: Child Welfare Certificate Program.** MDHHS continues to implement the Child Welfare Certificate Program through a partnership with the Michigan schools of social work. Students participating in the program complete 60 social work credit hours in child welfare-related course work and a 400-hour internship in a CPS, foster care or adoption program at MDHHS or a child-placing or tribal agency. When students with child welfare certification are hired into child welfare positions, they are able to attend a condensed version of the Pre-Service Institute. Thirteen universities participated in Michigan’s Child Welfare Certificate Program in 2017.

**Updating the curriculum for the CPS Pre-Service Institute** to ensure the content is relevant, up-

to-date and effective in preparing new workers. Alternative delivery methods for the knowledge-based segments of the training continue to be enhanced.

## **Progress in 2017**

The Governor's Task Force on Child Abuse and Neglect provided training and resources in 2017 to address child welfare legal issues. The Task Force developed an interagency agreement with SCAO to train child welfare professionals via the printing, distribution and implementation of resource guides, practice manuals and other materials. Specialized trainings that took place in 2017 include:

- **Nurturing the Self: Understanding Secondary Trauma and Learning the Mindful Practice of Self Care:**
  - This training helped participants understand secondary traumatic stress, the conditions that may expose staff to secondary traumatic stress and provided the space to assess exposure to workplace conditions that may affect mental health. Attendees identified supports and resources, as well as self-assessment tools for reflection. A self-care toolkit was developed during the workshop and individualized for each participant. There were 129 attendees.
- **Lawyer Guardian ad Litem (LGAL) "Boot Camp"**
  - This training is an introduction for attorneys who are new to the LGAL role and a refresher for experienced LGALs. Participants reviewed the statutory responsibilities and discussed strategies to fulfill the requirements, including conducting an independent investigation, accessing case information, monitoring service plan implementation and working with children to effectively advocate for their best interests. Participants learned about attachment bonding in infants and toddlers, how to elicit meaningful testimony about parent-child interactions, and the higher protections afforded to Indian Children pursuant to ICWA/MIFPA. There were 118 attendees.
- **Testifying in Court for Non-Lawyers (Child Protective Proceedings)**
  - This full-day training featured the components of witness testimony and courtroom hearing procedures and helped caseworkers develop and expand their courtroom presentations and improve their ability to testify effectively through role-play exercises. The presenter discussed details of testifying in court, including courtroom demeanor, and the substantive elements of effective testimony. There were 39 professionals in attendance.
- **Collaborating to Address the Impacts of the Opioid Epidemic on Children and Families**
  - This training provided information about cross-system collaboration efforts to better serve children and families affected by the opioid crisis. Participants learned about legislative changes, including the MDHHS response to the federal CARA of 2016. Promising practices were shared on local collaborative efforts that are improving the lives of children and families and information on opioid treatments for pregnant and parenting women. There were 157 participants.
- **Child Welfare Essentials and Reasonable Efforts Advocacy**

- This training provided participants with an overview of the legal framework governing child protective proceedings in Michigan, including statutes, court rules and MDHHS policy. Specific strategies were discussed for making reasonable efforts to preserve and reunify families. There were 56 attendees.
- **The Michigan Indian Family Preservation Act Conference**
  - This training provided participants with an overview of the Michigan Indian Family Preservation Act (MIFPA) and the Indian Child Welfare Act (ICWA). Specific statutory requirements, legal standards, federal regulations and guidelines, and MDHHS NAA policy was reviewed and discussed. Participants learned about the 2016 federal Bureau of Indian Affairs ICWA regulations and guidelines, the role of the Qualified Expert Witness, and requirements for emergency removals of Indian children from the home. A panel presentation on tribal courts was included. There were 101 participants at this training.
- **Representing Parents in Child Protective Proceedings**
  - This training examined different legal advocacy tools attorneys can use to represent parent clients in child protective proceedings, including storytelling, data, and litigation. The goal of implementing various advocacy tools is to change the prevailing narrative in child welfare cases. Attendees had the opportunity to share strategies they use to effectively represent parent clients and to develop a personal plan of action for strengthening their overall advocacy skills. There were 48 participants.
- **Courtroom Confidence for Child Welfare Caseworkers**
  - This training provided child welfare caseworkers with information and tools to build confidence and navigate the courtroom. Participants received an overview of Michigan’s judiciary and what to expect in court, including the purpose of child protective court proceedings, the caseworker’s role and decisions and findings the court must make at hearings. There were 110 attendees.

### **CAPTA Section 106(a) 8. Developing and facilitating training protocols for individuals mandated to report child abuse or neglect**

MDHHS educates mandated reporters on their responsibility to report suspected abuse and neglect as required under Michigan’s Child Protection Law. CPS program office provides technical assistance to the field, professional groups and the public on the role of CPS.

### **Progress in 2017 and 2018**

The CPS program office works with county offices and other local and state partners to provide statewide mandated reporter training. In 2018, CPS is taking the following steps to enhance mandated reporter training:

- Monthly meetings with the Mandated Reporter Training Committee, made up of internal and external training partners. This committee provides ongoing assessment and revision of the mandated reporter training curriculum.

- Maintaining and making updates as appropriate to the mandated reporter training website; [www.michigan.gov/mandatedreporter](http://www.michigan.gov/mandatedreporter).
- Maintaining and distributing an updated list of staff in each county that provide mandated reporter training. This list is updated bi-annually and available on the MDHHS mandated reporter website.
- An online training video to describe the responsibilities of mandated reporters, guidance for reporting abuse and neglect with available resources. This was updated in 2017 and 2018.
- Provision of brochures for mandated reporters, specific to their positions. In 2016, the group revised mandated reporter brochures for 10 types of reporters. Brochures continue to be a valuable resource for mandated reporters.
- Efforts were made to train Michigan's 83 birthing hospitals regarding mandated reporting requirements. MDHHS will continue to make efforts to do so.
- In 2018, the department is assessing the development of an online mandated reporter training and certification process.

MDHHS Centralized Intake provides staff for the Mandated Reporter Hotline. A contact phone number is provided to mandated reporters statewide who have questions about their role or concerns about a complaint they submitted. When mandated reporters contact the hotline, the following steps are taken:

- Centralized Intake management and BSC directors are notified about the concerns.
- A determination is made between Centralized Intake and BSC directors about who will address the mandated reporter's concerns.

Other MDHHS activities regarding mandated reporters include:

- Distribution of the Mandated Reporter's Resource Guide and maintaining the public website.
- Working with the Children's Trust Fund to provide prevention councils with training opportunities and mandated reporter education as part of Child Abuse Prevention and Awareness Month.
- Guidance regarding mandated reporting and training, as requested.
- Continuing to provide training to hospitals, schools and health departments throughout the state.
- Maintaining a statewide mandated reporter training initiative. This initiative ensures that trainers are available in every county MDHHS office throughout the state. Additional training support is provided by local Child Abuse Prevention Councils.

## **Progress in 2017**

### **Online Reporting for Mandated Reporters**

MDHHS created an online reporting portal for mandated reporters. This enhancement included a plan for changes in the MiSACWIS system. MDHHS initiated a pilot program for online

mandated reporting in 2017. Allowing mandated reporters the ability to report suspected child abuse and/or neglect online will provide an additional avenue for reporting and increase the likelihood that reports of abuse/neglect will be made in a timely manner, increasing the accuracy of the central registry.

**Web based trainings that were provided in 2017:**

- New State and Federal Child Welfare Laws Regarding Older Youth in Foster Care
  - Number of Attendees: 84
- Michigan Safe Delivery of Newborns Law
  - Number of Attendees: 54
- Accommodating Parents with Disabilities in the Child Protection System
  - Number of Attendees: 84
- MIFPA and ICWA: A Court Resource Guide
  - Number of Attendees: 27
- Human Trafficking and Michigan’s Dependency Law
  - Number of Attendees: 122
- Juvenile Guardianships and the Guardianship Assistance Program
  - Number of Attendees: 185
  
- The 21st Annual Summit theme was "Critical Threads within Child Welfare" occurred from May 25-26, 2017. The keynote speaker was Dr. Valerie Maholmes, Chief of Pediatric Trauma and Critical Illness. The event provided training on the co-occurrence between domestic violence and substance abuse, innovative solutions for homeless youth, a kinship family panel, helping youth with developmental disabilities and prevention of sexual abuse. There were 230 professionals in attendance.

**CAPTA Section 106(a) 9. Developing and implementing programs to assist obtaining services for families of disabled infants**

MDHHS chairs the Medical Advisory Committee, which reviews policies and makes recommendations on how MDHHS can meet the medical needs of children. The committee meets bi-monthly to discuss medical issues pertaining to child abuse and neglect. Topics of past meetings include:

- CPS policy.
- Medically fragile children.
- Medical child abuse.
- Drug-exposed infants.
- The use of psychotropic medication.

The committee convenes an annual conference on abuse and neglect for medical professionals and facilitates discussion of issues related to abuse and neglect. In 2017, the Medical Advisory Committee continued to work with MDHHS to provide guidance to the field regarding recent

changes in policy. The committee is considering community outreach in 2018, including quarterly meetings throughout the state to meet with medical providers and child welfare staff to discuss investigative and supportive services for families with disabled children and ways to improve assessments of abuse and neglect for these at-risk children.

## **Early On**

CAPTA requires all child victims, ages birth to 36 months in substantiated cases of CPS Categories I or II to be referred to a Part C-funded early intervention service. Michigan's early intervention service, Early On assists families with infants and toddlers that display developmental delays or have a diagnosed disability.

MDHHS continues to focus on enhancing developmental information provided by CPS workers about Early On to ensure appropriate services are provided. In 2017, MDHHS referred 5,858 children to Early On. Of these:

- The number of drug-exposed infants was 2,895, 49 percent.
- The number of infants less than 1-year-old at referral was 4,806, 82 percent.

As of March 31, 2018, 3,278 children were referred for Early On services. Of these, 1,824, 56 percent, were drug-exposed at birth and 2,114, 65 percent, were less than 1-year-old at the time of referral.

## **Planned Activities for 2018 and 2019**

In 2018, MDHHS is focusing on the following projects related to Early On:

- Service coordination between MDHHS staff and Early On to enhance and maintain a comprehensive early intervention system of services, referring children who are primarily eligible for Early On services and/or meet the requirements of CAPTA.
- Training MDHHS field staff regarding the MDHHS Early On referral process and information regarding the services Early On provides.
- Ongoing resources provided to MDHHS field staff, through the Early On link of the Michigan Automated Child Welfare Information System (MiSACWIS).
- Collaboration with Early On agency partners and remaining updated on projects and policies.

## **CAPTA Section 106(a) 10. Developing and delivering information to improve public education on the roles and responsibilities of the child protection system**

**Goal:** MDHHS will educate the public on the roles and responsibilities of the child protection system. CPS program office has contact with county office staff and the public daily, providing technical assistance with data systems and policy ongoing.

**Status:** MDHHS educates mandated reporters on their responsibility to report suspected abuse and neglect as required under Michigan's Child Protection Law. CPS program office will provide technical assistance to the field, professional groups and the public on the role of CPS.

**Enhancing mandated reporter training.** MDHHS will work with county offices and other local and state partners to provide statewide mandated reporter training. In 2018, CPS will take the following steps to enhance training:

- Ongoing assessment and revision as needed of the mandated reporter training curriculum.
- Distributing an updated list of staff in each county that provide mandated reporter training.
- Provision of an online training video to improve public understanding of reporting child abuse and neglect. This training describes the responsibilities of mandated reporters, guidance for reporting abuse and neglect and available resources.
- Provision of brochures for mandated reporters, specific to their position.
- Maintaining the mandated reporter training website:  
[www.michigan.gov/mandatedreporter](http://www.michigan.gov/mandatedreporter).
- Focus on training for mandated reporters in Michigan's birthing hospitals.

## **CAPTA Section 106(a) 11. Developing and enhancing the capacity of community-based programs to integrate shared leadership strategies**

### **Citizen Review Panels**

Michigan's three citizen review panels are:

- The Citizen Review Panel on Prevention.
- The Citizen Review Panel on CPS, Foster Care and Adoption.
- The Citizen Review Panel on Child Fatalities.

#### **Citizen Review Panel for Prevention**

Since 1999, the Children's Trust Fund has administered the Citizen Review Panel for Prevention. The purpose the panel is to develop and improve prevention services. The Children's Trust Fund promotes the health, safety and well-being of children and families by funding community-based abuse prevention programs.

#### **Citizen Review Panel on CPS, Foster Care and Adoption**

This panel functions as a committee of the Governor's Task Force and serves as a stakeholder group for Michigan's Child and Family Services Review and the Child and Family Services Plan.

#### **Citizen Review Panel on Child Fatalities**

The Michigan Child Death State Advisory Team serves as the Citizen Review Panel for Child Fatalities. The panel is comprised of MDHHS, law enforcement, medical examiners, hospitals, the courts, educational professionals and other advocates. The panel examines child fatality cases in which the family had previous interaction with CPS. The Child Death State Advisory Team is managed through a contract with the Michigan Public Health Institute, which helps coordinate the Michigan Child Death Review Program.

## **CAPTA Section 106 (a) 12. Supporting and enhancing interagency collaboration between the child protection system and the juvenile justice system for improved delivery of services and treatment**

MDHHS Juvenile Justice Programs formed a work group to create and modify dual ward policy and practice. Dual wards are youth who are both abuse/neglect and delinquent court wards. The group developed policies on service provision and coordination.

### **Juvenile Programs update**

MDHHS published policy on case management of dual wards that requires early identification of “crossover” youth and coordination of services and planning with other programs including CPS and foster care. State run and private, contracted juvenile justice residential treatment facilities document case management activities and case service plans in MISACWIS. This allows caseworkers to readily identify other workers assigned to work with the dual ward youth, and collaborate and coordinate services across programs.

**Goal:** MDHHS will improve data collection to assess the targeting of services to crossover youth and dual wards.

#### **Status:**

- The DCQI created a process that integrated of juvenile justice data into a single repository to facilitate integration of juvenile justice and child welfare reports.
- MDHHS Juvenile Justice Programs worked with the Data Management Unit to incorporate juvenile justice data into monthly reports on child welfare populations. Reports include the state facility populations, a breakdown of the juvenile justice population by legal status and the population of dual wards. Efforts continue to improve data collection and analysis.
- A report was developed to identify abuse/neglect and juvenile justice youth that have been reported as AWOL or escape in the MiSACWIS system. This allows follow-up by the Education and Youth Services unit with caseworkers to ensure appropriate actions are being taken to locate the youth.

**Goal:** MDHHS will improve services to youth reentering the community from residential placement.

**Status:** Medicaid now allows Wraparound services to be provided by the community mental health system to youth reentering the community for up to 180 days prior to the release date. Juvenile Justice Programs will continue to collaborate with the Division of Mental Health Services to Children and Families and the Office of Workforce Development and Training to provide guidance to workers on the use and implementation of extended service availability.

### **Planned Activities for 2018 and 2019**

Planning is ongoing for the enhancement of programs and services for young adults including:

- Enhancing re-entry services to disabled youth who can work or be rehabilitated, ensuring supports are available to help them return to the community.
- Working with the Education and Youth Services Unit on the development of a best practice guide for working with youth who identify as lesbian, gay, bisexual, transgender or intersex.
- The Children’s Services Agency will provide training to child welfare and juvenile justice staff on the use of trauma screening and assessment tools and services.
- Enhancement of MDHHS’ juvenile justice website to include information on the evaluation of competency to proceed in delinquency matters for youth involved in the juvenile justice system.

**CAPTA Section 106(a) 13. Supporting and enhancing collaboration among public health agencies, the child protection system and private community-based programs to provide child abuse and neglect prevention and treatment services.**

**Goal:** MDHHS will work collaboratively with community partners to promote better outcomes for children.

**Status:** MDHHS collaborates with other agencies and community partners through:

- Coordination of the Governor’s Task Force on Child Abuse and Neglect (GTF) through the CPS program office. The GTF promotes effective handling of CPS complaints through initiatives, protocols and publications in collaborative efforts.
- Participating in the statewide infant safe sleep steering committee focused on prevention of sleep related fatalities, support for at-risk families and education for Michigan families regarding safe sleep practices.
- Coordination with Public Health offices to address substance use and abuse collaboration, maintenance of the Policy Academy to address parental substance use and abuse and the collaboration with birthing hospitals and home visitation programs to ensure development of plans of safe care.

**CAPTA Section 106(a) 14. Developing and implementing procedures for collaboration among CPS, domestic violence services and other agencies**

In 2015, the department contracted with David Mandel and Associates (now the Safe and Together Institute) to introduce the Safe and Together approach to handling domestic violence cases in child welfare. Training was mandatory for all public and private child welfare staff and supervisors. Sustainability efforts of the model are currently being developed.

The goal for CPS is that in every investigation, domestic violence should be evaluated. If the victim of domestic violence is not taking action to protect the children, or is willing to take action but does not know what resources are available, the worker should refer the non-offending parent to supportive services. The worker is also required to develop a safety plan with the non-abusing parent.

## CHILD MALTREATMENT DEATHS

Michigan receives reports on child fatalities from a number of sources, including law enforcement agencies, medical examiners/coroners and local child death review teams. Because fatality reports are obtained from these sources in their role as mandated reporters, the reports are not inserted into Michigan's National Child Abuse and Neglect Data System (NCANDS) submission until a link between the child fatality and maltreatment is established after completion of a CPS investigation. If the link between the death and maltreatment is confirmed, it is recorded as a fatality due to abuse and/or neglect in MiSACWIS and included in NCANDS submissions.

Michigan utilizes information provided by the state vital statistics department through the Michigan Fetal Infant Mortality Review and the Sudden Unexplained Infant Death Registry. This data is compiled with the assistance of the Michigan Public Health Institute and is incorporated with the information obtained from local child death review teams, law enforcement, local health departments and medical examiners/coroners to ensure accurate recording of child deaths in Michigan. Each year, this information is compiled into the [Annual Michigan Child Death Report](#) provided to the governor and Michigan state legislature.

### **Michigan Child Death State Advisory Committee**

The committee reviews findings and data from local Child Death Review Teams to make recommendations for policy and statute changes and guide statewide education and training to prevent child deaths. The committee disseminates an annual compilation of the reviews of child deaths in Michigan and outlines recommendations on policy, legislation and procedures to reduce the number of preventable deaths. Sleep-related fatalities, fetal drug exposure resulting in death and violence are areas critical for future study. The project coordinator of the National Citizen Review Panels has recognized this team as the model for other states' citizen review panels.

### **Child Death Investigation Training**

Training on child death investigations, uniform definitions, protocols and prevention is offered annually to CPS staff, medical examiners, law enforcement and other professionals. Participants are trained on the use of the reporting form, learn from case examples and discuss all aspects of child death scene investigations. Trainings are provided by MDHHS and partner agencies on an ongoing basis.

### **Family First Prevention Services Act**

In 2018, the department created a comprehensive work group to ensure compliance with the Family First Prevention Services Act. In 2019, MDHHS will implement the act requirements on tracking and preventing child maltreatment deaths by working with CSA managers, public

health partners, local and state child death review teams and others to track and compile complete information on child maltreatment deaths from specified sources by:

- Developing a comprehensive summary of the steps taken to compile complete and accurate information on child maltreatment deaths as identified by MDHHS and reported to NCANDS. This will include all relevant information on the deaths from information gathered through entities included, but not limited to, state vital statistics department, child death review teams, law enforcement agencies, offices of medical examiners and others.
- Describing steps taken by MDHHS to develop and implement a comprehensive statewide plan to prevent child maltreatment fatalities that engages public and private agency partners, including those in public health, law enforcement and the courts.
- Ensure that this information is provided in MDHHS' annual compilation of child fatalities provided to the Michigan legislature.

## EXPANDING AND STRENGTHENING PROTECTIVE SERVICES

Michigan developed unique approaches to address the prevention and treatment of risk and safety factors that may contribute to child abuse and neglect, including:

- Utilizing the Safe and Together approach to domestic violence in child welfare cases. Workers statewide are trained in utilization of Safe and Together and the skills it provides are incorporated into Michigan's case practice model, MiTEAM.
- Statewide Safety by Design training for frontline workers and supervisors. This training provides a child-centered approach to effective safety planning.
- Ongoing training and support to prevent unsafe sleep deaths statewide.
- Utilizing the Quality Improvement Council Placement and Safety sub-teams to improve placement assessment and decision-making. Child-centered safety approaches are discussed and information is brought to the teams for support and planning.
- In 2017, MDHHS began the revalidation process of risk and safety assessment (structured decision-making) tools to improve caseworker response, service delivery and child and family outcomes.

## CAPTA ANNUAL STATE DATA REPORT

### **CPS Staffing Allocations and Ratios; Qualifications and Training Requirements**

**Goal:** MDHHS will improve the skills, qualifications and availability of staff and supervisors that provide services to children and families.

**Status:** In 2017, there are 1,568 CPS workers allocated statewide. In addition, there were 33 CPS Maltreatment in Care Specialists and 140 Centralized Intake staff.

The following CPS staffing ratios, defined by the modified settlement agreement, remain the standard for MDHHS:

- CPS cases per ongoing worker: 17 to 1, for CPS Categories I, II and III.
- CPS cases per investigation worker: 12 to 1.
- CPS worker to supervisor: 5 to 1.

CPS workers must possess a bachelor's or master's degree with a major in one of the following:

- Social work.
- Sociology.
- Psychology.
- Family ecology.
- Consumer/community services.
- Family studies.
- Family and/or child development.
- Guidance/school counseling.
- Counseling psychology.
- Criminal justice.
- Human services.

CPS workers must successfully complete a nine-week pre-service training and a minimum of 270 hours of competency-based classroom and field training. The employee is required to pass a competency-based performance evaluation, including a written examination. The employee must also complete a minimum number of hours of in-service training each year.

The CPS supervisory training is a competency-based 40-hour curriculum for child welfare supervisors who have not previously had supervisory training. At the conclusion of the training, the supervisor must pass a competency-based evaluation. MDHHS will continue to provide program-specific training for supervisors in the monitoring of staff performance, policy and case reading.

The demographic information on CPS worker allocations includes their location in the state, by county. Statewide and county level CPS worker information is in APSR 2019 Attachment D: Worker Allocations 2018.

## POPULATION AT THE GREATEST RISK OF MALTREATMENT

In 2017, the population identified at greatest risk of maltreatment were children ages 3 and younger, living with their biological parents (constituting 40 percent of total child victims); this data was captured through MiSACWIS. The percentage of identified victims ages 3 and younger has been between 38 and 39 percent during the previous three reporting years. MDHHS will try to determine if this indicates a trend and if so, what steps to consider when determining services to families with young children.

The policies and services described below are directed toward this vulnerable population. Other policy enhancements and services described earlier are applicable and available to all children regardless of their age, except where specific populations are noted.

Factors included in identifying the population of children at the greatest risk of maltreatment include vulnerability due to their age and stressors on parents because of the children's dependent status. Five areas of policy and practice focus on this population in Michigan:

1. Multiple Complaint policy
2. Safe Sleep policy
3. Birth Match System
4. Early On policy and service provision
5. Protect MiFamily, Michigan's Title IV-E waiver project
6. Infant Mental Health Home Visitation, described in the Services Continuum section of this report
7. Plans of Safe Care

### **Multiple Complaint Policy**

The multiple complaint policy requires that whenever MDHHS Centralized Intake receives a third complaint in a home with a child under 3 years of age, a preliminary investigation must be completed to assess the likelihood of maltreatment. This ensures that repeat abuse and neglect complaints on the youngest children are not screened out, but at a minimum, undergo investigation to determine risk to the children and their service needs.

### **Safe Sleep Policy**

The Safe Sleep policy, described earlier in this report, requires that workers include in their assessments of children under 12 months (regardless of investigation type) the factors that place a child at risk of suffocation in his or her sleep environment.

### **Birth Match System**

This screening system identifies when a parent who previously lost rights to a child or committed an egregious act of abuse or neglect has given birth to a new baby in Michigan. This service includes automatic case assignment and requires workers to make immediate contact to assess the safety and well-being of the infant and evaluate the risk of maltreatment. Each year, this system identifies over a thousand matches, leading to investigation and in some cases, services for children who may be at high risk of maltreatment.

### **Early On**

All child victims aged birth to 36 months in substantiated cases of categories I or II are referred to Michigan's Part C-funded early intervention service, Early On. Early On is described earlier in this report.

### **Protect MiFamily**

In 2017, Protect MiFamily, Michigan's Title IV-E waiver project, focused on reducing the likelihood of maltreatment or repeat maltreatment. Protect MiFamily continues operation in Macomb, Muskegon and Kalamazoo counties. Results from the family satisfaction surveys continue to suggest that the families are highly satisfied with program services.

### **Infant Mental Health Services**

Infant mental health services provide home-based parent-infant support and intervention services to families where the parent's condition and life circumstances or the characteristics of the infant threaten the parent-infant attachment and the consequent social, emotional, behavioral and cognitive development of the infant. The infant mental health specialist provides home visits to families who are enrolled during pregnancy, around the time of birth or during the infant's first year. The specialist provides weekly home visits, or more frequently if the family is in crisis.

### **Plans of Safe Care**

In accordance with the 2016 federal CARA, Michigan attempted legislative changes and successfully modified policies to address the needs of infants exposed to medications or substances.

## **JUVENILE JUSTICE TRANSFERS**

One hundred sixteen young people in Michigan's abuse/neglect foster care system were adjudicated as delinquent in FY 2017. This data was derived from the wardship coding in MiSACWIS that counted those children and youth whose type of wardship changed from abuse/neglect to juvenile justice, or became dual abuse/neglect-juvenile justice wards in FY 2016. As of Feb. 5, 2018, there were 179 dual abuse/neglect-juvenile justice wards in Michigan.

The juvenile justice system in Michigan is decentralized, with each county responsible for its juvenile delinquent population. County courts may refer a youth to MDHHS for delinquency care and supervision as a temporary delinquent court ward under the Social Welfare Act, 1939 PA 280 or commit the youth as a public ward under the Youth Rehabilitation Services Act, 1974 PA 150 as dispositional options under the Probate Code, 1939 PA 288.

### **Juvenile Supervision in Michigan**

In Michigan, most youth in the juvenile justice system remain the responsibility of the local court. Some youth who have had open foster care cases enter the juvenile justice system and remain under court supervision. The state does not have access to the case management systems used by court programs; therefore, determining the number of dual wards is challenging.

- **Goal:** MDHHS will work collaboratively with the county courts to improve data collection.
- **Status:** Juvenile Justice Programs continues participation in a statewide work group formed by county family courts called Juvenile Justice Vision 20/20. In October 2015, MDHHS implemented a juvenile justice case management system into MiSACWIS.

### **Services to Court-Supervised Youth**

In Michigan, court-supervised youth are treated in the community, in county or court-operated juvenile facilities, or in privately operated juvenile facilities under contract to the court or county. Some youth are in foster homes licensed through the court. These youth are often younger than those the state supervises, have committed less severe offenses, and generally do not require specialized services. The Child Care Fund is the primary funding mechanism for juvenile justice services in Michigan. This fund reimburses counties for 50 percent of eligible costs for juvenile justice and non-Title IV-E-eligible youth. Many counties utilize their Child Care Fund dollars to develop effective lower cost community-based interventions for juvenile delinquents.

### **Regional Detention Support Services**

Regional Detention Support Services (RDSS) is a nationally recognized program. The purpose of RDSS is to provide alternatives to jail and detention for detained juvenile offenders who are awaiting a hearing and/or a placement. RDSS components include holdover, home detention, transportation and tether. Eligible jurisdictions include 53 rural counties that do not have secure detention facilities in Michigan and Native American Tribal jurisdictions. Local MDHHS office juvenile justice specialists may utilize all RDSS program components through establishment of a protocol with the local court.

### **Services to State-Supervised Youth**

Youth referred or committed to MDHHS for juvenile justice services are provided with case management by MDHHS juvenile justice specialists. A youth may remain in home or in a community-based out of home placement and receive local services or be placed through the Juvenile Justice Assignment Unit in public or private residential treatment facilities.

# APSR 2019 Attachment D CPS 2018 Staffing Allocation

## FY2018 CPS ALLOCATION

Run Date: 10/09/17	Ongoing		Assigned Investigations			FY2018 Initial CPS Calculated Workers	Additional Positions for MLOA/ Vac/Train 21.19%	Total Rounded CPS Worker County Allocation	Additional Positions for BSC Flex 5%	Total Rounded CPS Wkr BSC Flex Allocation	Total Calculated CPS Worker	Total Rounded CPS Wkrs for Supe Calculation	FY'18 Final CPS Rounded Workers at 100%	FY'17 Final CPS Rounded Workers	Change from FY'17
	FACT SHEET		FACT SHEET												
	Aug 2016 - July 2017 Ongoing Caseload	@ 17	Aug 2016 - July 2017 FACT SHEET Assignmts.	1.511	@ 12										
<b>STATE TOTAL</b>	<b>3916.9</b>	<b>230.41</b>	<b>7629.8</b>	<b>11528.7</b>	<b>960.72</b>	<b>1191.13</b>	<b>252.40</b>	<b>1486.00</b>	<b>59.56</b>	<b>63.00</b>	<b>1503.09</b>	<b>1539.00</b>	<b>1549.00</b>	<b>1568.00</b>	<b>-19.00</b>
<b>BSC1</b>										<b>7.00</b>			<b>7.00</b>	<b>6.00</b>	<b>1.00</b>
ALCONA/	14.8	0.87	7.1	10.7	0.89	1.76	0.37	3.00	0.09		2.22	3.00	3.00	2.00	1.00
IOSCO	28.1	1.65	31.1	47.0	3.91	5.57	1.18	7.00	0.28		7.02	8.00	7.00	7.00	0.00
ALPENA/	21.8	1.28	27.1	40.9	3.41	4.69	0.99	6.00	0.23		5.92	6.00	6.00	6.00	0.00
MONTMORENCY	4.8	0.28	6.8	10.2	0.85	1.13	0.24	2.00	0.06		1.43	2.00	2.00	2.00	0.00
ALGER/	9.0	0.53	5.7	8.6	0.71	1.24	0.26	2.00	0.06		1.57	2.00	2.00	3.00	-1.00
MARQUETTE/ SCHOOLCRAFT	35.9	2.11	57.4	86.8	7.23	9.34	1.98	12.00	0.47		11.79	12.00	12.00	12.00	0.00
ANTRIM/ CHARLEVOIX/ EMMET	25.6	1.50	23.1	34.9	2.91	4.41	0.93	6.00	0.22		5.57	6.00	6.00	7.00	-1.00
BARAGA/ HOUGHTON/ KEWEENAW	24.6	1.45	38.5	58.2	4.85	6.29	1.33	8.00	0.31		7.94	8.00	8.00	11.00	-3.00
BENZIE/ MANISTEE	5.5	0.32	6.9	10.5	0.87	1.19	0.25	2.00	0.06		1.51	2.00	2.00	2.00	0.00
CHEBOYGAN/ PRESQUE ISLE	11.8	0.69	18.2	27.4	2.29	2.98	0.63	4.00	0.15		3.76	4.00	4.00	4.00	0.00
CHIPPEWA/ LUCE/	8.7	0.51	17.5	26.4	2.20	2.71	0.57	4.00	0.14		3.42	4.00	4.00	4.00	0.00
MACKINAC/ CRAWFORD/ OSCODA/	13.3	0.78	22.3	33.7	2.81	3.59	0.76	5.00	0.18		4.53	5.00	5.00	5.00	0.00
OTSEGO	24.3	1.43	25.8	38.9	3.24	4.67	0.99	6.00	0.23		5.90	6.00	6.00	6.00	0.00
DELTA/ DICKINSON/ MENOMINEE	5.5	0.32	7.7	11.6	0.97	1.29	0.27	2.00	0.06		1.63	2.00	2.00	2.00	0.00
GOGEBIC/ IRON/ ONTONAGON	24.7	1.45	34.6	52.3	4.35	5.81	1.23	8.00	0.29		7.33	8.00	8.00	7.00	1.00
GRAND TRAVERSE/ KALKASKA/ LEELANAU	5.5	0.32	4.9	7.4	0.62	0.94	0.20	2.00	0.05		1.19	2.00	2.00	2.00	0.00
OGEMAW/ ROSCOMMON	4.9	0.29	5.9	8.9	0.75	1.03	0.22	2.00	0.05		1.31	2.00	2.00	2.00	0.00
MISSAUKEE/ WEXFORD	10.8	0.63	15.1	22.8	1.90	2.53	0.54	4.00	0.13		3.19	4.00	4.00	3.00	1.00
	4.8	0.28	7.7	11.6	0.97	1.25	0.26	2.00	0.06		1.58	2.00	2.00	2.00	0.00
	18.9	1.11	27.7	41.8	3.48	4.60	0.97	6.00	0.23		5.80	6.00	6.00	5.00	1.00
	6.3	0.37	32.1	48.5	4.04	4.41	0.93	6.00	0.22		5.56	6.00	6.00	6.00	0.00
	4.9	0.29	22.5	34.0	2.83	3.12	0.66	4.00	0.16		3.94	4.00	4.00	4.00	0.00
	6.3	0.37	22.3	33.6	2.80	3.17	0.67	4.00	0.16		4.00	4.00	4.00	4.00	0.00
	18.1	1.06	14.0	21.2	1.76	2.83	0.60	4.00	0.14		3.57	4.00	4.00	3.00	1.00
	9.3	0.54	10.8	16.4	1.36	1.91	0.40	3.00	0.10		2.41	3.00	3.00	3.00	0.00
	4.3	0.25	3.8	5.8	0.48	0.74	0.16	1.00	0.04		0.93	1.00	1.00	1.00	0.00
	68.2	4.01	79.2	119.6	9.97	13.98	2.96	17.00	0.70		17.64	18.00	17.00	14.00	3.00
	18.8	1.11	21.7	32.7	2.73	3.84	0.81	5.00	0.19		4.84	5.00	5.00	4.00	1.00
					0.00	0.00									
	12.3	0.73	24.3	36.6	3.05	3.78	0.80	5.00	0.19		4.77	5.00	5.00	4.00	1.00
	9.7	0.57	23.4	35.4	2.95	3.52	0.75	5.00	0.18		4.44	5.00	5.00	4.00	1.00
	54.3	3.19	64.2	97.0	8.08	11.27	2.39	14.00	0.56		14.22	15.00	14.00	15.00	-1.00
<b>TOTAL</b>	<b>522.9</b>	<b>30.76</b>	<b>716.6</b>	<b>1082.8</b>	<b>90.23</b>	<b>120.99</b>	<b>25.64</b>	<b>163.00</b>	<b>6.05</b>	<b>7.00</b>	<b>152.68</b>	<b>166.00</b>	<b>170.00</b>	<b>164.00</b>	<b>6.00</b>
<b>BSC2</b>										<b>11.00</b>			<b>11.00</b>	<b>10.00</b>	<b>1.00</b>
<b>GENESEE</b>															
INGHAM	125.1	7.36	272.2	411.2	34.27	41.63	8.82	51.00	2.08		52.53	53.00	51.00	47.00	4.00
SAGINAW	82.4	4.85	174.0	262.9	21.91	26.76	5.67	33.00	1.34		33.77	34.00	33.00	31.00	2.00
ARENAC/ BAY	5.0	0.29	11.4	17.3	1.44	1.73	0.37	3.00	0.09		2.19	3.00	3.00	3.00	0.00
CLARE/ ISABELLA	43.7	2.57	110.8	167.5	13.96	16.52	3.50	21.00	0.83		20.85	21.00	21.00	20.00	1.00
CLINTON/ EATON	16.5	0.97	33.8	51.1	4.26	5.23	1.11	7.00	0.26		6.60	7.00	7.00	8.00	-1.00
GLADWIN/ MIDLAND	29.3	1.73	56.8	85.7	7.15	8.87	1.88	11.00	0.44		11.19	12.00	11.00	12.00	-1.00
GRATIOT/ SHIAWASSEE	16.0	0.94	34.8	52.5	4.38	5.32	1.13	7.00	0.27		6.71	7.00	7.00	6.00	1.00
HURON/ LAPEER/ TUSCOLA	45.3	2.66	94.5	142.8	11.90	14.56	3.09	18.00	0.73		18.37	19.00	18.00	22.00	-4.00
ST. CLAIR/ SANILAC	25.4	1.50	26.7	40.3	3.36	4.85	1.03	6.00	0.24		6.12	7.00	6.00	7.00	-1.00
	34.1	2.00	56.2	84.9	7.07	9.08	1.92	12.00	0.45		11.45	12.00	12.00	12.00	0.00
	18.1	1.06	39.3	59.4	4.95	6.02	1.27	8.00	0.30		7.59	8.00	8.00	7.00	1.00
	39.7	2.33	66.9	101.1	8.43	10.76	2.28	14.00	0.54		13.58	14.00	14.00	12.00	2.00
	22.7	1.33	26.6	40.2	3.35	4.68	0.99	6.00	0.23		5.91	6.00	6.00	6.00	0.00
	34.8	2.05	58.8	88.8	7.40	9.45	2.00	12.00	0.47		11.92	12.00	12.00	10.00	2.00
	24.0	1.41	47.3	71.4	5.95	7.36	1.56	9.00	0.37		9.29	10.00	9.00	10.00	-1.00
	57.2	3.36	141.8	214.3	17.86	21.22	4.50	26.00	1.06		26.78	27.00	26.00	23.00	3.00
	30.5	1.79	40.6	61.3	5.11	6.90	1.46	9.00	0.35		8.71	9.00	9.00	7.00	2.00
<b>TOTAL</b>	<b>649.7</b>	<b>38.22</b>	<b>1292.3</b>	<b>1952.7</b>	<b>162.73</b>	<b>200.94</b>	<b>42.58</b>	<b>253.00</b>	<b>10.05</b>	<b>11.00</b>	<b>253.57</b>	<b>261.00</b>	<b>264.00</b>	<b>253.00</b>	<b>11.00</b>

**FY2018 CPS ALLOCATION**

Run Date: 10/09/17	Ongoing		Assigned Investigations			FY2018 Initial CPS Calculated Workers	Additional Positions for MLOA/ Vac/Train 21.19%	Total Rounded CPS Worker County Allocation	Additional Positions for BSC Flex 5%	Total Rounded CPS Wkr BSC Flex Allocation	Total Calculated CPS Worker	Total Rounded CPS Wkrs for Supe Calculation	FY'18 Final CPS Rounded Workers at 100%	FY'17 Final CPS Rounded Workers	Change from FY'17
	FACT SHEET		FACT SHEET												
	Aug 2016 - July 2017 Ongoing Caseload	@ 17	Aug 2016 - July 2017 FACT SHEET Assignmts.	@ 0	@ 12										
BSC 3										14.00			14.00	14.00	0.00
BERRIEN	63.9	3.76	122.3	184.7	15.39	19.15	4.06	24.00	0.96	24.17	25.00	24.00	31.00	24.00	-7.00
CALHOUN	86.7	5.10	165.2	249.6	20.80	25.90	5.49	32.00	1.29	32.68	33.00	32.00	24.00	32.00	8.00
KALAMAZOO	185.8	10.93	299.8	453.0	37.75	48.68	10.32	59.00	2.43	61.43	62.00	59.00	63.00	59.00	-4.00
KENT															
MUSKEGON	201.3	11.84	193.2	291.9	24.32	36.17	7.66	44.00	1.81	45.64	46.00	44.00	48.00	44.00	-4.00
OTTAWA	81.8	4.81	139.8	211.2	17.60	22.41	4.75	28.00	1.12	28.28	29.00	28.00	23.00	28.00	5.00
VAN BUREN	58.9	3.47	74.6	112.7	9.39	12.86	2.72	16.00	0.64	16.22	17.00	16.00	16.00	16.00	0.00
ALLEGAN/	92.9	5.47	103.8	156.8	13.06	18.53	3.93	23.00	0.93	23.38	24.00	23.00	27.00	23.00	-4.00
BARRY	36.6	2.15	49.4	74.7	6.22	8.37	1.77	11.00	0.42	10.57	11.00	11.00	12.00	11.00	-1.00
CASS/	13.8	0.81	46.8	70.8	5.90	6.71	1.42	9.00	0.34	8.46	9.00	9.00	9.00	9.00	0.00
ST. JOSEPH	40.2	2.36	69.9	105.6	8.80	11.17	2.37	14.00	0.56	14.09	15.00	14.00	12.00	14.00	2.00
IONIA/	26.7	1.57	68.8	104.0	8.67	10.24	2.17	13.00	0.51	12.92	13.00	13.00	11.00	13.00	2.00
MONTCALM	40.5	2.38	82.4	124.5	10.38	12.76	2.70	16.00	0.64	16.10	17.00	16.00	20.00	16.00	-4.00
LAKE/	16.0	0.94	14.3	21.5	1.79	2.74	0.58	4.00	0.14	3.45	4.00	4.00	5.00	4.00	-1.00
NEWAYGO	63.5	3.74	50.8	76.7	6.39	10.13	2.15	13.00	0.51	12.78	13.00	13.00	16.00	13.00	-3.00
MASON/	32.4	1.91	29.3	44.3	3.69	5.60	1.19	7.00	0.28	7.07	8.00	7.00	10.00	7.00	-3.00
OCEANA	35.3	2.07	33.3	50.2	4.19	6.26	1.33	8.00	0.31	7.90	8.00	8.00	7.00	8.00	1.00
MECOSTA/	55.2	3.25	60.1	90.8	7.57	10.81	2.29	14.00	0.54	13.64	14.00	14.00	12.00	14.00	2.00
OSCEOLA															
<b>TOTAL</b>	<b>1131.3</b>	<b>66.55</b>	<b>1603.6</b>	<b>2423.0</b>	<b>201.92</b>	<b>268.47</b>	<b>56.89</b>	<b>335.00</b>	<b>13.42</b>	<b>14.00</b>	<b>338.78</b>	<b>348.00</b>	<b>349.00</b>	<b>360.00</b>	<b>-11.00</b>
BSC 4										6.00			6.00	5.00	1.00
JACKSON	103.0	6.06	208.5	315.0	26.25	32.31	6.85	40.00	1.62	40.78	41.00	40.00	41.00	40.00	-1.00
LIVINGSTON	38.6	2.27	80.4	121.5	10.13	12.40	2.63	16.00	0.62	15.64	16.00	16.00	12.00	16.00	4.00
MACOMB															
OAKLAND															
WASHTENAW	51.4	3.02	159.7	241.3	20.10	23.13	4.90	29.00	1.16	29.19	30.00	29.00	27.00	29.00	2.00
WAYNE															
BRANCH/	36.7	2.16	41.4	62.6	5.22	7.37	1.56	9.00	0.37	9.30	10.00	9.00	10.00	9.00	-1.00
HILLSDALE	20.8	1.22	54.3	82.1	6.84	8.06	1.71	10.00	0.40	10.17	11.00	10.00	10.00	10.00	0.00
LENAWEE/	60.2	3.54	82.5	124.7	10.39	13.93	2.95	17.00	0.70	17.57	18.00	17.00	16.00	17.00	1.00
MONROE	42.2	2.48	98.9	149.5	12.46	14.94	3.16	19.00	0.75	18.85	19.00	19.00	18.00	19.00	1.00
<b>TOTAL</b>	<b>352.8</b>	<b>20.75</b>	<b>725.8</b>	<b>1096.6</b>	<b>91.38</b>	<b>112.13</b>	<b>23.76</b>	<b>140.00</b>	<b>5.61</b>	<b>6.00</b>	<b>141.50</b>	<b>145.00</b>	<b>146.00</b>	<b>139.00</b>	<b>7.00</b>
BSC 5										25.00			25.00	26.00	-1.00
GENESEE CSA	211.9	12.47	422.6	638.5	53.21	65.68	13.92	80.00	3.28	82.88	83.00	80.00	81.00	80.00	-1.00
KENT CSA	242.6	14.27	537.4	812.0	67.67	81.94	17.36	100.00	4.10	103.40	104.00	100.00	95.00	100.00	5.00
MACOMB CSA	153.8	9.05	423.4	639.8	53.32	62.36	13.21	76.00	3.12	78.70	79.00	76.00	69.00	76.00	7.00
OAKLAND CSA	231.8	13.64	490.8	741.5	61.79	75.43	15.98	92.00	3.77	95.19	96.00	92.00	88.00	92.00	4.00
WAYNE CSA	420.1	24.71	1417.4	2141.7	178.48	203.19	43.06	247.00	10.16	256.40	257.00	247.00	293.00	247.00	-46.00
<b>TOTAL</b>	<b>1260.3</b>	<b>74.13</b>	<b>3291.6</b>	<b>4973.6</b>	<b>414.47</b>	<b>488.60</b>	<b>103.53</b>	<b>595.00</b>	<b>24.43</b>	<b>25.00</b>	<b>616.56</b>	<b>619.00</b>	<b>620.00</b>	<b>652.00</b>	<b>-32.00</b>
CSA															
<b>STATE TOTAL</b>	<b>3916.9</b>	<b>230.41</b>	<b>7629.8</b>	<b>11528.7</b>	<b>960.72</b>	<b>1191.13</b>	<b>252.40</b>	<b>1486.00</b>	<b>59.56</b>	<b>63.00</b>	<b>1503.09</b>	<b>1539.00</b>	<b>1549.00</b>	<b>1568.00</b>	<b>-19.00</b>

**MICHIGAN CIVIL SERVICE COMMISSION**  
**JOB SPECIFICATION**  
**SERVICES SPECIALIST**

**JOB DESCRIPTION**

Employees in this job complete and oversee a variety of professional assignments to provide services to socially and economically disadvantaged individuals in programs administered by the Michigan Department of Health and Human Services (MDHHS) such as protective services, foster care, adoption, juvenile justice, foster home licensing, and adult services.

There are four classifications in this job.

**Position Code Title - Services Specialist-E**

Services Specialist 9

This is the entry level. As a trainee, the employee carries out a range of professional services specialist assignments while learning the methods of the work.

Services Specialist 10

This is the intermediate level. The employee performs an expanding range of professional services specialist assignments in a developing capacity.

Services Specialist P11

This is the experienced level. The employee performs a full range of professional services specialist assignments in a full-functioning capacity. Considerable independent judgment is required to carry out assignments that have significant impact on services or programs. Guidelines may be available, but require adaptation or interpretation to determine appropriate courses of action.

**Position Code Title - Services Specialist-A**

Services Specialist 12

This is the advanced level. At this level, employees may function as a lead worker overseeing the work of lower level Services Specialists or have regular assignments which have been recognized by Civil Service as having significantly greater complexity than those assigned at the experienced level. The recognized senior-level assignments for this level are MiTEAM Specialist and Maltreatment in Care (MIC) Children's Protective Services worker.

**NOTE:** Employees generally progress through this series to the experienced level based on satisfactory performance and possession of the required experience.

**JOB DUTIES**

**NOTE:** The job duties listed are typical examples of the work performed by positions in this job classification. Not all duties assigned to every position are included, nor is it expected that all positions will be assigned every duty.

Engages in face-to-face contact with alleged victims of abuse and/or neglect and visits their homes or designated placements.

Provides casework services to dependent, neglected, abused, and delinquent children and youth; children with disabilities; socially and economically disadvantaged and dependent adult clients; and other individuals and families.

Observes individuals, families, and living conditions.

Determines the appropriate method and course of action and implements service, treatment, and learning plans.

Develops plans and finds resources to address clients' and families' problems in housing, counseling, and other areas, using specific service methods; monitors services provided.

Writes and maintains social case histories, case summaries, case records, and related reports and correspondence.

Provides or secures protective services for endangered children and adults qualifying for such services.

Provides direct counseling services to clients.

Screens individuals newly committed to the department and develops plans for care, service, treatment, and learning.

Conducts family assessment and placement studies.

Presents assessment and service plans at pre-dispositional and dispositional hearings.

Interprets behavioral problems for parents and other caregivers and otherwise assists them in providing appropriate care to children.

Serves as liaison between the department and community groups in developing programs, interpreting rules and regulations, and coordinating programs and services.

Provides 24-hour crisis intervention assistance.

Provides on-call services.

Evaluates applications for family and group, day care, home registration and licensing purposes; regulates child care in approved homes through periodic reviews.

Recruits and trains new foster parents.

Investigates, assesses, and follows up on complaints of abuse or neglect.

Visits abused or neglected wards, family, and other support persons in their homes, foster homes, or residential placements.

Prepares legal documents, forms, and petitions; utilize state tools and systems to record case assessments and actions.

Testifies in court on progress and services rendered to children and families.

Transports clients to court hearings, clinic appointments, and placement homes.

Responds to general inquiries and conducts searches for adoptive placements for special needs children; provides post-adoptive services for the children and families.

Attends and completes annual, in-service training as required.

Performs related work as assigned.

### **Additional Job Duties**

#### **Services Specialist 12 (Lead Worker)**

Oversees the work of professional staff by making and reviewing work assignments, establishing priorities, coordinating activities, and resolving related work problems.

## Services Specialist 12 (Senior Worker)

### MiTEAM Specialist:

Model, coach, train, observe and provide feedback to Child Welfare Workers to develop and increase their knowledge, skills and abilities related to MiTEAM competencies.

Collaborate with local offices to gather, assess, and analyze available data regarding county trends in case practice.

Participate in creating local improvement plans aimed at addressing identified trends and factors contributing to those trends.

Support local and statewide efforts to improve and implement policy and programs that will strengthen case practice.

Participate in MDHHS Strengthening Our Focus on Children and Families Implementation Efforts.

Coordinates team meetings by determining who the participants will be.

Serves as team leader during the team meetings by facilitating case planning and problem resolution and encouraging participation of all team members.

Provides expertise to the team members regarding child welfare legal requirements, policies, and procedures.

### Maltreatment in Care (MIC) Children's Protective Services Worker:

Conducts investigations of child abuse and neglect in licensed and unlicensed foster homes, residential facilities, juvenile justice facilities, day care centers, and day care homes.

Coordinates with multiple child placement agencies, court systems, and counties in relation to investigations; maintains an understanding of the court systems, and adapts work methods, processes, and approach to meet requirements and needs of the involved parties to assure successful intervention.

Redacts confidential information from Investigative Reports that are provided to the interested parties of the investigation; assures that policies and legal requirements are met and assure that each party only receives information they are legally entitled to.

The CPS-MIC investigator takes the lead on coordinating the investigation involving multiple child welfare programs and/or law enforcement and facilitates the dispositional case conference with all parties to review and ensure consistency with the investigative findings.

## **JOB QUALIFICATIONS**

### **Knowledge, Skills, and Abilities**

**NOTE:** Some knowledge in the area listed is required at the entry level, developing knowledge is required at the intermediate level, considerable knowledge is required at the experienced level, and thorough knowledge is required at the advanced level.

Knowledge of state and federal social welfare laws, rules and regulations.

Knowledge of social work theory and casework, group work and community-organization methods.

Knowledge of interviewing techniques.

Knowledge of human behavior and the behavioral sciences, including human growth and development, dynamics of interpersonal relationships, and family dynamics.

Knowledge of cultural and subcultural values and patterns of behavior.

Knowledge of the basic principles of casework involving analysis of the physical, psychological, and social factors contributing to maladjustment.

Knowledge of the problems of child welfare work with reference to dependent children, children with behavior problems and other children in need of special care.

Knowledge of casework methods and problems involved in the adoption and boarding of children.

Knowledge of juvenile court procedures.

Knowledge of social problems and their causes, effects, and means of remediation.

Knowledge of the types of discrimination and mistreatment to which clients may be subjected.

Knowledge of family and marital problems, and their characteristics and solutions.

Knowledge of community resources providing assistance to families and individuals.

Knowledge of departmental assistance payments programs.

Ability to observe client conditions and environments.

Ability to operate a motor vehicle.

Ability to maneuver through homes safely.

Ability to apply rehabilitation principles and concepts to social casework.

Ability to develop, monitor, and modify client service plans.

Ability to communicate with individuals who have emotional or mental problems and with members of different cultural or subcultural groups.

Ability to persuade or influence people in favor of specific actions, changes in attitude, or insights.

Ability to interpret laws, regulations, and policies.

Ability to maintain records and prepare reports and correspondence related to the work.

Ability to communicate effectively with others.

Ability to maintain favorable public relations.

### **Additional Knowledge, Skills, and Abilities**

#### **Services Specialist 12 (Lead Worker)**

Ability to set priorities and assign work to other professionals.

Ability to organize and coordinate the work of others.

Ability to organize and facilitate meetings.

Ability to maintain confidentiality in accordance with laws, regulations, policies, and procedures.

Knowledge of federal and state mandated confidentiality laws; ability to accurately apply these laws and redact documents accordingly.

Ability to utilize the competencies of teaming, engagement, assessment, and mentoring in all aspects of job responsibilities.

#### **Services Specialist 12 (Senior Worker)**

Ability to organize and facilitate meetings.

Knowledge of child welfare statutes, policies, and procedures.

Knowledge of group dynamics and processes.

Knowledge of risk assessment.

Ability to maintain confidentiality in accordance with laws, regulations, policies, and procedures.

Knowledge of federal and state mandated confidentiality laws; ability to accurately apply these laws and redact documents accordingly.

Knowledge of how to prepare legal documents, forms and petitions.

Knowledge of how to utilize state tools and systems to record case assessments and actions.

Ability to be proficient at teaming, engaging, assessing and mentoring.

Ability to impact change by using leadership skills.

Ability to use conflict resolution, respectful communication, facilitation, negotiation and organizational skills.

Ability to work autonomously.

Ability to enhance and develop the knowledge and skills needed to act as a technical expert.

Ability to collect and use critical thinking to analyze data.

Ability to work with several different software systems.

Ability to professionally communicate both in writing and orally.

Ability to utilize the competencies of teaming, engagement, assessment, and mentoring in all aspects of job responsibilities.

### **Working Conditions**

Some jobs require considerable travel.

Some jobs require an employee to work in adversarial situations.

Some jobs require an employee to work in a hostile environment.

### **Physical Requirements**

Some jobs require the ability to lift 25 lbs. in order to complete the duties of the position. This can include children and equipment.

### **Education**

Possession of a bachelor's or master's degree with a major in one of the following human services areas: social work, sociology, psychology, family ecology, community services, family studies, family and/or child development, guidance/school counseling, counseling psychology, criminal justice, or human services.

### **Experience**

#### **Services Specialist 9**

No specific type or amount is required.

#### **Services Specialist 10**

One year of professional experience providing casework services to socially and economically disadvantaged individuals equivalent to a Services Specialist 9.

#### **Services Specialist P11**

Two years of professional experience providing casework services to socially and economically disadvantaged individuals equivalent to a Services Specialist, including one year equivalent to a Services Specialist 10.

## Services Specialist 12

Three years of professional experience providing social casework services to socially and economically disadvantaged individuals equivalent to a Services Specialist, including one year equivalent to a Services Specialist P11.

### **Special Requirements, Licenses, and Certifications**

Candidates are subject to a MDHHS background check.

Any candidate hired as a Services Specialist in a protective services, foster care services, or adoption services position must successfully complete an eight week pre-service training program that includes a total of 270 hours of competency-based classroom and field training. The employee will also be required to pass a competency-based performance evaluation which shall include a written examination. Additionally, the employee must successfully complete a minimum number of hours of in-service training on an annual basis.

Possession of a valid driver's license.

**NOTE:** Equivalent combinations of education and experience that provide the required knowledge, skills, and abilities will be evaluated on an individual basis.

### **JOB CODE, POSITION TITLES AND CODES, AND COMPENSATION INFORMATION**

#### **Job Code**

SOCSEERSPL

#### **Job Code Description**

SERVICES SPECIALIST

#### **Position Title**

Services Specialist-E

Services Specialist-A

#### **Position Code**

SOCSSPLE

SOCSSPLA

#### **Pay Schedule**

W22-079

W22-080

KB

03/26/2017

**Michigan Citizen Review Panels  
2017 Annual Report**

**Executive Summary**

Sections 106 (b)(2)(A)(x) and (c) of the Child Abuse Prevention and Treatment Act (CAPTA), as amended (42 U.S.C. 5101 et seq.) requires the establishment of Citizen Review Panels in all states receiving CAPTA funding.

**Purpose**

The purpose of the Citizen Review Panels is to provide new opportunities for citizens to play an integral role in ensuring that States are meeting their goals of protecting children from abuse and neglect.

**Number of Panels Required**

Michigan was required to establish three panels by June 30, 1999.

The panels were established with membership from three existing citizen advisory committees: the Children's Trust Fund, the Governor's Task Force on Child Abuse and Neglect, and the State Child Death Review Team.

The panels are:

Citizen Review Panel for Prevention,  
Citizen Review Panel for Children's Protective Services, Foster Care and Adoption, and  
Citizen Review Panel for Child Fatalities.

**Reports**

The panels must develop annual reports and make them available to the public. These reports are due March 31 of each year. The contents of the reports include the following:

1. A summary of the panel's activities.
2. Findings and recommendations.

The Michigan Department of Health and Human Services must provide a written response to the findings and recommendations of the three panels.

Below are the recommendations of each of the panels. See the entire report for the 2016 activities, findings, and complete recommendations for each of the panels.

**Citizen Review Panel for Prevention  
(Children's Trust Fund)**

The Citizen Review Panel (CRP) formally submits the following recommendations:

**Recommendation #1: MDHHS should take the lead on securing funding for dedicated staff and for the formation and implementation of an on-going cross-departmental group to continue the work of the original Michigan Task Force on the Prevention of Sexual Abuse of Children.**

**MDHHS Response: The MDHHS Children's Services Agency (CSA) is one respondent among many with responsibility for responding to the recommendations of the Michigan Task Force on the Prevention of Sexual Abuse of Children. The department provided preliminary responses to the recommendations and will continue to address MDHHS/CSA-related concerns identified within the report. In 2018, MDHHS/CSA will work with the MDHHS Michigan Domestic and Sexual Violence Prevention and Treatment Board to assess the status of recommendations pertaining to CSA and their implementation.**

**Recommendation #2: More resources need to be directed toward new initiatives and home visiting programs that connect families with people with whom they can form nonthreatening and respectful relationships.**

**MDHHS Response: MDHHS agrees with the importance of providing non-threatening, destigmatizing services and supports for families. A communication was provided to child welfare staff to educate them on the availability of home visiting programs, and their benefits. The communication also provided a pictogram of a description of the five most commonly implemented evidence-based home visitation models in Michigan, and a statewide map of all home visiting programs available in individual communities.**

**At the state level, MDHHS has also made efforts to collaborate with home visiting programs to support the connection between child welfare and referrals to home visiting programs. MDHHS agrees to continue to strengthen this relationship and connect families with valuable services, including opportunities made available with the passage of the Family First Preservation Services Act (FFPSA) in early 2018.**

**Recommendation #3: The Department should work with local programs and Health Departments to ensure that Pack N Plays, or equivalent products, are quickly and easily accessible to families in need.**

**MDHHS Response: MDHHS CSA actively encourages and supports local offices reaching out to community agencies and programs to ensure that**

**safe sleep environments (including, but not limited to Pack N Plays) are available to families in need. Many local county offices have identified and access local resources. Local counties have developed fund raising efforts among staff to purchase Pack N Plays to store at the office in the event of a need. MDHHS agrees to continue to support local offices in all efforts to support safe sleep practice and to encourage collaboration with local agencies and Health Departments to further secure this process.**

**MDHHS' Division of Maternal Infant Health (DMIH), as the department's lead in efforts of improving safe sleep education and practice, also plays an important role in providing supportive services and material goods to families in need of safe sleep environments. Each year, MDHHS/DMIH provides mini-grants to public health departments throughout the state to provide these resources to parents and families in need.**

**Citizen Review Panel for  
Children's Protective Services, Foster Care and Adoption  
(Governor's Task Force on Child Abuse and Neglect)**

The purposes of this Citizen Review Panel process included giving stakeholders an opportunity to voice their observations and concerns, to gain information and knowledge about the functioning of the child welfare system with special attention to trauma issues, and to compose a number of recommendations for systemic improvement based on the information learned from this community and consumer feedback.

These recommendations comprise information from the testimony of participants and input from the questionnaires. Recommendations are crafted from statements of stakeholders and the Citizen Review Panel and Task Force membership.

The Citizen Review Panel (CRP) formally submits the following recommendations:

**Recommendation #1: Require a meeting for the worker(s) with a counselor/therapist following any incident of a child death or more serious incidences (to be defined by the Department) of child neglect or abuse.**

**MDHHS Response: MDHHS agrees with the importance of supporting staff experiencing stress, secondary trauma, or a sense of being overwhelmed. MDHHS is unable to require that worker(s) meet with a counselor/therapist. The Children's Services Agency (CSA) has made significant strides in recognizing and addressing secondary trauma in workers. The department currently holds a contract with the Children's Trauma Assessment Center (CTAC) through Western Michigan University. This contract includes providing mandatory Secondary Trauma Training & Culture/Climate Assessment and Development to CPS and foster care staff including supervisors and other leadership. The components of this contract include development and implementation of secondary traumatic stress teams within local offices, training, and consultation and coaching. MDHHS will continue to support participation and encourage use of secondary traumatic teams within the local office to offer workers a voluntary decompression session with a trained secondary trauma response team member whenever needed.**

**Recommendation #2: Conduct an assessment of all workers for secondary trauma, every six to twelve months. This assessment can be conducted through a trauma questionnaire that should be created with the assistance of a trauma specialist, reviewed by an expert once completed, and provide additional services to those in need of further trauma treatment.**

**MDHHS Response:** Rather than conducting routine assessments of staff, MDHHS provides training to staff to help them recognize signs and symptoms, alleviate stress, and build resiliency. Efforts are in place and will continue to develop secondary traumatic stress teams, provide training and support, and continue the enhancement of developed teams in local offices. MDHHS feels that these types of responses are more sensitive to individual worker needs and addresses secondary trauma. As part of the CSA's contract with CTAC, the Secondary Traumatic Stress Index-Organizational Assessment is being provided to staff.

**MDHHS offers voluntary assessment and referrals for employees experiencing personal or work-related problems, including secondary trauma through the Employee Services Program (ESP). Access to the ESP is provided in the MDHHS Employee Handbook, and contact information is provided.**

**Recommendation #3:** Incorporate formal flexible schedule options so that workers can have some arrangements that increase their ability to work efficiently, to address work life balance, and to promote worker retention. For example, a nine-hour work day with two three day weekends per month; or the ability to once every two weeks have a formal "work-at-home" day so that a worker can address paperwork or other tasks that can be completed remotely. A formal flex policy would facilitate the scheduling of work so there is complete and seamless coverage.

**MDHHS Response:** The MDHHS Employee Handbook allows for local offices to offer flexible work schedules to their employees. Many offices participate in this option and there is a state-wide form for worker request of a flexible work schedule. Michigan is a vast state with variable regional population for service by our agency. Staffing levels are individualized to each office and are known to fluctuate. MDHHS encourages local offices to offer flexible work schedules whenever feasible based on a balance of worker needs, staffing needs, and community servicing needs.

**Recommendation #4:** Formalize a mentoring program for new workers for the first six months of employment. This would include recruiting, training and supervising mentors, incentivizing mentoring, and designating a mentoring coordinator and other resources to administer and support mentoring and coaching for new workers. This is particularly crucial as more orientation shifts to on-the-job training and with the pressures on new workers and the desire to promote worker retention. Provide for ongoing mentoring after the initial six months (for example, voluntary selection of mentor). New workers should also be required to meet with their immediate supervisor at least every other week to ensure that the mentoring component of their orientation is beneficial for both parties.

**MDHHS Response:** MDHHS values and has prioritized developing a mentor program for new workers. Revamping of a department-wide mentorship program for new employees in local offices is included in the 2018 Employee Engagement Action Plan. Although the target date for completion of the mentor program is 09/30/2018, the process is currently behind schedule. Despite state-wide delay in the project, many local counties have developed and implemented mentor programs for new workers. Two examples are Bay and Genesee Counties. MDHHS agrees with the CRP's identification of the importance of a mentor program and mentoring and will continue to assess the success of local county programs and to work toward development and implementation of an effective mentor program including procedural guidelines to address processes for the mentor, the new worker, and supervision.

**Recommendation #5:** Develop an individual worker, county, and state training plan (for example, content and topics, timing) and to address trauma knowledge and effective practice. For example, require a certain number of trauma workshops each year.

**MDHHS Response:** MDHHS supports ongoing training around trauma knowledge and effective practice. We have partnered with universities within the state to offer training on the topic of trauma. Each year a catalog of trainings is provided both in paper form and online, to provide free training specific to child welfare workers (state and contracted). Caseworkers are required by policy to annually complete 32 hours of general training pertaining to his/her position. Training to address trauma would qualify to meet these required hours. In 2018, 17 training opportunities are available through the university collaboration on the topic of trauma, either through in-person training, or webinar format.

Because of CSA's prioritization of incorporating trauma informed practice into the work conducted with children and families, components of trauma informed practice are present throughout the MiTEAM Practice Model. Additionally, CSA has developed a Trauma Protocol. MDHHS has contracted with the CTAC through Western Michigan to provide trauma screening training to child welfare staff utilizing the Trauma Screening Checklist developed by CTAC. This training is required for all workers.

**Recommendation #6:** Strengthen training and support for frontline supervisors with regard to retention-focused practices, reassessing and responding to secondary trauma. Require training hours on specific topics to support supervisory skill (such as retention, onboarding new workers, addressing trauma).

**MDHHS Response:** Through the Employee Engagement Plan, MDHHS has identified a need to support training and professional development of supervisors to promote workforce retention. Projects specifically identified to address these issues are creation of an intranet page for training opportunities and to develop a comprehensive evaluation tool to help supervisors continue professional development and performance improvement. Other efforts include, but are not limited to:

- Increasing the awareness of and focus on the impact of supportive supervision is a critical part of staff retention. The role of the supervisor in supporting staff is addressed through training.
- In 2018, additions to the MDHHS Child Welfare New Supervisor Training Institute will include creating office culture, trauma informed supervision, assessing staff for performance, onboarding and support of new workers, and creating support plans to provide a supportive path for workers.
- Office of Workforce Development and Training (OWDT) is currently developing a mid-manager training. The middle manager training track is being designed to provide training and professional development in the following key areas: Accountability, Coaching, Communication, Conflict, Critical Thinking, Delegating, Engaging & Motivating, Building a Successful Team, Trust, Empathy and Leadership skills. A tentative pilot of the program is set to begin September of 2018.
- In 2017, Wayne County Supervisors were provided a strength-based supervisor training to enhance existing skills and to provide skills to enhance engagement and result in improved outcomes with frontline staff.
- OWDT has instituted continuing education credits as an employment requirement. These learning opportunities allow staff to increase their existing skill-sets, improve proficiency and has the secondary impact of improving retention. The current areas of focus for training topics include: Building Teams Using the PERMA model (PERMA=Positive emotion, Engagement, Relationships, Meaning, Accomplishments), Strengthening the Culture of Your Team, Women in Leadership, Crucial Accountability, Leading Change, and Accountable Leadership for Men. The PERMA model is based on seeking positive emotion in our day, engagement or flow when completing tasks, building relationships, finding meaning in what we do, supporting staff with goals and rewarding accomplishments.
- The partnership with the universities for training also includes training for supervisors specifically around secondary trauma and operationalizing retention-focused management. MDHHS supports encouragement of supervisors seeking training in the areas of addressing trauma and onboarding new workers and will continue to collaborate to provide ongoing training in these areas.
- CSA currently has a contract with CTAC to provide secondary trauma training to directors, supervisors and staff across the state. Local

**office culture and climate is also being analyzed and directors are creating action plans to address with the goal of improving office culture/climate and ultimately increasing staff retention.**

**Citizen Review Panel for Child Fatalities  
(State Child Death Review Team)**

There were many recommendations made as a result of the reviews conducted by the CRP for Child Fatalities. Highlighted below are those that address the most significant findings (corresponding to the order in which they are listed above) that the panel felt DHHS should prioritize. Rationales are included in order to illuminate why the panel chose these specific recommendations for DHHS focus.

Recommendations for the Michigan Department of Health and Human Services:

**Recommendation #1: The well-being of all children should be verified, whether or not it is an abbreviated investigation.**

This recommendation addresses the first finding. The panel urges the Department to ensure the safety of all children named in a case, regardless of it being an abbreviated investigation.

**MDHHS Response: Except in abbreviated investigations, the verification of safety and whereabouts of all children in all CPS complaint investigations is a requirement. Abbreviated investigations are those in which there is no basis in fact to support the allegations or the family is unable to be located. Approval for an abbreviated investigation is required and occurs in exceptional circumstances. A field contact is required for abbreviated investigations. This may include interviews with the alleged victim and/or caretaker. Approval for an abbreviated investigation is required not only by a supervisor, but by the county office director as well.**

**Current policy provides parameters and guidance for use and application of abbreviated investigations. In situations where a family is unable to locate, verification of the wellbeing of children would not be able to occur. Caseworkers are guided by policy to make exhaustive efforts to locate families in these rare situations. The two-level process (supervisor and director) ensures that there are no remaining viable options for location of the family. Given the limited scope for reasoning of an abbreviated investigation (no basis in fact or unable to locate), the specific parameters within policy, and the extra approval path for the director, MDHHS believes that the all-encompassing policy is both respectful of families and provides best efforts to attempt assurance of safety of children during abbreviated investigations.**

**Recommendation #2: A random review of four cases per month should be conducted by second line managers, with a particular focus on safety concerns and risk factors.**

This recommendation focuses on the second finding. The panel believes that a second-line manager should randomly pull three denied cases and one confirmed case from alternating frontline supervisors to increase oversight effectiveness. This should occur monthly and within two weeks of the frontline supervisors' review and approval.

**MDHHS Response: MDHHS will consult with six county directors of varying size and population to explore a pilot. MDHHS would like to apply the suggestions for six months to a year with these counties, gather perspectives and then further assess the effectiveness of the suggestion.**

**Additionally, the Department of Continuous Quality Improvement (DCQI) division has developed a Quality Assurance Process and tool to train reviewers and complete a review of CPS investigation and ongoing cases to measure that reports are competently investigated, and actions taken, and services provided are appropriate to the circumstances. This review is tentatively scheduled to begin in September or October of 2018.**

**Recommendation #3: Any medical neglect allegation should trigger a medical examination within 72 hours from case assignment and, when appropriate, a subsequent comprehensive evaluation. Additionally, PSM 713.4 should be amended to include a time frame of 48 hours for commencing collateral contacts in medical neglect/medically fragile cases.**

These two recommendations speak to the third finding. The panel believes that, due to the complex nature of these type of cases, a complete medical examination within 72 hours from assignment should be a priority. To ensure that more immediate medical needs are addressed in a timely fashion, collateral contacts on medical neglect/medically fragile cases should be expedited to within 48 hours of case commencement.

**MDHHS Response: An allegation of medical neglect does not indicate a need for a medical examination in all instances. A case in which contact is established with a primary care physician and the physician indicates a regular medical response and no concerns for medical neglect would not necessarily warrant a medical exam.**

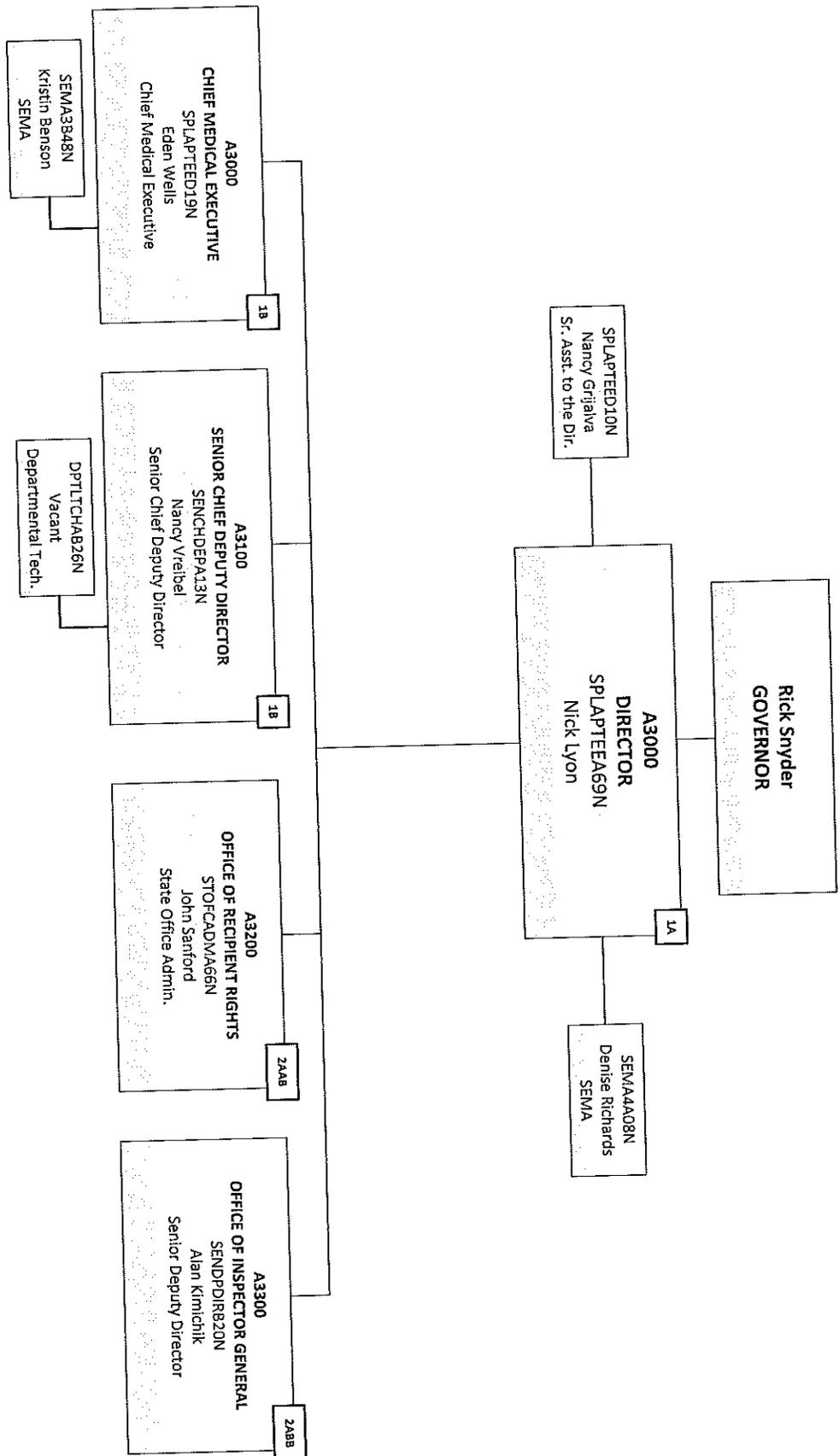
**Current policy does direct caseworkers to consult with a medical practitioner immediately when an examination is needed. Medical concerns, or injuries may not always be apparent at the onset of an investigation. Often, cases are assigned for allegations separate from a discovery of an injury or awareness of medical concern. The direction in policy allows for caseworkers to address the need for a medical examination as concerns arise as opposed to within specific timeframes of case assignment when concerns may not be known.**

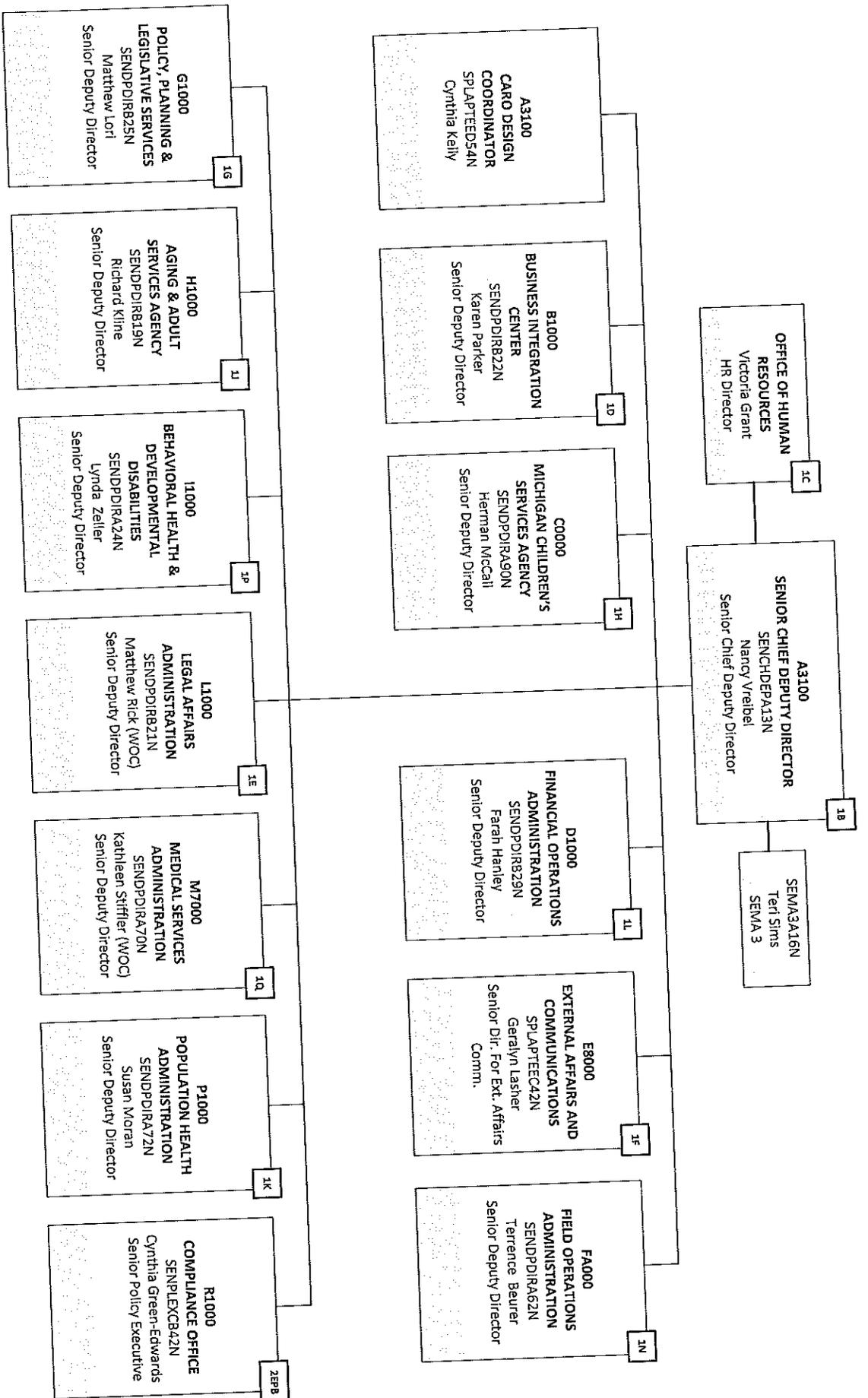
**MDHHS will continue consult with the MDHHS Medical Advisory Committee to determine advisable timeframes for medical examinations and recommendations on collateral contacts for medical neglect/medically fragile cases. The Medical Advisory Committee is composed of knowledgeable and competent medical professionals and experts who can provide further recommendation.**

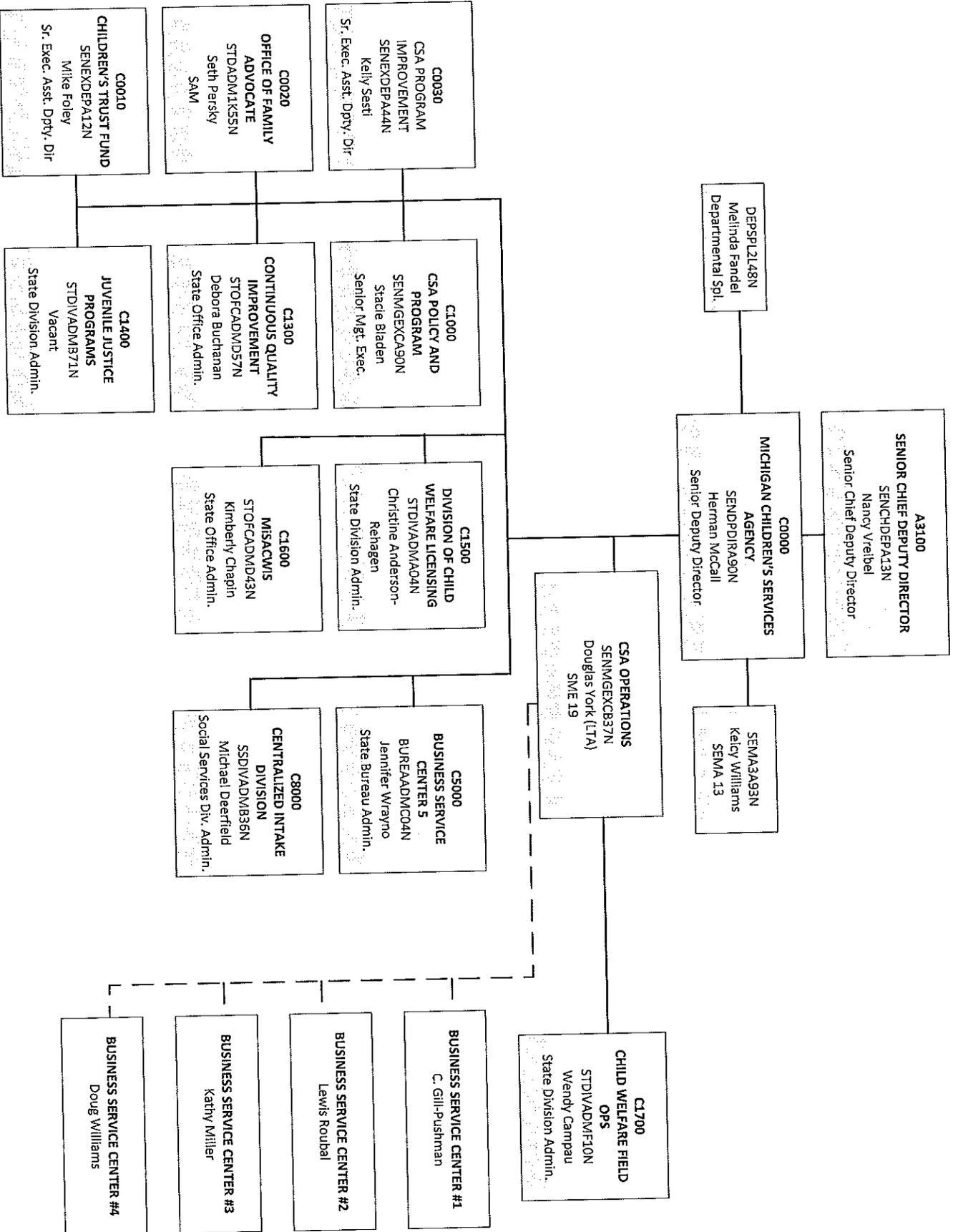
**Recommendation #4: To ensure the standard of promptness is met on new referrals during an open investigation, the cases should not be linked. The new referral should be assigned as a separate investigation.**

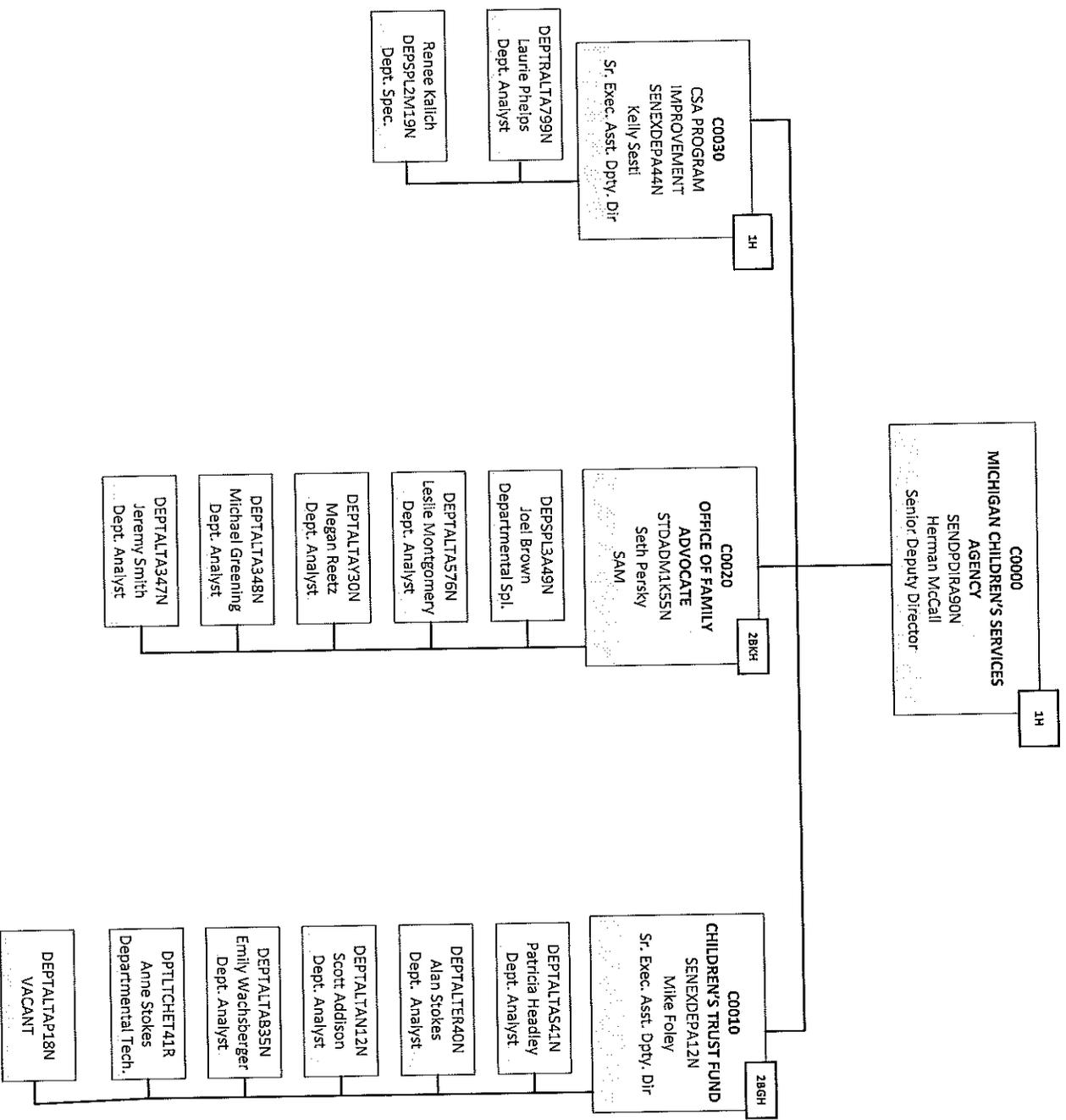
This recommendation addresses the fourth finding. The panel reviewed a case in which a new referral was reported toward the end of an open investigation. The new allegations were briefly mentioned in a case note and the dispositional findings, but it was clear that a full investigation of those allegations did not occur. The panel urges the Department to change the policy that cases be linked during an open investigation and instead assign any new referrals as if it were a separate investigation.

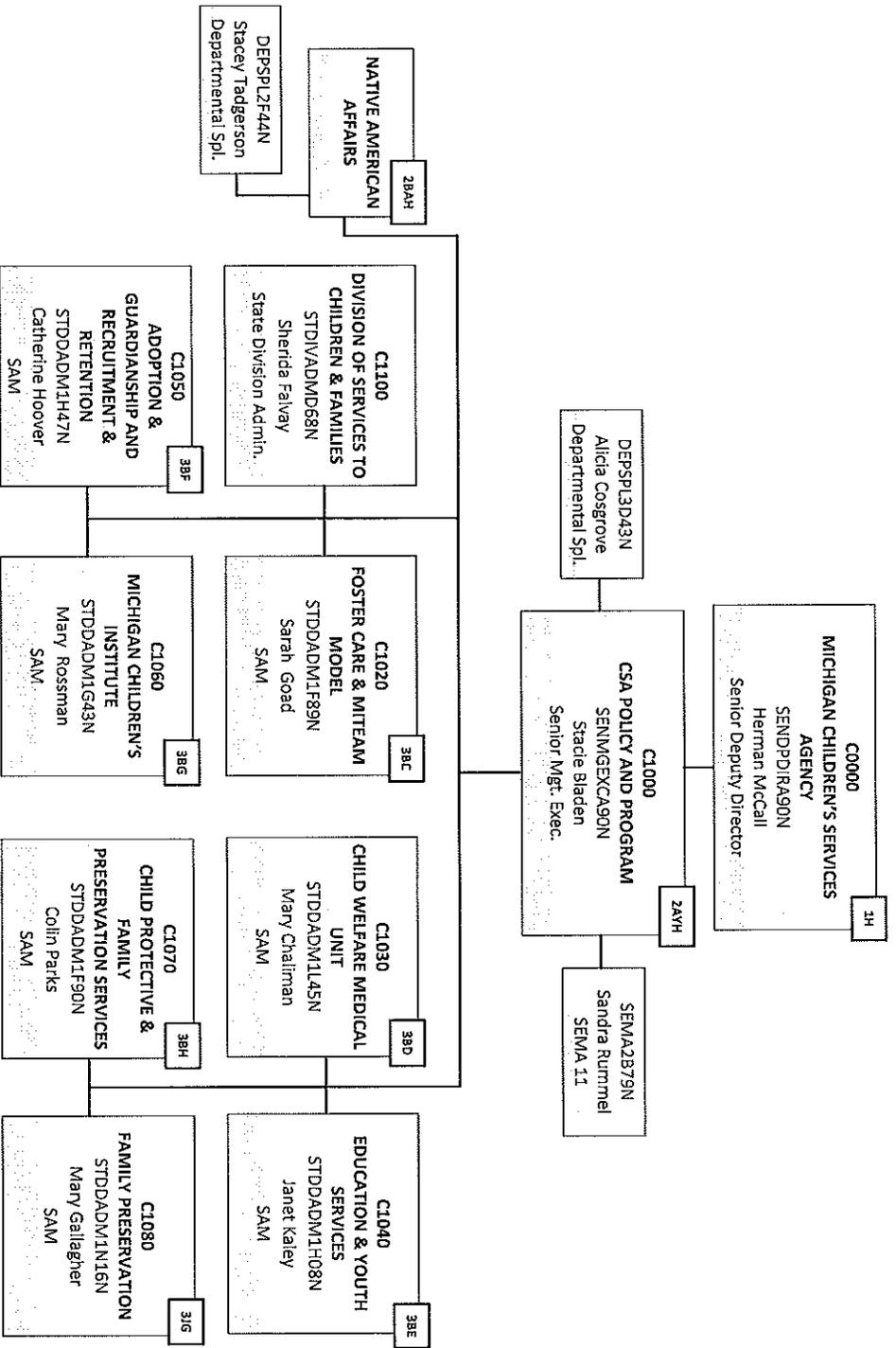
**MDHHS Response: Although the Department has modified policy and practice to allow for new complaints to be linked to existing investigations, neither the standards of promptness or policy requirements for existing investigation requirements have changed. All policy requirements for a standard investigation apply for a linked investigation and the standard of promptness must still be followed. The Department has made every effort to provide guidance both through statewide communications and upcoming policy changes to reinforce these compliance requirements. Accept and linked cases do not diminish the policy and practice expectations for CPS investigations. The Department will continue to monitor these changes and feedback from the field and provide policy and practice guidance as needed.**

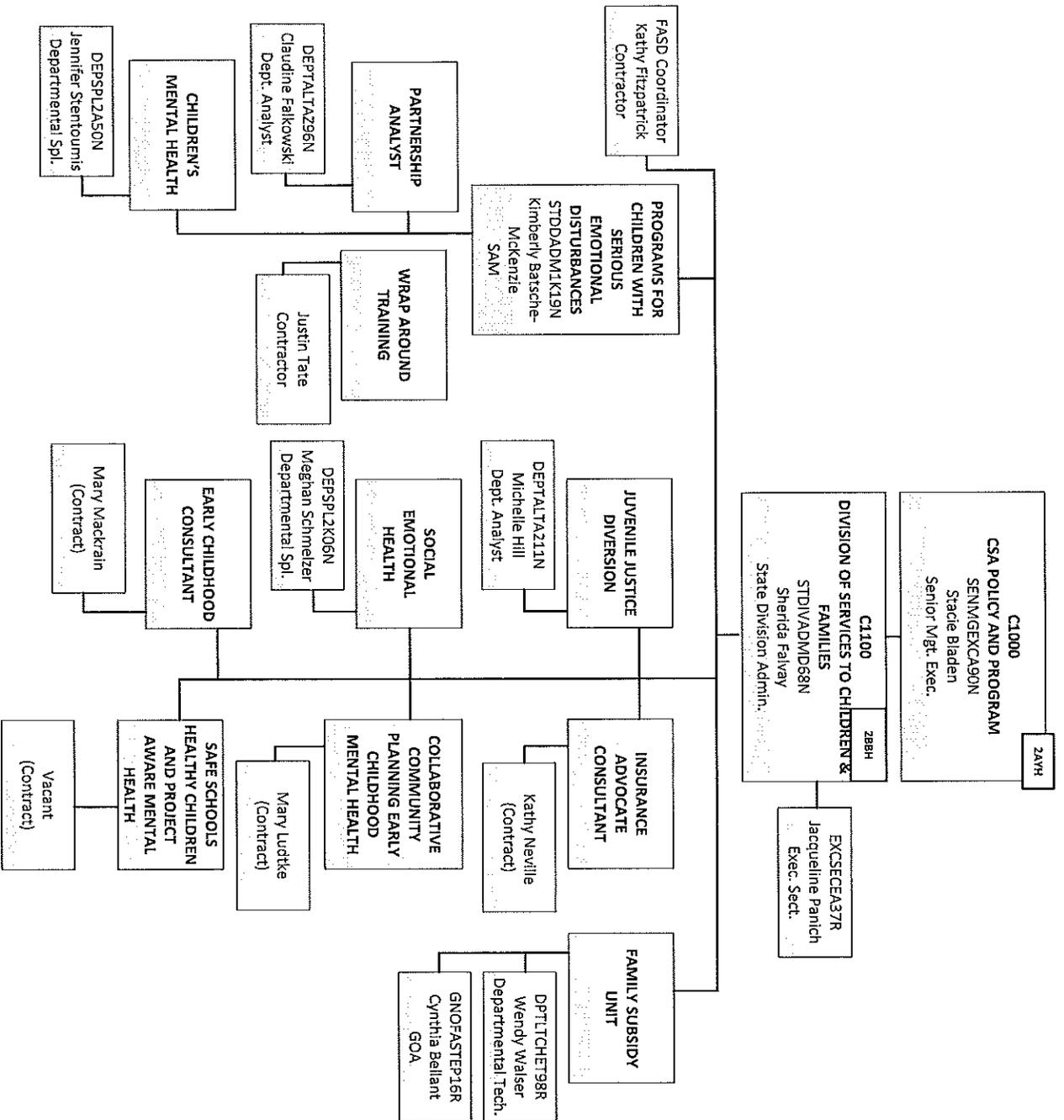




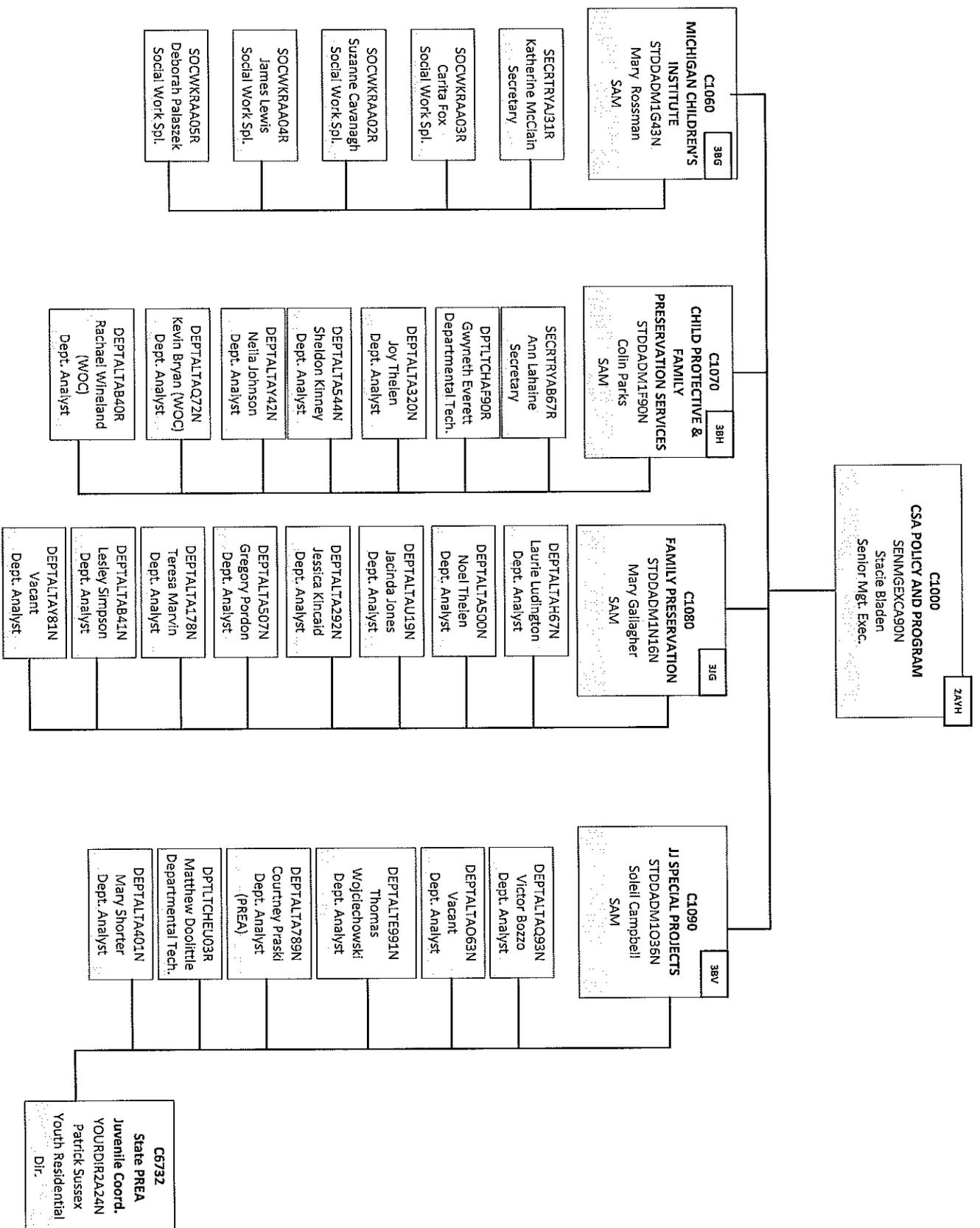


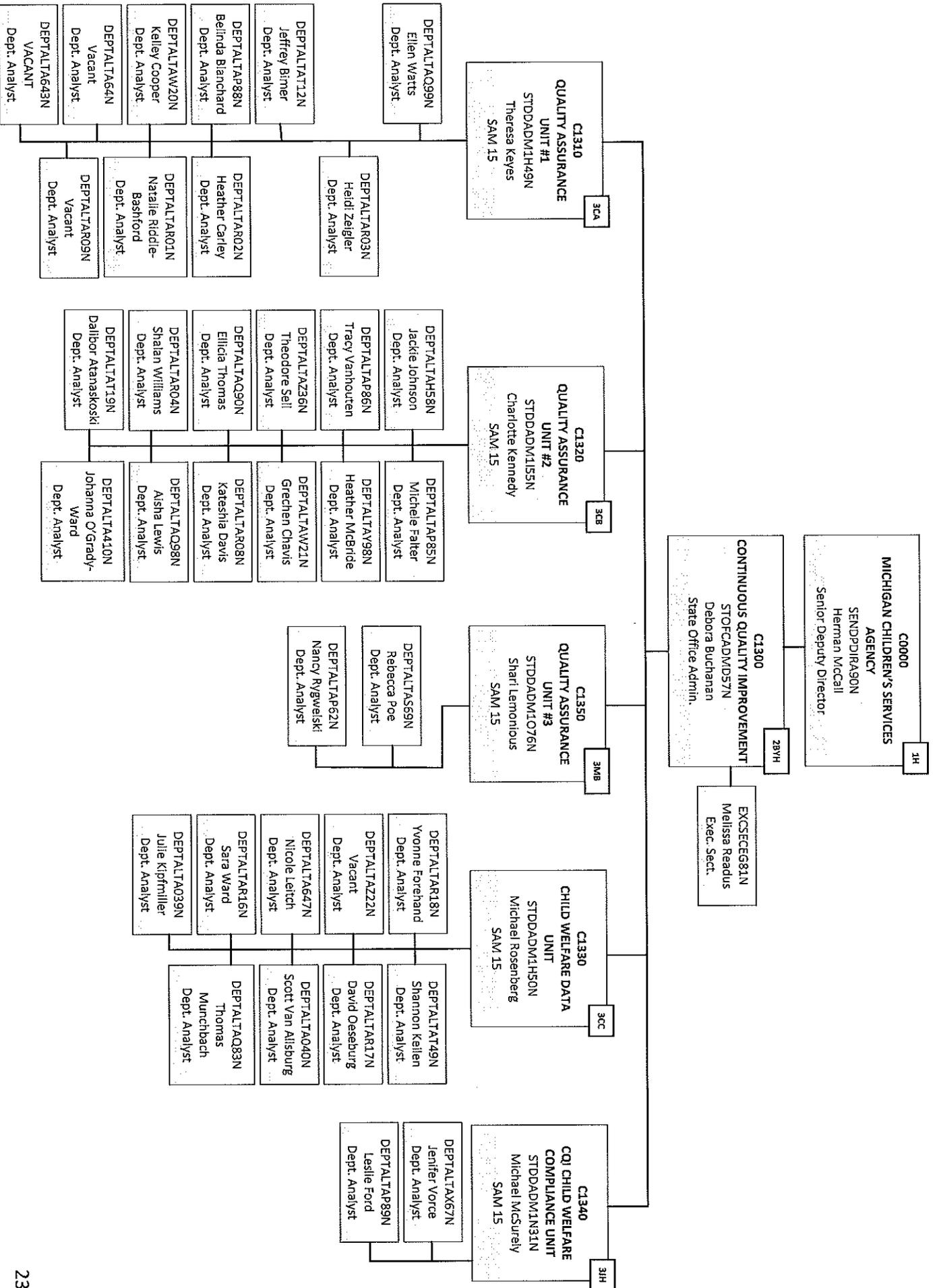


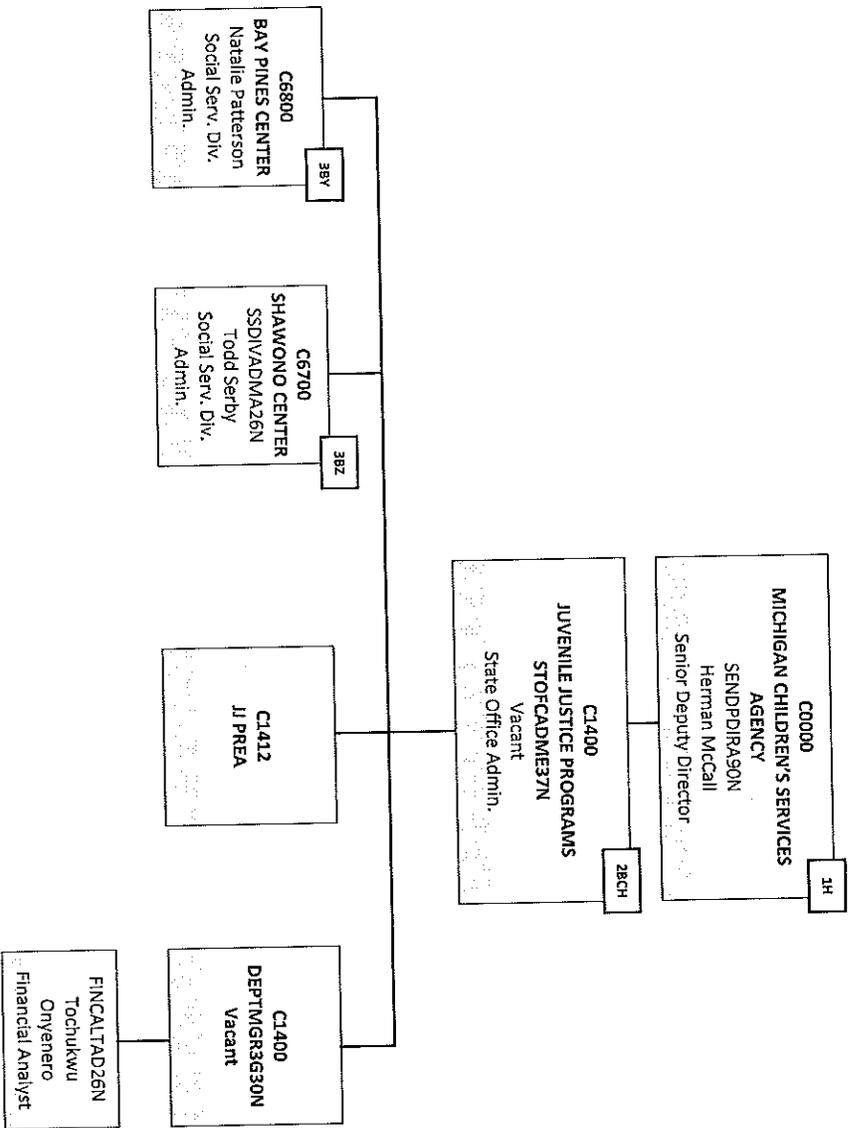


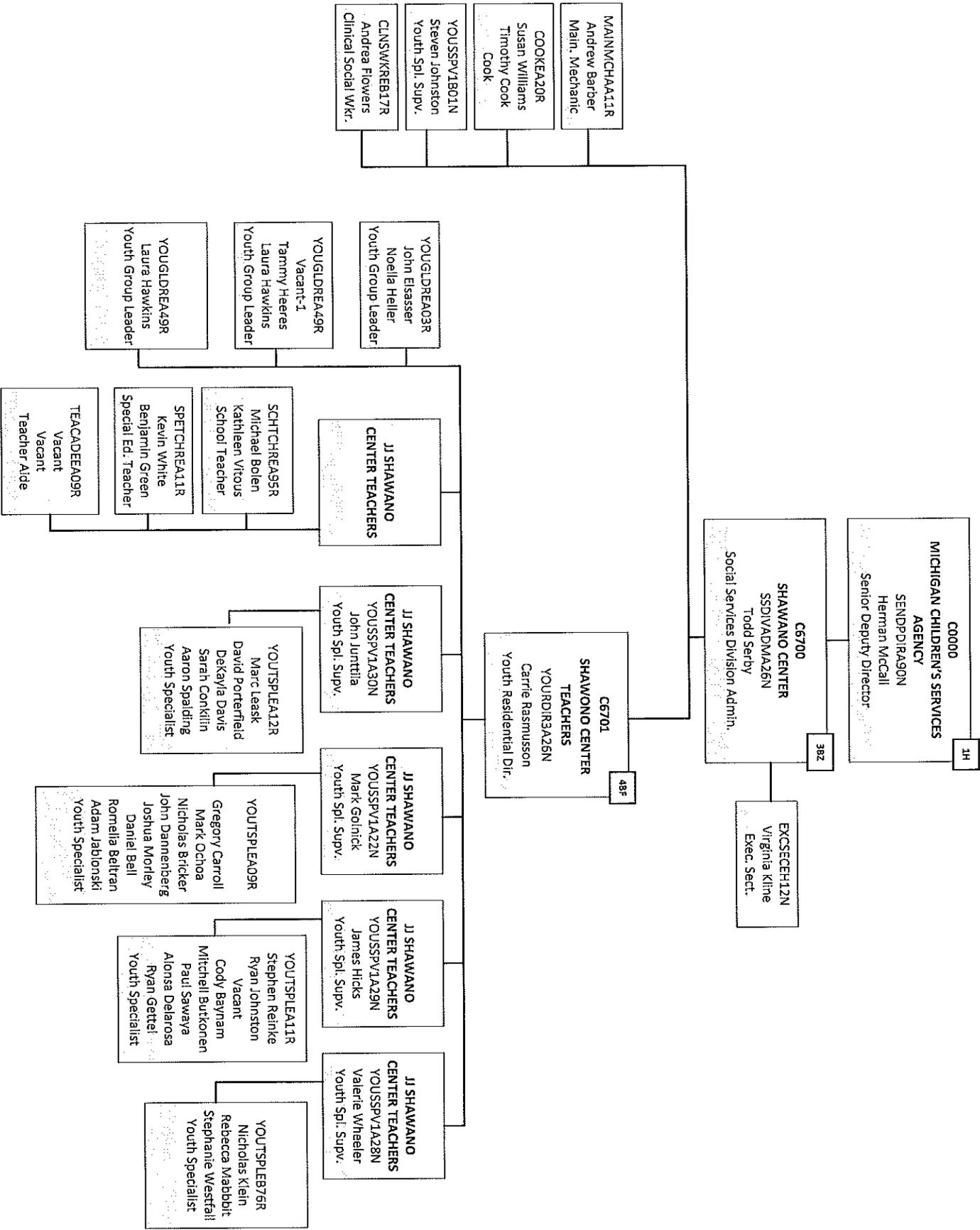


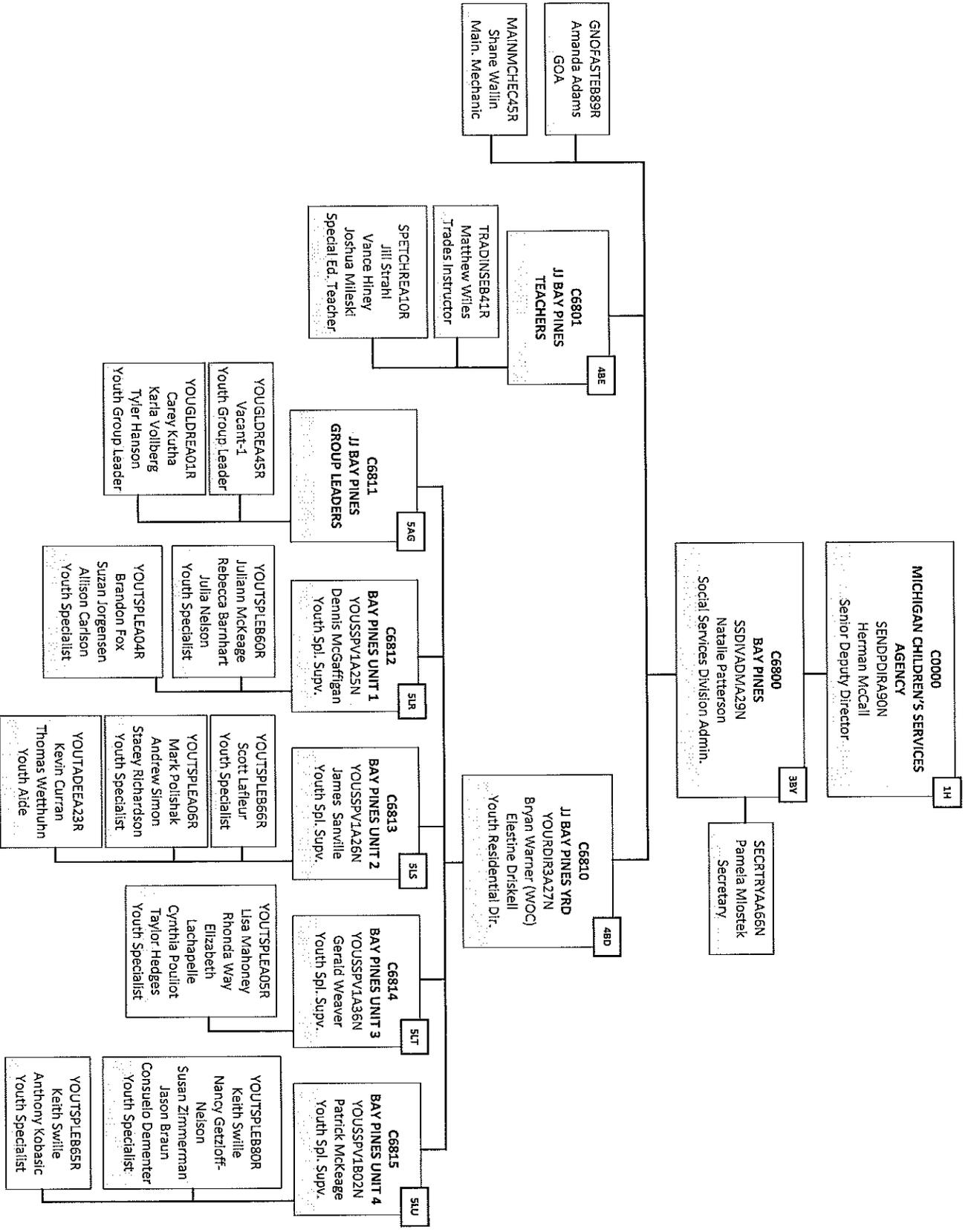


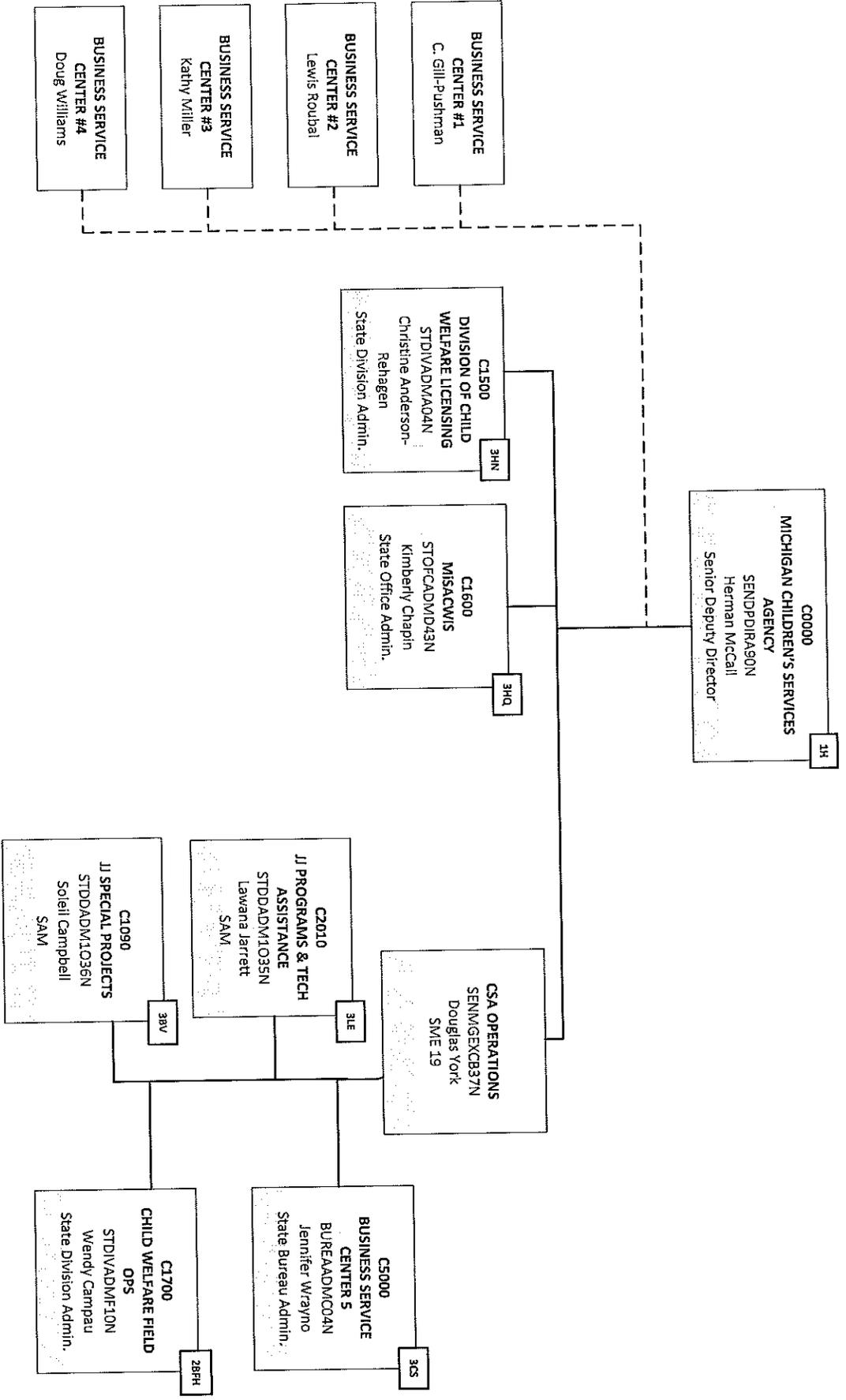


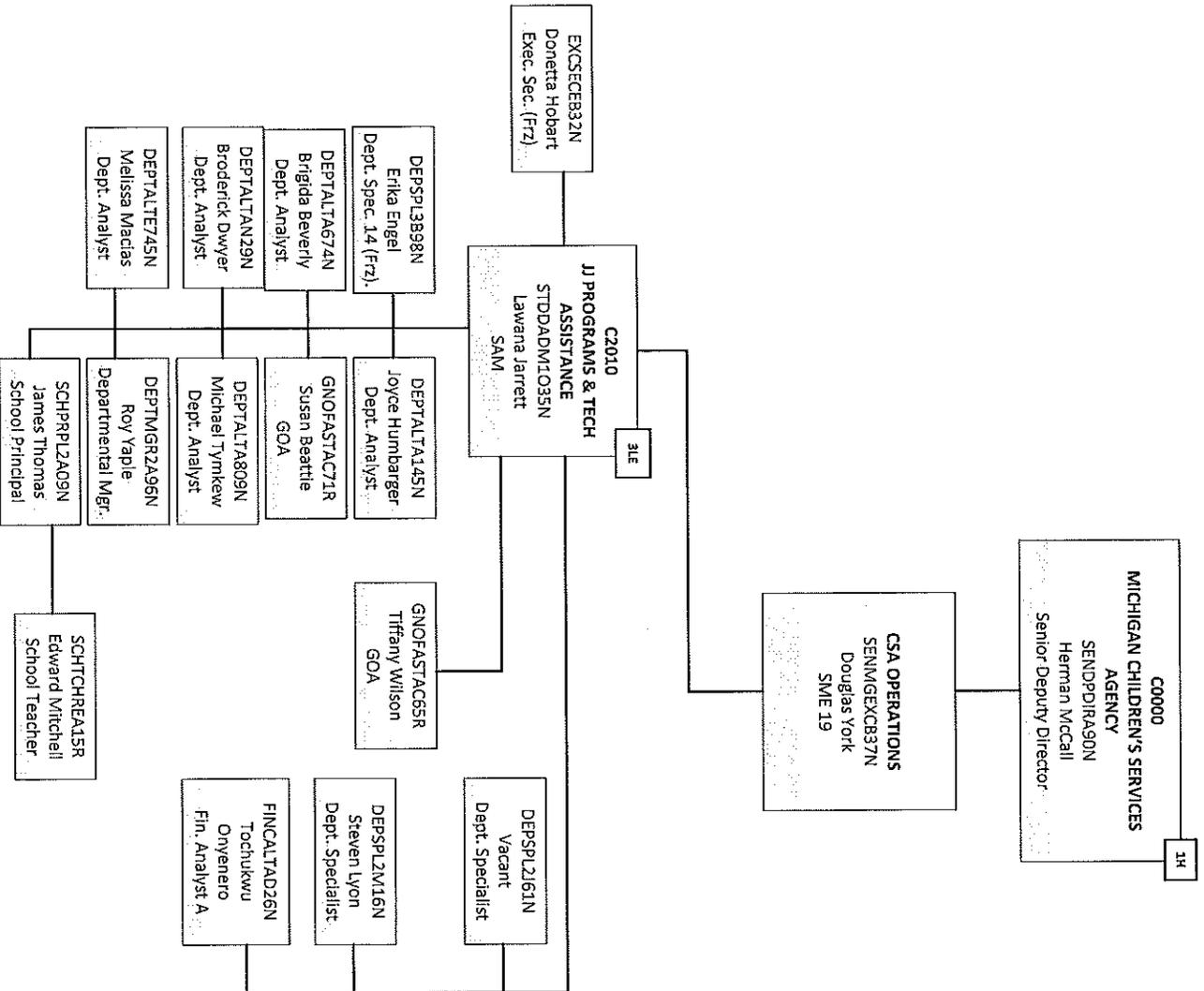


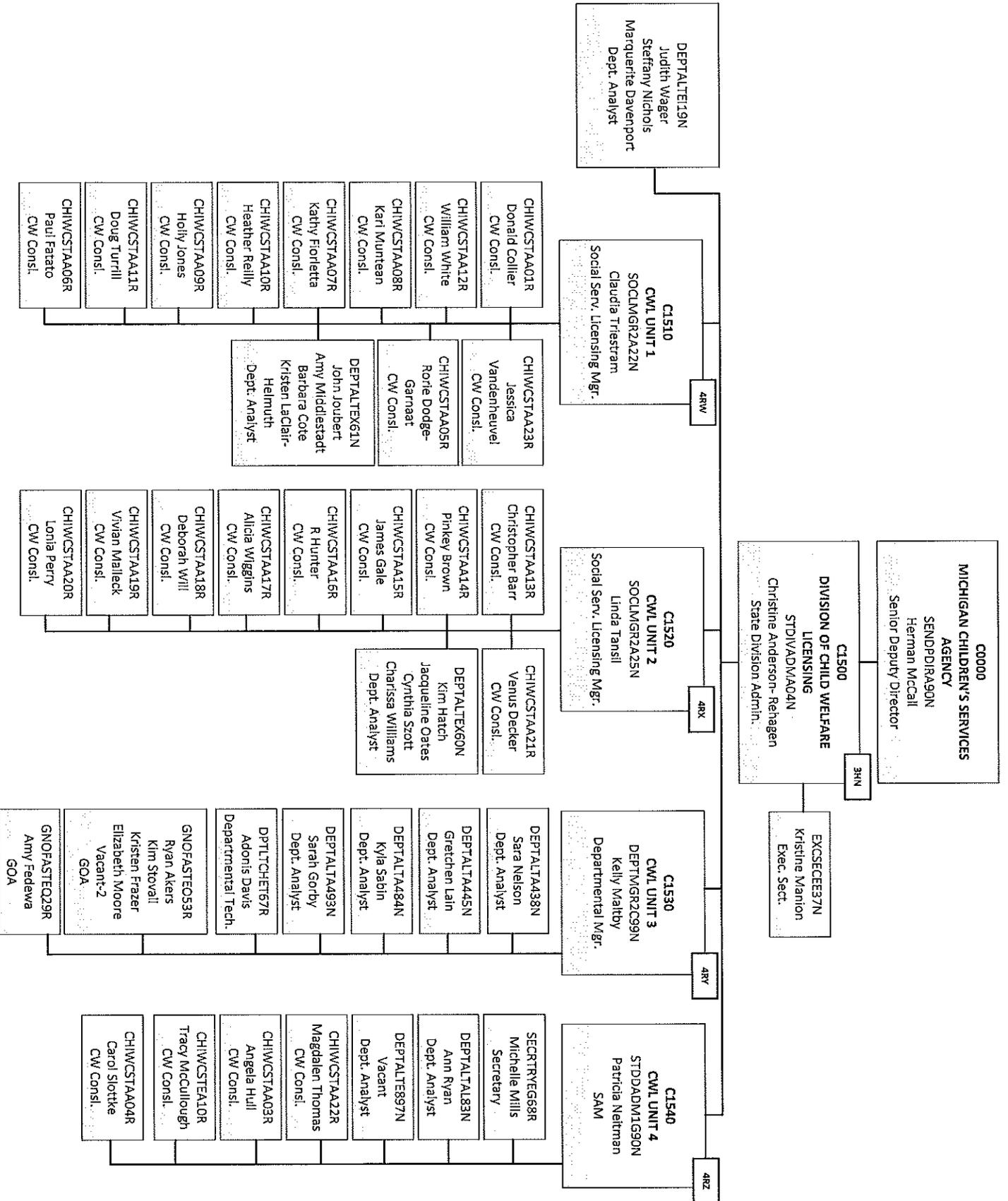












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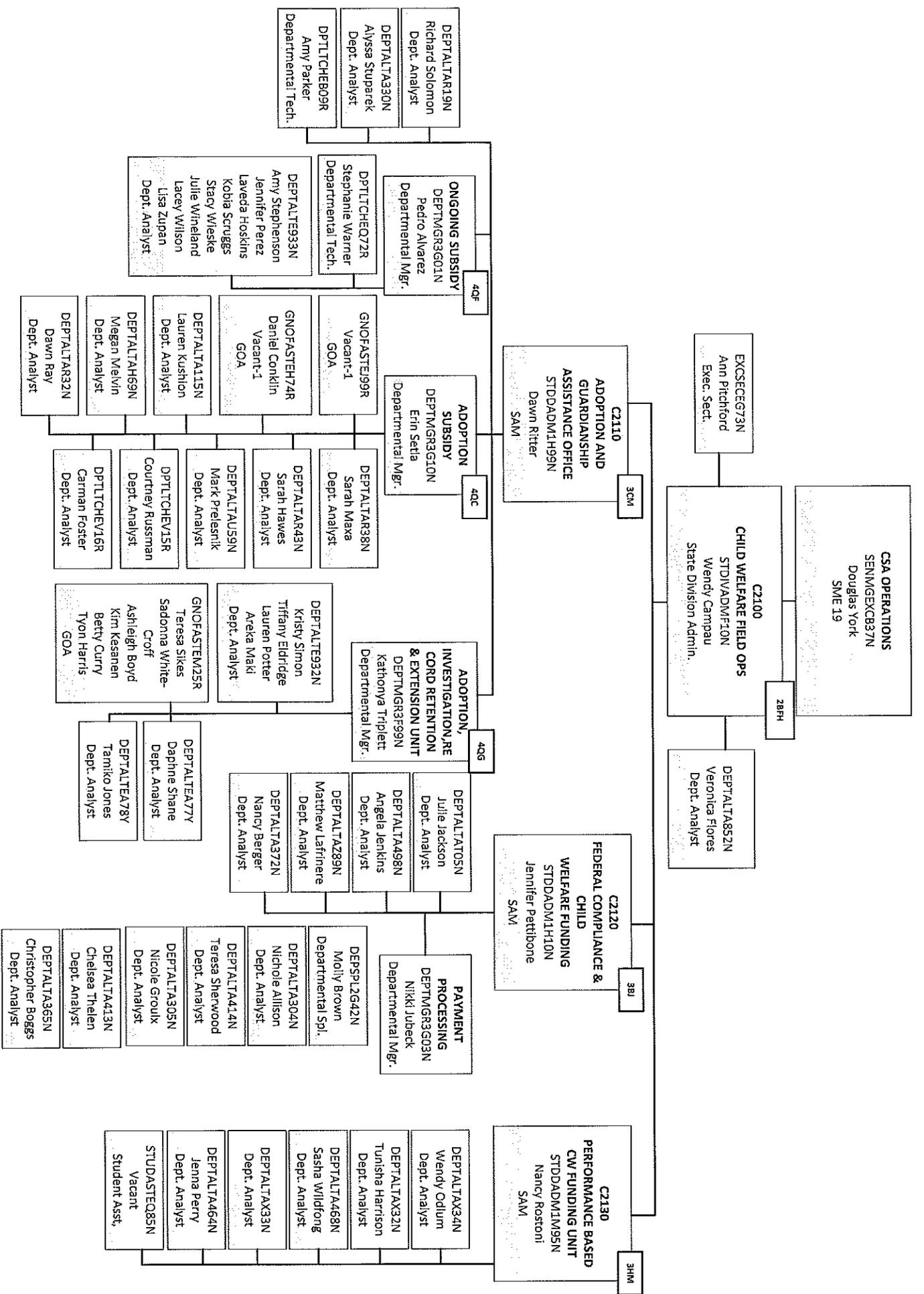
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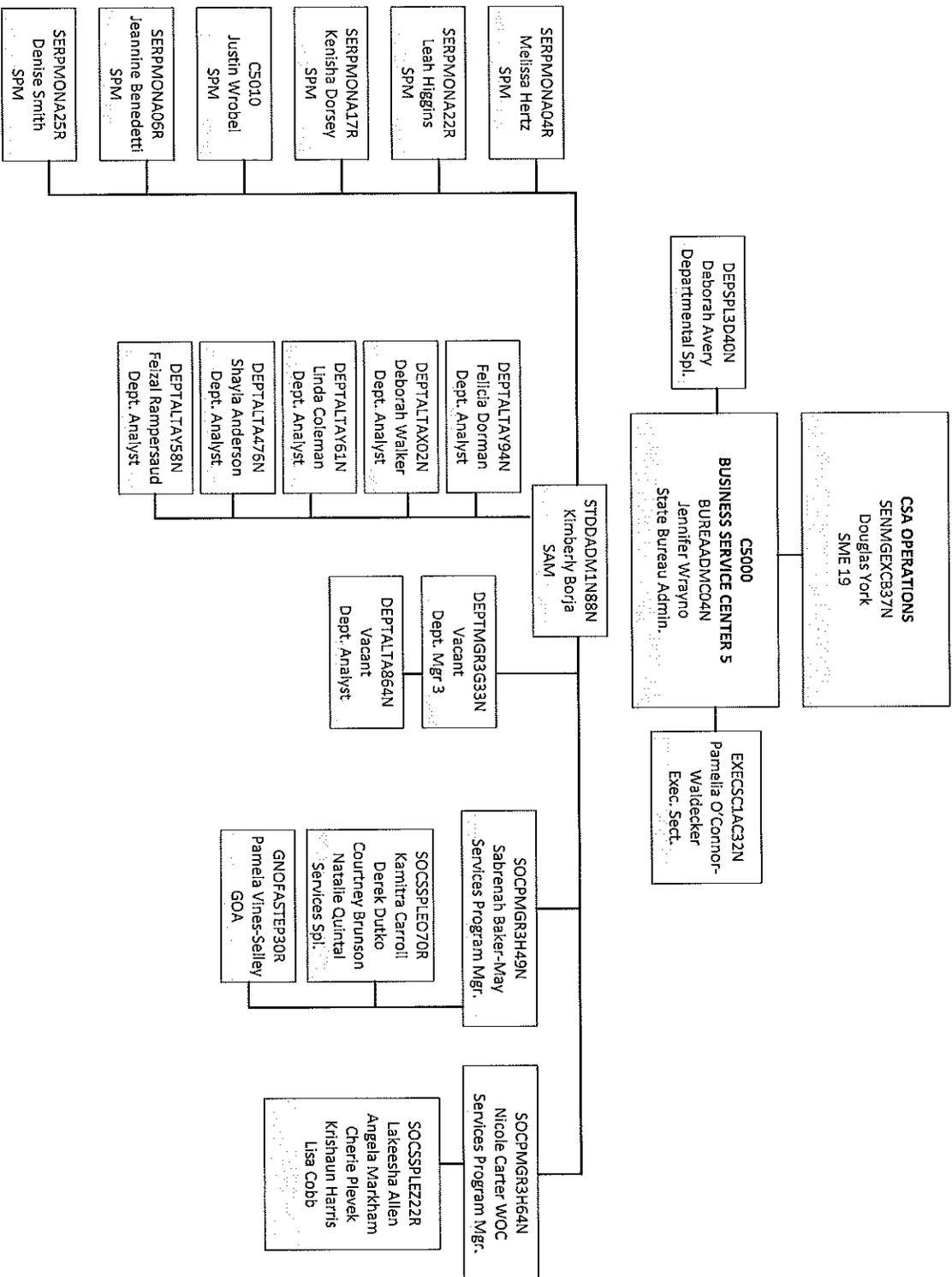
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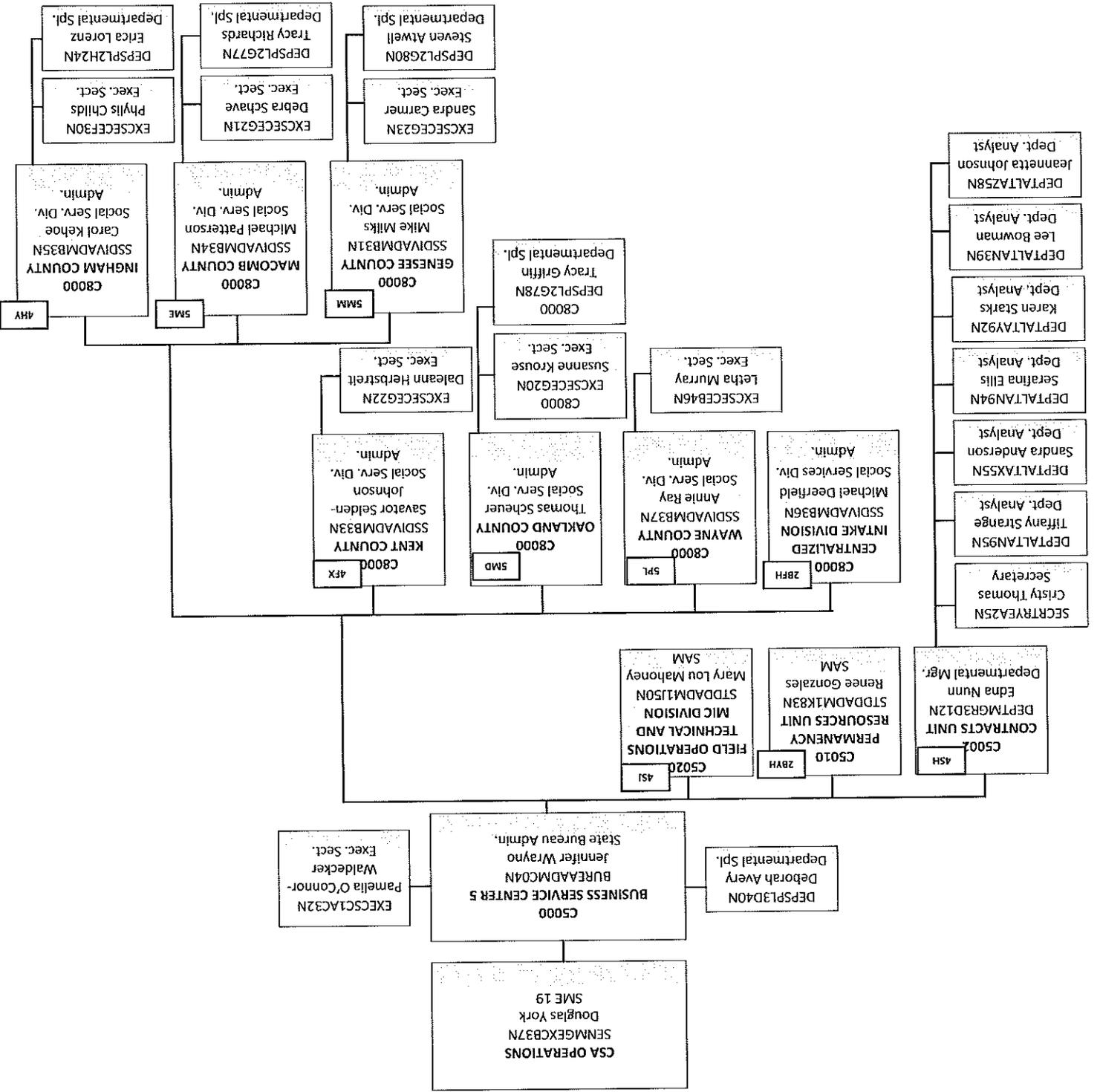
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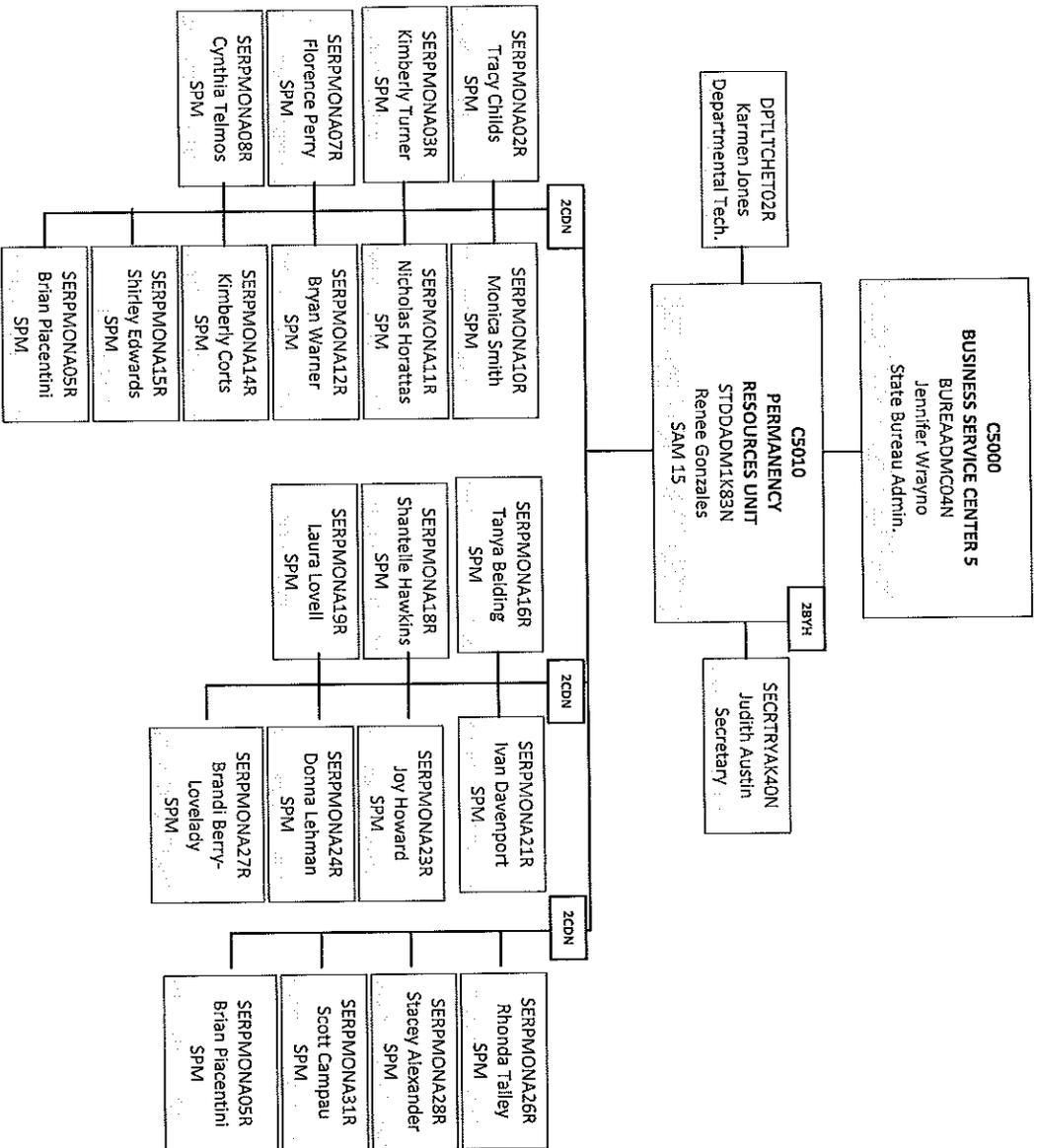
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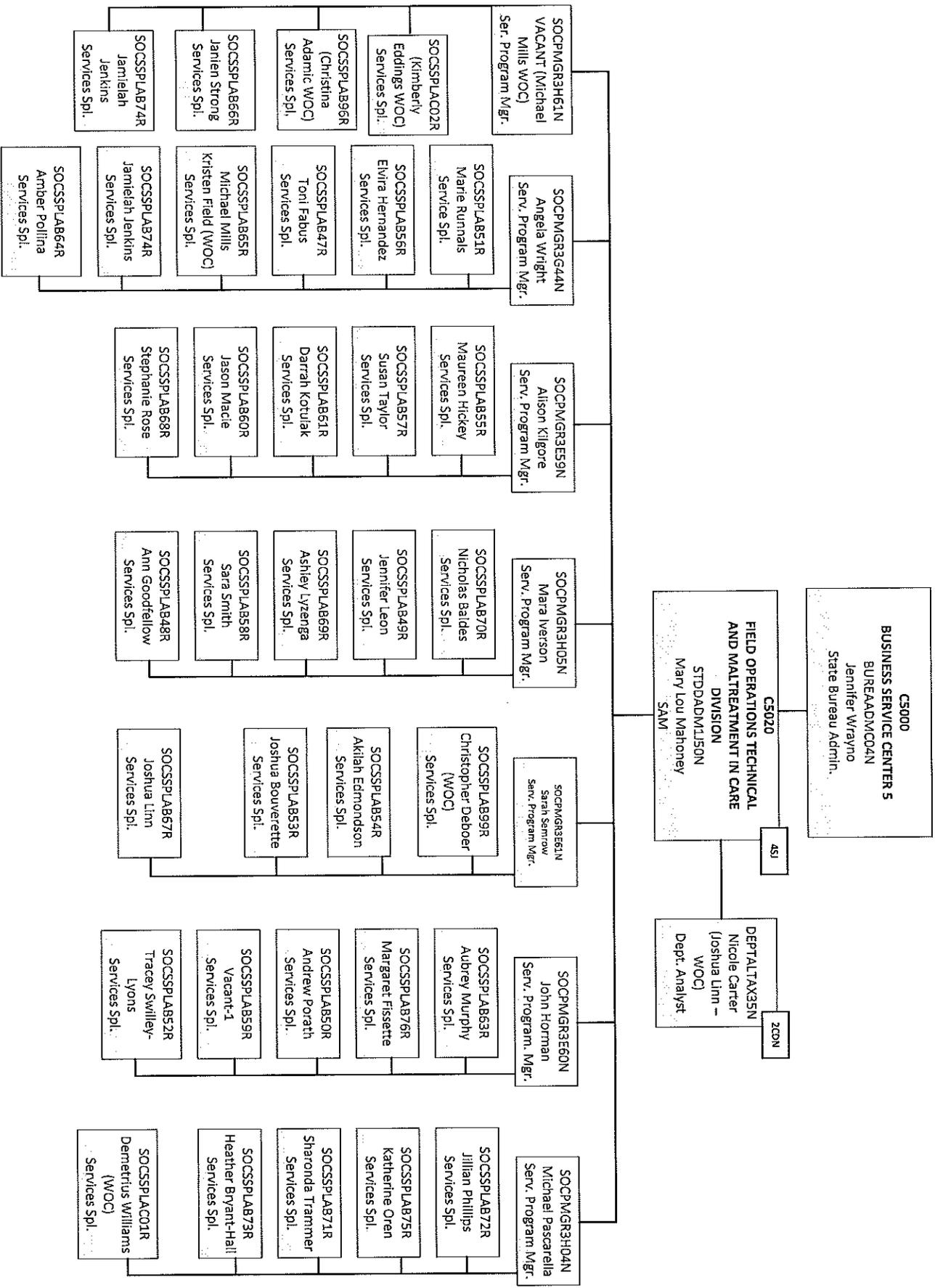


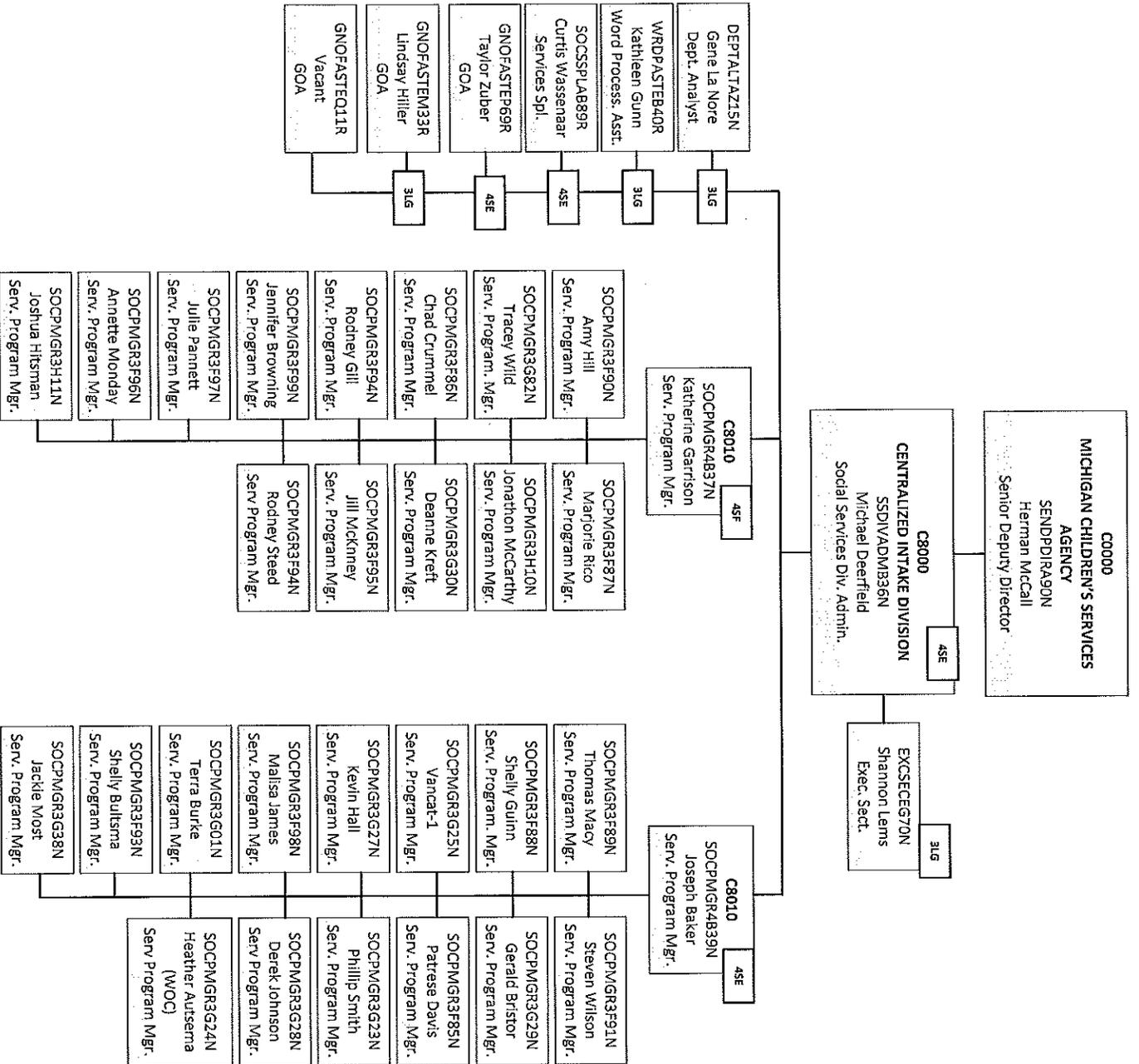












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 Matthew Deaton  
 Ashleigh Wassenaar  
 Colln James  
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 Rodney Stead  
 Serv. Program Mgr.

SOCPMGR3H41N  
 Jessica Vance  
 (WOC)  
 Serv. Program Mgr.

SOCSSPLEND3R  
 Benjamin Harden  
 Jennifer Castro  
 Rachael Arnston  
 Michael Tschirley  
 Services Spl.

SOCSSPLEL10R  
 Jamie Metz  
 Brittni Woodfork  
 Adam Chaffee  
 Vacant-1  
 Services Spl.

SOCSSPLEP02R  
 Lesley Helsom  
 Services Spl.

SOCSSPLEP12R  
 Jessica Vance  
 Services Spl.

SOCSSPLEL06R  
 Elizabeth Nawrocki  
 Debra Worden  
 Vacant-1  
 Services Spl.

SOCSSPLEP03R  
 Jacob Simon  
 Services Spl.

SOCSSPLEM03R  
 Benjamin Mosley  
 Mitch Enoch  
 Tyrie Moore  
 Vacant  
 Services Spl.

SOCSSPLEP20R  
 Erin Mundell  
 Services Spl.

SOCSSPLEM17R  
 Patricia Thomas  
 Charles West  
 Samantha Crawford  
 Nikeya Cabine  
 Margaret Davis  
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SOCSSPLEK98R  
 Shaari Vines  
 Jeremy Orr  
 Matthew Brong  
 Jessica Aboosamra  
 Shannon Papist  
 Services Spl.

SOCSSPLEP10R  
 Vacant  
 Services Spl.

SOCSSPLAB24R  
 Sebrina Clark  
 Services Spl.

SOCSSPLEL05R  
 Ashley McClarin  
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April, 2018

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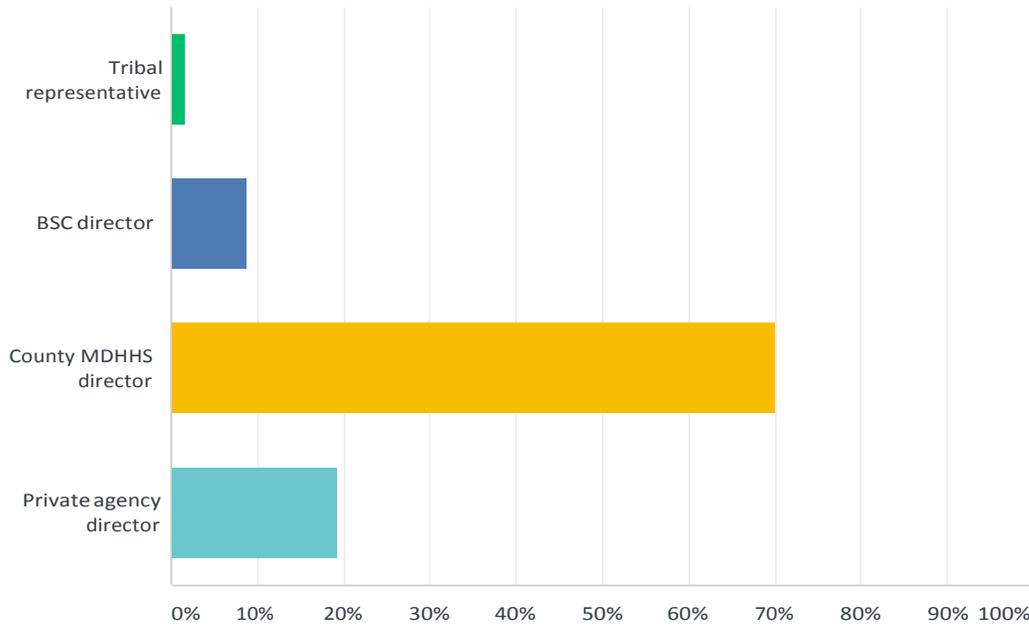
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## Q1 What is your professional role in child welfare?

Answered: 57 Skipped: 4



ANSWER CHOICES	RESPONSES
Tribal representative	1.75% 1
BSC director	8.77% 5
County MDHHS director	70.18% 40
Private agency director	19.30% 11
<b>TOTAL</b>	<b>57</b>

## Q2 What are examples of effective practices that your staff have implemented when handling foster care cases involving Indian children?

Answered: 58 Skipped: 3

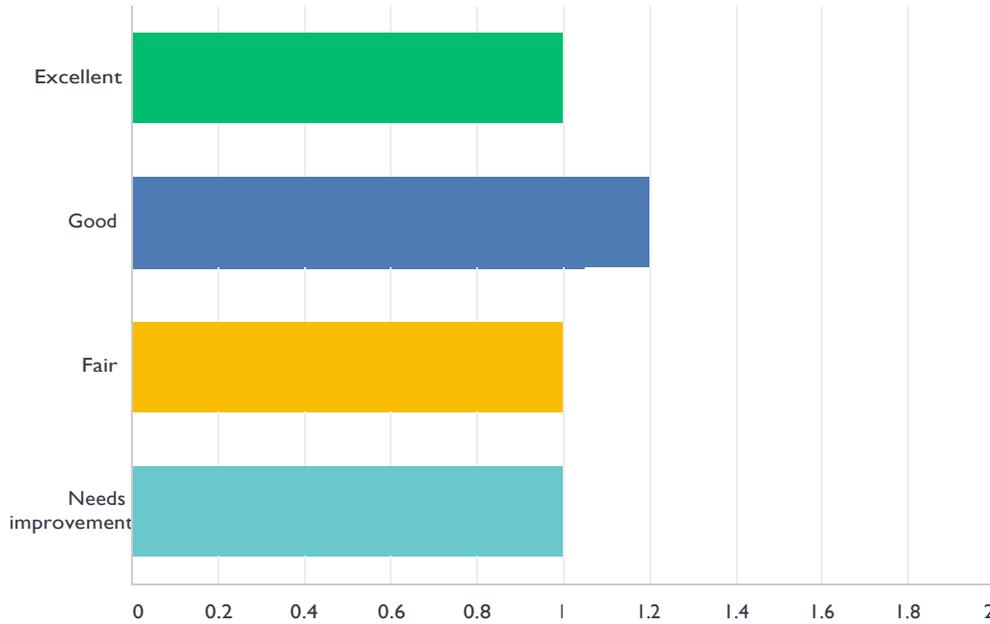
#	RESPONSES	DATE
1	Contacting ICWA officials to determine tribal affiliation. Involving the identified tribe with the child(ren) and participating in tribal events.	4/30/2018 9:06 AM
2	Obtain the 1555-CS and make contact right away with the tribe to consult on services and what the tribe would like for the family.	4/29/2018 8:07 PM
3	Having certain designated staff in both CPS and Foster Care who have a higher level of knowledge/training policy requirements for cases involving Indian children. Having meetings with tribal representatives and tribal court leaders to ensure open lines of communication.	4/27/2018 12:50 PM
4	Communication. The DHHS policies regarding severing contact with the Tribe's has negatively impacted this process. It feels like the practices have gone backwards instead of forwards and we are starting at square one with working for children and families.	4/27/2018 10:36 AM
5	Researching the Tribe, connecting with the Tribe, assisting parents and foster parents with this information. Trying to set up connections for the children to learn about their heritage	4/24/2018 3:46 PM
6	Frequent communication and follow up with Tribal affiliates to clarify case service.	4/20/2018 12:51 PM
7	Begin working the tribal representative as soon into the case as possible.	4/20/2018 10:40 AM
8	*getting them enrolled with their tribe *following active efforts for parents and placement priorities	4/19/2018 4:03 PM
9	Our most effective practice is building a good working relationship with the Indian Outreach Worker/ ICWA MFPA worker.	4/19/2018 2:58 PM
10	Direct and consistent contact via phone and email.	4/19/2018 11:44 AM
11	Consultation and collaboration with the tribe when the tribe will collaborate.	4/19/2018 11:25 AM
12	Connection with the tribe for services	4/19/2018 10:53 AM
13	We have not had a foster case in several years, however, when we have it is important to focus on Active Efforts and collaboration with tribe.	4/18/2018 1:45 PM
14	Immediate notification to tribe, as well as continued notification and inclusion regarding reports, progress, court, etc.	4/18/2018 7:10 AM
15	Following ICWA policy	4/17/2018 6:18 PM
16	We have not had any Indian children at our agency.	4/17/2018 5:54 PM
17	Communication with the parent, extended family, children (if older) and tribe throughout the case.	4/17/2018 1:56 PM
18	Constant communication with the tribe to discuss case/ situation.	4/17/2018 1:42 PM
19	We have not had any cases.	4/17/2018 12:50 PM
20	We have had limited experience and the cases we have services came to out agency with everything already in place.	4/17/2018 12:48 PM
21	Working closely with tribal case managers to supervisors to identify prospective tribal foster homes. Informing tribe of on going recruitment events to share at counsel meetings.	4/17/2018 12:17 PM
22	At this time we do not have have any ICWA cases.	4/17/2018 12:03 PM
23	Follow policy and obtained education from the court systems	4/17/2018 11:49 AM
24	Efforts to contact tribes to verify status, engage tribe in court or contact the tribe to discuss placement decisions.	4/17/2018 11:26 AM
25	Initiate involvement of Indian Outreach Worker (IOW), close communication with tribal social services.	4/17/2018 9:37 AM

26	Utilizing active efforts with court orders which include transportation assistance, supervised/unsupervised parenting time, coordination with tribal services on a constant basis, encouraging caregivers to participate in cultural/tribal activities, and facilitating relative engagement and visitation when possible.	4/17/2018 9:21 AM
27	1) Immediate consultation with the tribe. 2) Monthly meetings MDHHS child welfare managers, second line and the director with tribal child welfare supervisors, second line and the director	4/17/2018 9:18 AM
28	Consultation with NAA staff to make sure we are doing things correctly as we do not have a large Native American Population in our counties	4/17/2018 9:02 AM
29	MDHHS Monitoring worker provides extra involvement on the case to assure that the PAFC providing direct services is providing active efforts.	4/17/2018 8:21 AM
30	The Indian Outreach Program assists in assuring open communication, closing any gaps in MDHHS programs available by having a regular presence at tribal social services (regular office hours and attending tribal CW staff meetings)	4/17/2018 8:01 AM
31	120's are sent out timely. We have regular meetings with the Tribe on cases involving tribal children. We have a specialized foster care worker and supervisor that handles all tribal cases.	4/16/2018 5:13 PM
32	open communication with our tribal partners, ensuring we are always evaluating relative placement options,	4/16/2018 5:10 PM
33	Our local training through our CPS lead worker, emphasizes working with tribes directly when a family is a member of a tribe.	4/16/2018 4:10 PM
34	Actively seek to involve the appropriate Tribal involvement (complete forms, submit, mail in).	4/16/2018 1:34 PM
35	Identifying the child as eligible/tribal member as soon as possible	4/16/2018 12:20 PM
36	Ensure staff uses tool to determine if descendent family NAA Policy and Tribal services are required	4/16/2018 11:27 AM
37	Strong communication between the tribe and MDHHS. In addition to upfront processes that ensure identification of tribal affiliation.	4/16/2018 11:09 AM
38	Continue local office training on a frequent basis given staff turnover and infrequency of these case types.	5/30/2017 3:37 PM
39	South Central DHHS has created a binder for staff to obtain pre-printed labels of many of the frequently used tribes to reduce the time spent typing and labeling letterhead.	5/26/2017 2:54 PM
40	Accept help and support from formal and informal supports. We tend to overlook valuable input and resources from within the tribal network because someone doesn't have a title or a role you would associate with Child Welfare. Be open and receptive, actively reach out within the tribal network for input to make culturally informed decisions.	5/25/2017 11:58 AM
41	Have close working relationship with community partners for the best interest of the child	5/25/2017 10:18 AM
42	Every County could utilize an Indian Outreach worker.	5/24/2017 5:28 PM
43	Making sure workers are aware of the steps they need to take once an ICWA case is opened. Completion of the DHS 120 during the investigation process even if there is no court involvement. Inquire about NAH and possible Tribes during face to face with parents/caretakers.	5/24/2017 12:52 PM
44	Cross-disciplinary coordination among service providers	5/24/2017 11:00 AM
45	Training and collaboration with our Tribal partners, Utilization of our IOW to assist with engaging our Native American partners and parents in efforts to provide services.	5/24/2017 8:58 AM
46	Staff attend Tribal Child Protection Team/Child Welfare meetings and request written recommendation from the Tribe regarding Tribal cases. The Tribe is engaged during State court proceedings involving Tribal children and participates by providing expert witness testimony and recommendations to the court.	5/22/2017 3:08 PM
47	Monthly meetings with DHHS and Tribal Social Services Child Welfare Supervisors. Deal with specific ICWA cases and related issues, discuss new developments with tribal delivery of services as it relates to Active Efforts. Periodic meetings with Tribal ICWA attorneys regarding issues as they develop.	5/22/2017 9:51 AM
48	NA	5/22/2017 8:58 AM
49	Checklist that mirrors the tasks and responsibilities that CPS has. Preferably in MiSACWIS	5/22/2017 7:54 AM

50	N/a	5/21/2017 12:45 PM
51	Joint C.S. worker staff meetings in counties that have trust land (reservation). Directors included.	5/18/2017 11:09 AM
52	regular training, reminders.	5/18/2017 11:09 AM
53	Regular training on ICWA/MIFPA and active efforts.	5/18/2017 10:51 AM
54	Insure that on every case, information regarding potential tribal affiliation is gathered and that tribes are informed at the earliest possible point.	5/18/2017 10:45 AM
55	Ensuring required questions regarding native American heritage are asked by CPS and FC staff.	5/18/2017 10:43 AM
56	Collaboration with local offices as well as assistance with the proper process with counties who don't have involvement with ICWA cases regularly	5/18/2017 8:33 AM
57	Attending quarterly tribal state partnership meetings and disseminating information to the staff; setting up ICWA refresher trainings periodically for staff	5/18/2017 8:30 AM
58	When a county that does not have many ICWA cases receives a case they contact and works with a county that has an ICWA worker.	5/17/2017 9:36 PM

### Q3 How would you rate your agency/office's effectiveness in serving Indian children and their families who encounter the child welfare system?

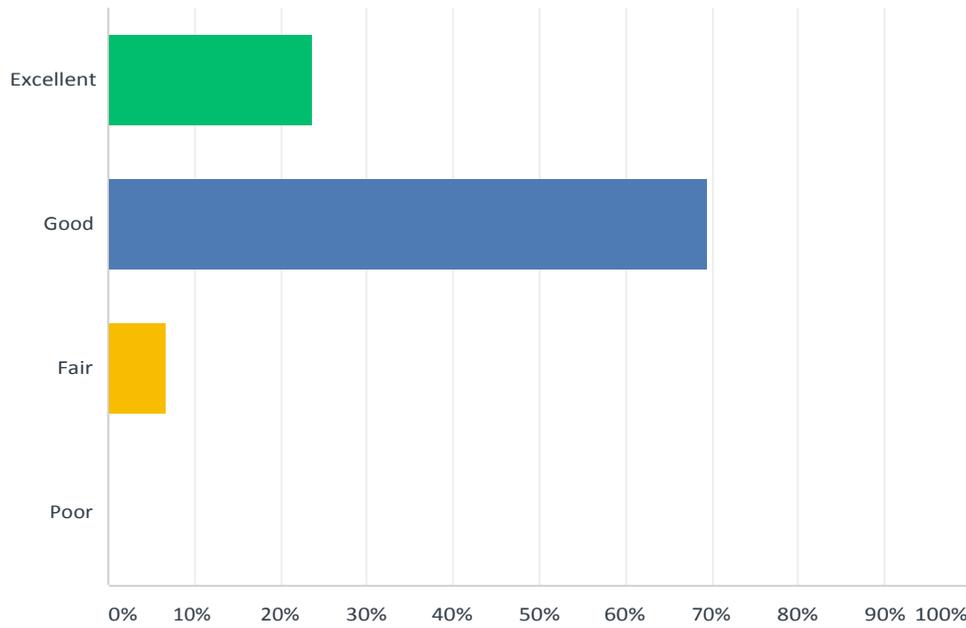
Answered: 36 Skipped: 25



	(NO LABEL)	(NO LABEL)	(NO LABEL)	(NO LABEL)	(NO LABEL)	TOTAL	WEIGHTED AVERAGE
Excellent	100.00% 12	0.00% 0	0.00% 0	0.00% 0	0.00% 0	12	1.00
Good	94.74% 18	5.26% 1	0.00% 0	0.00% 0	0.00% 0	19	1.05
Fair	100.00% 4	0.00% 0	0.00% 0	0.00% 0	0.00% 0	4	1.00
Needs improvement	100.00% 3	0.00% 0	0.00% 0	0.00% 0	0.00% 0	3	1.00

### Q4 Please rate your working relationships among tribal representatives, local MDHHS and private agency staff.

Answered: 59 Skipped: 2



ANSWER CHOICES	RESPONSES	
Excellent	23.73%	14
Good	69.49%	41
Fair	6.78%	4
Poor	0.00%	0
<b>TOTAL</b>		<b>59</b>

## Q5 What are you doing to improve or sustain effective collaboration among tribal representatives, local MDHHS and private agency staff?

Answered: 54 Skipped: 7

#	RESPONSES	DATE
1	Increasing communication between all parties, reminding staff to update regularly people involved on the case, complete monthly FTMs, as well as have monthly case reviews which is very helpful.	4/30/2018 9:06 AM
2	Making arrangements to have staff visit the tribe for training and discussion.	4/29/2018 8:07 PM
3	Attending regular tribal partners meetings. Ensuring that we have CW staff who are trained at a higher level to maximally address the specific needs of Indian CW cases.	4/27/2018 12:50 PM
4	We call/e-mail, and collaborate daily on a case by case basis. We meet monthly with local office supervisors. We meet quarterly with DHHS for Tribal State Partnership and also with the Private Agency Directors in our primary service area. We have formal consultation with the DHHS Director once per year.	4/27/2018 10:36 AM
5	trying to arrange meetings	4/24/2018 3:46 PM
6	Attend TSP meetings as often as possible. Meet with Tribal partners whenever necessary and invite them to participate in community collaborative events/meetings.	4/20/2018 12:51 PM
7	*The worker contacts the tribe monthly for NA children and speaks with the tribal contact. *The tribal contact is involved /invited to court hearings. *The worker was able to get the children enrolled with their tribe.	4/19/2018 4:03 PM
8	The one county we work with has bi-monthly PAFC meetings which help us to work together and collaborate.	4/19/2018 2:58 PM
9	We believe in a collaborative approach based upon consistent communication and good training on law and policy.	4/19/2018 11:44 AM
10	Attendance at the tribal partnerships, discussion and contact information to tribal partners and leaders.	4/19/2018 11:25 AM
11	Continue to participate with Quarterly Tribal State Partnership meetings and continue to enhance relationships with tribes	4/19/2018 10:53 AM
12	Attend trainings, meetings and encourage collaboration at all levels.	4/18/2018 1:45 PM
13	Inclusion via phone, email, reports, FTM and other case related matters so that the tribe is current and can participate in the ongoing care of the case to ensure the children's needs are met according to Federal and Tribal laws and wishes.	4/18/2018 7:10 AM
14	Bi-monthly and/or quarterly meetings with other county directors, supervisor and tribal leaders if available and appropriate.	4/17/2018 6:18 PM
15	We have not had to work with tribal representative.	4/17/2018 5:54 PM
16	Communication is the key. We have had more Native American children recently which has increased our knowledge.	4/17/2018 1:56 PM
17	We in Midland/Gladwin have not had many cases involving tribal representatives. The few cases we have had were handled effectively.	4/17/2018 1:42 PM
18	We recently reviewed our internal ICWA policy to make sure we were meeting standards and expectations of DHHS.	4/17/2018 12:48 PM
19	Trying to keep the lines of communication as opened as possible. Inviting tribal reps to FTMS, etc. so that they have a voice at the table.	4/17/2018 12:17 PM
20	We obtain cases on a non regular basis so meeting with the tribal representative when we receive a case for effective communication is key.	4/17/2018 11:49 AM
21	Maintain good communication to ensure understanding of expectations at every step	4/17/2018 11:26 AM

22	All parties work together on annual foster home planning, holding joint activities such as foster parent recognition, training and recruitment. All agency staff meetings are held on occasion.	4/17/2018 9:37 AM
23	Attendance in the Tribal/State Partnership meetings. Utilizing Indian Outreach Services in order to provide direct services to tribal families in the service area. Continued engagement in cultural trainings/activities among staff. Courtesy visits for tribal social services.	4/17/2018 9:21 AM
24	Continued collaboration. Open communication. Reviewing use of IOW staff to find ways to better improve access.	4/17/2018 9:18 AM
25	Participation in TSP as much as possible and collaboration with other counties who have a larger tribal presence.	4/17/2018 9:02 AM
26	Quarterly all staff meetings with MDHHS/tribe, inviting tribe to local office trainings	4/17/2018 8:01 AM
27	We meet on a regular basis to discuss tribal cases.	4/16/2018 5:13 PM
28	Making sure we invite our tribal partners to all trauma informed system events and trainings, maintaining open communication when issues or problems arise - not allowing the issue to "fester" but rather addressing it immediately.	4/16/2018 5:10 PM
29	I attend some of the tribal state partnership meetings. Because we do not have a tribe located in our county, there is not a lot of direct collaboration with tribes.	4/16/2018 4:10 PM
30	Nothing directly.	4/16/2018 1:34 PM
31	Nothing really. We continue to collaborate when we have a child in common, along with attending Tribal partnership meetings when able.	4/16/2018 12:20 PM
32	Meeting with staff and tribal representatives to ensure we have a good working relationship	4/16/2018 11:27 AM
33	Regular meetings at the local level, quarterly at the state level and annual state director meeting with all tribal leaders.	4/16/2018 11:09 AM
34	Given the infrequency of these case types here, we need to continue to focus on regular training intervals.	5/30/2017 3:37 PM
35	We host them twice per year for training for all staff.	5/26/2017 2:54 PM
36	We are working on our communications. There really needs to be a strong communication network in order to be successful with ICWA and MIFPA. There are too many variables to put everything in a rule book. We view ICWA and MIFPA as much as a practice as we do a policy. It requires communication and cooperation.	5/25/2017 11:58 AM
37	Keeping everyone informed	5/25/2017 10:18 AM
38	We are working with our courts by forming stronger collaborations, meeting quarterly, and attending joint trainings offered by both DHHS and by the court.	5/24/2017 5:28 PM
39	Making sure workers continue to receive training on ICWA definitions, active efforts and placement priorities. Review new updates and policies regarding ICWA with CW staff	5/24/2017 12:52 PM
40	Stakeholder's meetings, sharing of information	5/24/2017 11:00 AM
41	Scheduling specific presentations for the child welfare division with our Native American Partners	5/24/2017 8:58 AM
42	See #2 and #3	5/22/2017 3:08 PM
43	Child welfare staff from DHHS and Tribal Social Services meet regularly to staff cases. Trainings from both entities are shared so that staff from both agencies attend trainings together to develop a closer working relationship. MiTeam Specialist provides training to Tribal partners. Jointly develop Foster Care recruitment plans.	5/22/2017 9:51 AM
44	NA	5/22/2017 8:58 AM
45	To be frank, there are not a lot of tribes that our county comes into contact with.	5/22/2017 7:54 AM
46	Open communication	5/21/2017 12:45 PM
47	Joint staff meetings MDHHS/Tribe	5/18/2017 11:09 AM
48	Regular meetings with tribe including inviting the tribe to PAFC meetings that are held bi-monthly. Active training opportunities between the tribe and MDHHS.	5/18/2017 11:09 AM
49	Nothing as nothing has been brought up.	5/18/2017 10:51 AM

50	Attempt to attend the statewide Tribal partnership meeting at least a few times per year.	5/18/2017 10:43 AM
51	Case stuffings with director and staff when we have these cases	5/18/2017 8:33 AM
52	Continuing communication and education	5/18/2017 8:30 AM
53	Extending conversations with tribal and local office entities.	5/18/2017 8:23 AM
54	Attending tribal partner meetings and learning as much as I can regarding ICWA and MiFPA	5/17/2017 9:36 PM

## Q6 Please provide one or two suggestions for strategies, procedures, policies or programs that may result in positive outcomes for tribal children and families.

Answered: 40 Skipped: 21

#	RESPONSES	DATE
1	Everyone working together, healthy communication, and tribal events to allow participation in cultural activities.	4/30/2018 9:06 AM
2	Changes within MiSACWIS that allows the tribes to see only their cases. This will require coding changes but it can allow for viewing of tribal families only. This will require collaboration with the tribes as well.	4/29/2018 8:07 PM
3	same as above	4/27/2018 12:50 PM
4	It appears that the Upper Management at DHHS and the front line staff and supervisors are disconnected. People making decisions do not seem to have a good grasp on what is actually happening in the field. When suggestions are made, they don't seem to be effectively understood and implemented. It seems to actually make things worse. This is disheartening as there are a lot of smart competent people out there working hard to make a difference every day. If DHHS would embrace a process and engage in true collaboration it seems like much good could be done. However, there is a lot of time and effort that seems to go into deflecting and dissecting issues that are really not large in number. Percentage of population wise, Native's are a true minority. Tribes advocate for their members and at times DHHS seems to spend more time and effort not addressing things when the solution is simple and really only affects a very few number. But for Tribe's these small numbers are our future and are important to us. It doesn't seem like our voices are heard, or if they are heard, it is with the intention to work around our concerns or ignore them rather than truly working together to effect positive change. Tribes are here to help, but we spend more time and energy fighting our way in, when if true collaboration could occur we would have the best of both worlds, a system working together and maximizing the use of all resources to make a positive change for children and families and securing a healthy future.	4/27/2018 10:36 AM
5	webinar trainings for staff who do not have many tribal cases	4/24/2018 3:46 PM
6	Continued focus at the worker level on why it is important to follow policy and practice guidelines related to families who are, or may be, affiliated with a tribe. Tribal liaison within local DHHS offices where there is not regular interaction with tribal families.	4/20/2018 12:51 PM
7	A good working relationship among all agencies who help the families. The workers having the knowledge of ICWA and the practices that go with that.	4/19/2018 2:58 PM
8	Continue to provide joint training and support teamwork.	4/19/2018 11:44 AM
9	The Little River Band is effective at meeting with our families in conjunction with our workers and trying to resolve problems or issues. I think the tribes participation in case planning is helpful. There is a differing opinion between the agency and the tribes at this time on the information they are entitled to on a case. The tribe feels that they are entitled to all of the family information to treat the whole family which is a valid argument however they also feel that they should have all of the medical and psychological information on the non-tribal members which is a violation of HIPPA unless the family is willing to sign a release. This is consistently a point of contentions.	4/19/2018 11:25 AM
10	I have not strategies at this time, we follow current policies, set by state and always inquire with the tribe as to specific wishes and needs they have for service implementation to their members.	4/18/2018 7:10 AM
11	Better understanding and follow ICWA policies. As a private agencies we sometimes struggle with our monitors and following ICWA policy/requirements as we read and understand them. Maybe more job aides for both roles would be helpful with this? It also doesn't always feel like the courts are on the same page with ICWA policy and that makes it tough.	4/17/2018 6:18 PM
12	N/A	4/17/2018 5:54 PM
13	Ensuring that tribal membership is fully documented at the beginning of a case.	4/17/2018 1:56 PM

14	As part of a larger resource guide for staff it would be helpful to provide website links to agencies that provide support to ICWA families. For example in Dearborn we can contact services providers dedicated to families of a specific cultural background. I would have to search to find supports for ICWA families because I do not know a central place to find that support.	4/17/2018 12:48 PM
15	Policy should be rewritten to include tribal members getting licensed for an Indian child to be regarded as "family", thereby providing licensors with a higher reimbursement rate for relatives. This would incentivize private agencies as they are incentivized when licensing relatives, and in turn, allow Indian children to remain placed within their tribe.	4/17/2018 12:17 PM
16	Determine tribal affiliation as soon as possible. Not waiting until termination hearing for a biological parent to bring up at court they think they are a member of a tribe.	4/17/2018 11:49 AM
17	Even when agencies do not actively accept or regularly have intakes of NA children/families, it is helpful to have trainings that revisit the policy expectations and remind workers on what to do when they get a new case or what to do if NA ancestry is claimed/identified. Often workers get a piece of this in CWTI and that is it - nothing ongoing to my knowledge.	4/17/2018 11:26 AM
18	Joint planning and program activity is very helpful.	4/17/2018 9:37 AM
19	More coordination with tribal services during investigations involving Native families in order to provide prevention services.	4/17/2018 9:21 AM
20	Local offices need to meet regularly with the local tribes. Communication is key. We need to be able to share information as soon as possible.	4/17/2018 9:18 AM
21	Training by Child Welfare Staff from counties with large Native American populations on best practices. Provide this training to those counties with little Native American population.	4/17/2018 9:02 AM
22	Plan to start a twice a year meeting with Tribal social services and MDHHS staff. Plan to meet quarterly with Tribal Social Services Director and prosecuting attorney to assure we are meeting the needs of the families effectively.	4/17/2018 8:21 AM
23	Investigating CPS complaints and/or providing foster care services to descendant children that are domiciled on the reservation can be difficult for staff. An updated Tribal/State Agreement would assist in providing clarification for MDHHS authority to conduct these services on tribal land without their knowledge in the event a signed release of information is not obtained. This is especially important for CPS investigations because of the timeframes and nature of the investigation.	4/17/2018 8:01 AM
24	Communication is the key, along with continuing to educate our new staff on ICWA and MIFPA.	4/16/2018 5:13 PM
25	Multi- agency trainings on how to manage tribal cases, which would include the court, private agencies, attorneys and DHHS.	4/16/2018 4:10 PM
26	Annual training on procedures, policies, and the laws that impact our tribal children and their families. In areas where it is infrequent regular training opportunities can be beneficial. This could be provided throughout the state to minimize travel issues.	4/16/2018 1:34 PM
27	For counties that don't often have Indian children, refresher trainings and meet/greet type of meetings would be beneficial.	4/16/2018 12:20 PM
28	County directors or their designee should attend the quarterly tribal meetings, especially the county directors which have a large tribal community. DHHS needs to have a more active role in meeting the needs of the tribal communities to ensure their needs are met. At the last tribal meeting the question came up as to why MISACWIS is not available to tribal representatives and no answer was given	4/16/2018 11:27 AM
29	none	4/16/2018 11:09 AM
30	For many sites tribal cases are a rare or less than common occurrence. I think having MDHHS and Tribal providers sit down and work through case scenarios in a facilitated/supportive workshop would help develop the skill and rapport to meet challenges when they do occur.	5/25/2017 11:58 AM
31	understanding ICWA	5/25/2017 10:18 AM
32	Continue to have on-going workshops/training with tribes and provide the training to foster care workers and supervisors. Include placement options, court proceeding and ICWA process from the beginning of the case to case closure.	5/24/2017 12:52 PM
33	Better coordination and participation is critical	5/24/2017 11:00 AM
34	I would not want to presume to make any suggestions here.	5/22/2017 3:08 PM

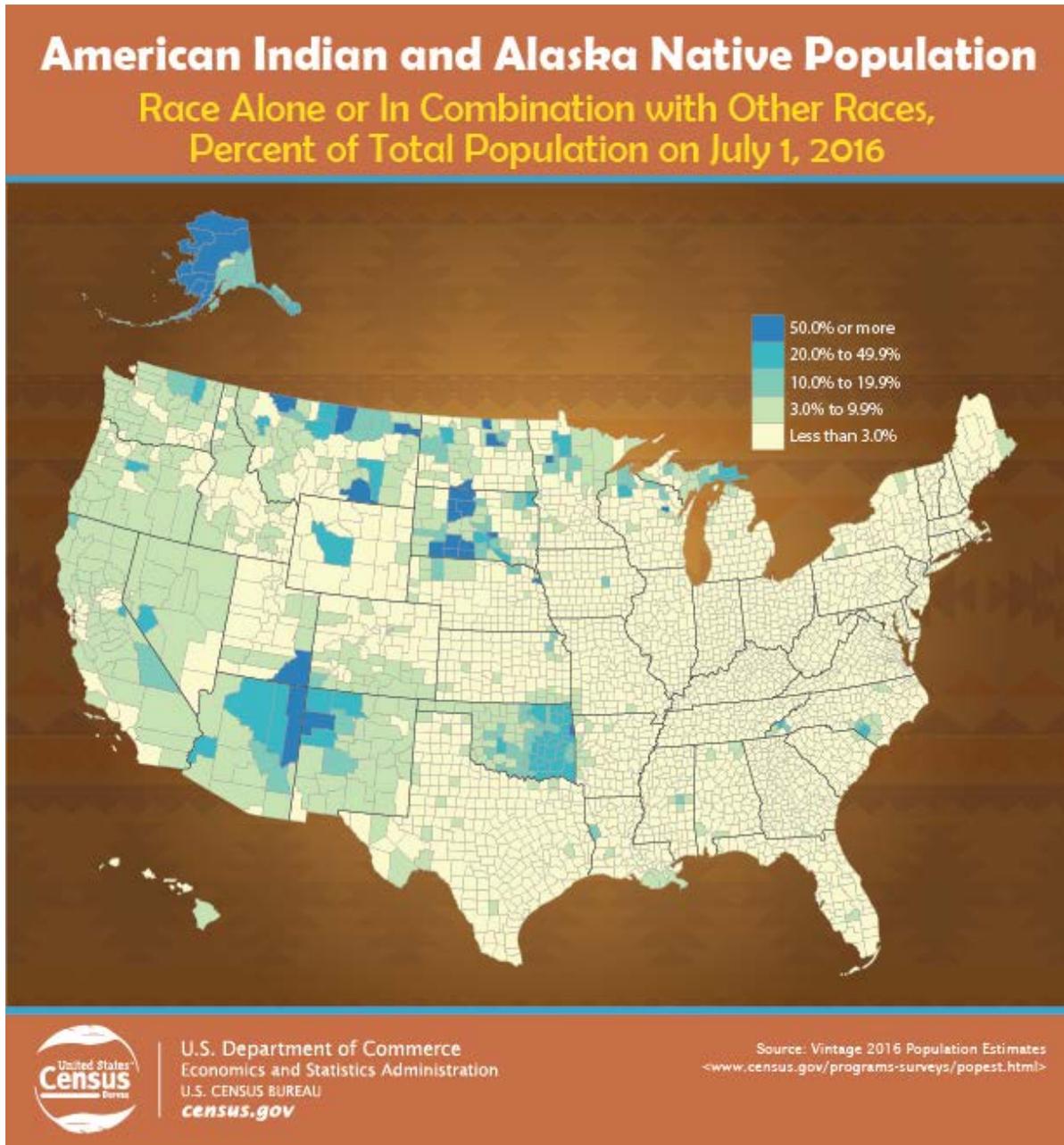
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35	Should have an DHHS ICWA/MIFPA expert visiting all tribal Social Services agencies on a regular basis to engage tribes in discussions about ICWA/MIFPA issues they are experiencing so tribes know that they will have regular opportunities to discuss any issues that may be developing.	5/22/2017 9:51 AM
36	NA	5/22/2017 8:58 AM
37	Licensing tribe as CPA, increased IOW activities to preserve native families.	5/18/2017 11:09 AM
38	Regular training opportunities for first-line workers and supervisors on the laws and particularly active efforts.	5/18/2017 10:51 AM
39	Easy access to contacts for Tribes for countries who have few of these cases.	5/18/2017 8:33 AM
40	I think having the ICWA staff present at the tribal meeting was very helpful as I think it will help those counties that don't have a worker reach out for assistance.	5/17/2017 9:36 PM

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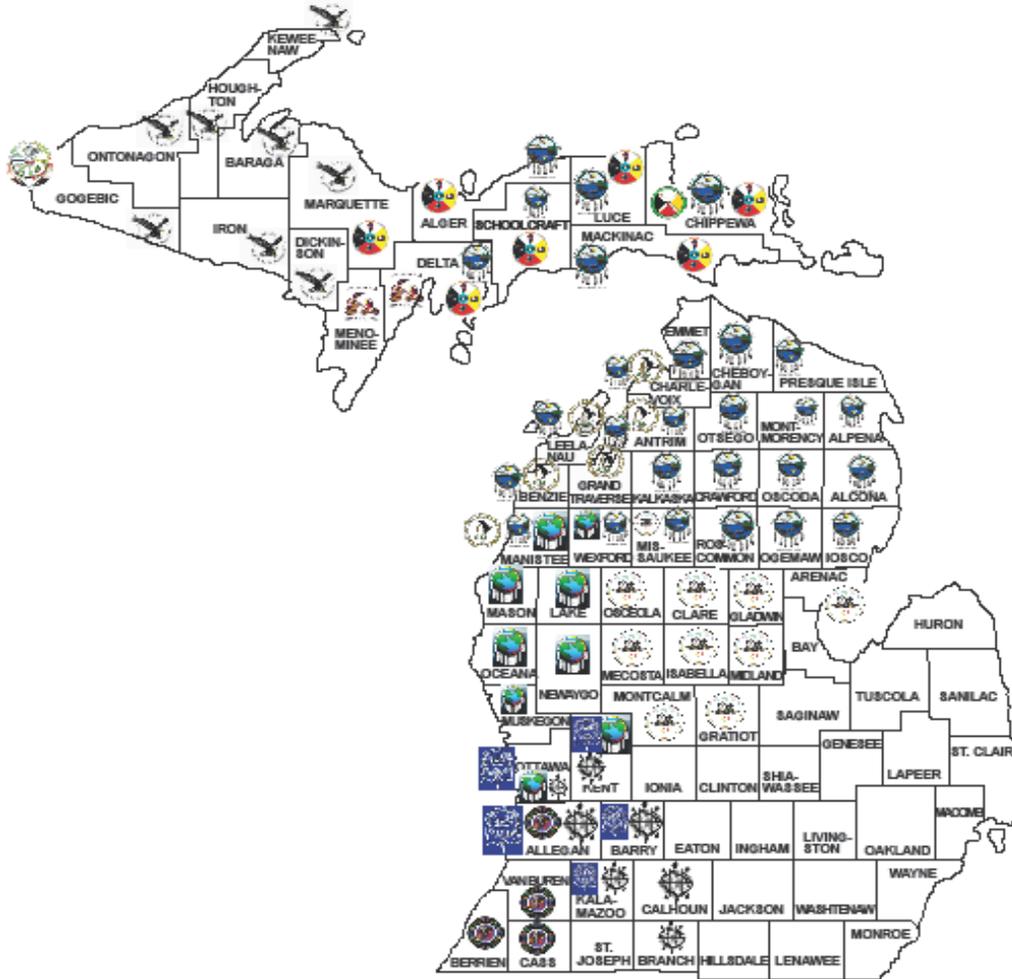
## American Indian/Alaska Native Population Maps

According to the most recent U.S. Census Bureau 2016 data, there were approximately 6.7 million people in the United States that identified as American Indian/Alaska Native (AI/AN) alone or in combination with another race. Michigan is one of twenty states with the largest populations of AI/AN populations in the country, and the largest tribal population east of the Mississippi River.





**Native American Affairs (NAA)**  
**Tribal Service Area Matrix**  
**(Map Reference)**  
**Counties Included in Tribes' Service Delivery Area**



Refer to legend.

Title IV-E Training Matrix

	B	C	D	E	F	G	H	I	J	K
	Course/Module Title	Course Description	Title IV-E Administrative Function	FFP Rate	Hrs	Venue	Trainer	Duration	Target Audience	
1										
2	<b>Allocation Methodology</b> <b>Costs for all courses are reduced by the title IV-E ratio to determine the IV-E</b>									
3	Adoption Assistance Negotiation Recorded Webinar	Effective January 21, 2014 the process for adoption assistance applications is being updated to include a worksheet to assist in the negotiation process. This webinar will discuss those changes described in CSA CI 13149. This webinar is mandatory training for all new hires.	Negotiation and review of adoption assistance agreements	75%	2	online		long term	child welfare	
4	Completing the DHS1927 Child Adoption Assessment	A job aid that shows how to complete the DHS-1927.	Adoptive home studies	75%	0.5	online		long term	child welfare	
5	Complying with the Mutiethnic Placement Act MEPA of 1994 and Interethnic Adoption Provisions IEAP of 1996	Provides information about MEPA and IEAP that adoption workers and foster care workers need to know	Training on referral to servicescase planning; case management	75%	1	online		long term	child welfare	
6	Note: Replaces Domestic Violence	Discusses definitions relating to domestic violence/intimate partner violence relationships, rationale and tactics used by abusers, impact of exposure to domestic violence, when	General issues related to children and families in child welfare systems	75%	1	online		long term	child welfare	

Title IV-E Training Matrix

	B	C	D	E	F	G	H	I	J	K
7	Education Requirements for Youth in Foster Care II	Attendees will learn about the new federal legislation, Every Student Succeeds Act, which is the first education legislation to include provisions to better serve youth who are in foster care. Attendees will also learn of the multiple college resources available for youth who have experienced foster care, including the Education and Training Voucher, the Tuition Incentive Program, the Fostering Futures Scholarship, and the work of campus based support programs, including the University of Michigan Blavin Program.	Case management and supervision; development of case plan; referral to services	75%	3	webinar	Education Planners	long term	Child Welfare	

Title IV-E Training Matrix

	B	C	D	E	F	G	H	I	J	K
8	Helping Adoptive Parents Apply for Adoption Assistance	This web-based training will show you how the Adoption and Guardianship Assistance Office determines adoption assistance eligibility and how you can help adoptive parents apply for adoption assistance programs	Negotiation and review of adoption assistance agreements	75%	0.5	online		long term	child welfare	

Title IV-E Training Matrix

	B	C	D	E	F	G	H	I	J	K
9	ICWA	<p>This CBT is designed to provide participants with knowledge to establish a fundamental understanding regarding Native American culture and history, and an introduction to Michigan’s federally recognized tribes. In addition, the participant will be provided a foundation in the ICWA, ICWA Mandates, DHS Office of Native American Affairs (NAA) and DHS Native American Affairs (NAA) policies and procedures. Participants will learn about the Michigan Indian Family Preservation Act (MIFPA) P.A. 565 of 2012. Participants will also learn about In Re Morris and In Re Gordon and how this impacts their duties and responsibilities when working with American Indian and Alaska Native children and families.</p>	Case planning; preparation for judicial determinations.	75%	1.5	online		long term	child welfare	

Title IV-E Training Matrix

	B	C	D	E	F	G	H	I	J	K
10	Management and Data-Driven Decision Making Training - Supervisor	During this recorded webinar, supervisors will learn the importance of data in child welfare. They will learn what data we use, why we use the data and how the data will improve case management	Generic skills needed to perform specific jobs	50%	1	online		long term	child welfare	
11	Management and Data-Driven Decision Making Training - Worker	During this recorded webinar, workers will learn the importance of data in child welfare. They will learn what data we use, why we use the data and how the data will improve case management	Generic skills needed to perform specific jobs	50%	1	online		long term	child welfare	
12	Mentoring PSI New Hires	This online course is intended for experienced caseworkers (CPS, Foster Care, and Adoption) who are or will be assigned to mentor a newly hired	Job performance enhancement skills	50%	1.5	online		long term	child welfare staff who will be mentoring PSI students	
13	MiTEAM Specialist and Liaison - Roles and Responsibilities	This course is a high-level introductory overview for the MiTEAM specialist position—previously known as a peer coach.	Social work practice - family centered practice; development of case plan	75%	1	online		long term	MiTEAM Specialist	
14	Petition Writing for Child Welfare Workers	This course will educate caseworkers on how to draft initial and supplemental petitions in court for a child protective proceeding. This training will help a worker identify the purpose for a court petition, when to file one and how to draft and file one. It will also provide a	Job performance enhancement skills	50%	1	online		long term	child welfare	

Title IV-E Training Matrix

	B	C	D	E	F	G	H	I	J	K
15	Young Adult Voluntary Foster Care	Young Adult Voluntary Foster Care (YAVFC) is the extension of foster care services until the age of 21 for youth who were in state supervised foster care at the age of 18 or older. This training is a guide to the implementation of the Young Adult Voluntary Foster Care Act. Learners will be informed of federal and state legislation, eligibility criteria, program requirements and case management responsibilities.	Case planning	75%	1	online		long term	child welfare	

Title IV-E Training Matrix

	B	C	D	E	F	G	H	I	J	K
16	*New A Guide to Critical Thinking in Child Welfare, DHS-3130a and DHS-588	This training will assist child welfare workers and supervisors in understanding the basics of critical thinking and help support the development of critical thinking skills utilized in the completion of thorough home assessments.	Communication skills related to working with children & families, social work practice	75%	1	online		long term	child welfare	
17	*New Abbreviated Licensing Training For Child Welfare Workers	A brief training to help CPS and Foster Care workers define the basic licensing application process, list pertinent licensing rules that apply to CPS and Foster Care placements, learn about the Family Incentive Grant (FIG) can help when licensing barriers exist.	Social work practice - family centered practice; development of case plan;	75%	1	online		long term	child welfare	

Title IV-E Training Matrix

	B	C	D	E	F	G	H	I	J	K
	Achieving Safety and Self-Sufficiency for Battered Women and Their Children <small>Note: This course replaces Domestic Violence</small>	Provides an introduction to the topic of domestic violence and the specific strategies that eligibility specialists and family independence specialists can use to help clients who are experiencing domestic violence. Produced in cooperation with the Michigan Domestic and Sexual Violence Prevention and Treatment Board.	General issues related to children and families in child welfare systems; case planning	75%	2	online		long term	child welfare	

Title IV-E Training Matrix

	B	C	D	E	F	G	H	I	J	K
19	<p>Caseworker-Child Visits</p> <p>Note: This course replaces CPS Caseworker Visits with Children and Foster Care - Adoption - JJ Caseworker Visits with Children</p>	<p>Find out what happens when MDHHS does not meet the federal goal for caseworker visits with children. Review your knowledge of policy for caseworker child visits by playing a fun trivia game. Discover the seven items that caseworkers commonly miss when documenting their visits in MiSACWIS</p>	<p>Social work practice - family centered practice; development of case plan; Participation in judicial findings.</p>	75%	1	online		long term	child welfare	
20	<p>*New</p> <p>MiTEAM Domestic Violence Enhancement Introduction</p>	<p>The MiTEAM Domestic Violence Enhancement Training is a perpetrator pattern based, child centered, survivor strengths approach to working with domestic violence. This is a pre-requisite to the classroom training.</p>	<p>case management and supervision; development of case plan; referral to services</p>	75%	2	online		long term	child welfare	

Title IV-E Training Matrix

	B	C	D	E	F	G	H	I	J	K
21	Working with the LGBTQ Community	Working with the LGBTQ Community is an appropriate course for staff who work directly with children in the child welfare system. Staff will learn about LGBTQ youth, the unique risks that LGBTQ youth in the child welfare system face, and the specific things staff can do to advocate for them. The course also covers how the new marriage equity laws apply to the work of foster care and adoption.	Social work practice, cultural competency, communication skills required to work with children in families, placement of the child, referral to services	75%	3	online		long term	child welfare	

	B	C	D	E	F	G	H	I	J
	Course/Module Title	Course Description	Title IV-E Administrative Function	FFP Rate	Hrs	Venue	Trainer	Duration	Target Audience
1									
2	<p><b>Allocation Methodology</b>  Costs for all courses are reduced by the title IV-E ratio to determine the IV-E eligible portion. The eligible portion is allocated between the Foster Care and Adoption Assistance programs by applying the FC/AA ratio. Each portion is claimed at either 50% or 75% FFP, for the respective programs.</p>								
3	Advanced adult Interviewing and Investigations	New techniques for interviewing clients and identify ways to improve communication skills with clients who may be deceptive. Attendees will also be refreshed on current DHS policy regarding investigative requirements.	adult interviewing skills	50%	6	classroom	multiple trainers	Long-term	child welfare

	B	C	D	E	F	G	H	I	J
4	Bringing MiTeam to Psychotropic Medication Consent	Foster care workers are charged with assisting children and families to achieve the goals of permanency, safety and well-being. Full integration of health and behavioral health care into case practice is critical, specifically when making decisions about psychotropic medications. This integration has been a challenge to achieve because it includes developing some degree of knowledge and expertise in the systems of medical care in addition to the child and family engagement embedded in the MiTEAM practice model. This conference will focus on psychotropic medication informed consent as an example of developing case practice integration. The specific topics included in the day will be: broadening the definition of MiTEAM case practice to include the process of decision making about psychotropic medications, engaging parents and youth during this process, defining the roles and activities of health and behavioral health providers in assessment and treatment of behavioral health problems, highlighting the commonalities in Shared Decision Making in health practice and the MiTEAM practice model and introducing new methods for managing psychotropic medication informed consent using MiSACWIS.	Development of case plan; referral to services	75%	6	classroom	Doctor	short term	child welfare
5	Child Welfare Funding Specialist - Refresher trainer	This 6 hour training is designed to provide the Child Welfare Funding Specialist with skills and knowledge on funding, court orders, legal status living, how to navigate MiSACWIS and resolve funding issues	Eligibility determinations and redeterminations	75%	6	classroom	Staff from Federal Compliance and Child Welfare Funding	long term	Child Welfare Funding Specialists
6	Child Welfare Funding Specialist Training (CWFS) - Day 1	Mandatory training for all new Child Welfare Funding Specialists and their supervisors. This training includes the process for determining a child's fund source. The primary focus is on title IV-E funding, which includes policy, legal requirements, MiSACWIS application, state systems and the impact of these determinations (correct and incorrect) on the Michigan foster care system.	Eligibility determinations and redeterminations	75%	6	classroom	Staff from Federal Compliance and Child Welfare Funding	long term	Child Welfare Funding Specialists

	B	C	D	E	F	G	H	I	J
7	Child Welfare Funding Specialist Training (CWFS) - Day 2	Mandatory training for all new Child Welfare Funding Specialists and their supervisors. This training includes the process for determining a child's fund source. The primary focus is on title IV-E funding, which includes policy, legal requirements, MISACWIS application, state systems and the impact of these determinations (correct and incorrect) on the Michigan foster care system.	Eligibility determinations and redeterminations	75%	6	classroom	Staff from Federal Compliance and Child Welfare Funding	long term	Child Welfare Funding Specialists
8	Child Welfare Funding Specialist Training (CWFS) - Day 3	Mandatory training for all new Child Welfare Funding Specialists and their supervisors. This training includes the process for determining a child's fund source. The primary focus is on title IV-E funding, which includes policy, legal requirements, MISACWIS application, state systems and the impact of these determinations (correct and incorrect) on the Michigan	Eligibility determinations and redeterminations	75%	6	classroom	Staff from Federal Compliance and Child Welfare	long term	Child Welfare Funding Specialists
9	Confidentiality Training for Child Welfare Workers	This class introduces new workers to confidentially for child welfare, including: HIPPA, substance abuse treatment, mental health and HIV/AIDS. State and Federal Law and policy are discussed, and legal prohibitions and penalties are addressed.	Confidentiality, referral to services,	75%	3	Classroom	Multiple trainers	Long-term	Child Welfare
10	Report Writing Skills for Child Welfare Note: Previously offered as two different classes, one for CPS and one for foster care. The curriculum now supports report and assessment writing across the continuum of care.	Caseworkers will gain an understanding of the importance of quality report writing; gain an understanding of the basic principles of behavior-based narrative writing; gain an understanding of the SMART goal writing method; will be able to identify MDHHS policy regarding FANS/CANS, Services Agreements, Social Work Contacts and write effective narratives.	communication skills, Preparation for and participation in judicial determinations	50%	6	classroom	multiple trainers	Long-term	child welfare

	B	C	D	E	F	G	H	I	J
11	Crucial Accountability for Workers	<p>Crucial Accountability is a program that was developed to address the difficulty many people experience with holding others accountable when agreements are not met; often one of the most challenging aspects of DHHS work. The skills trained will help participants to:</p> <ul style="list-style-type: none"> <li>- Address failure to meet expectations in a way that builds relationships and increases motivation.</li> <li>- Eliminate resistance by replacing fear and uncertainty with natural and enduring motivators and holding everyone accountable to the same standards, enhancing communication and trust.</li> <li>- Confront every broken promise or violated expectation in a way that not only solves the problem, but also strengthens relationships, improves engagement and offers opportunities for effective mentoring.</li> </ul> <p>The training teaches a straightforward step-by-step process for identifying and resolving performance gaps, mastering face-to-face performance discussions, motivating without using power, enabling without taking over, and moving to action. Throughout the training employees will have the opportunity to apply Crucial Accountability principles and skills to real life challenges that they may be facing.</p>	Communication skills related to working with children & families	75%	14	classroom	multiple certified trainers	long term	child welfare
12	Crucial Conversations	Effective communication in high stakes situations when there is disagreement and unpredictable emotional responses. Focuses on building relationships by consciously building a trusting relationship.	communication skills	75%	16		multiple trainers	long term	child welfare
13	Cultural Competence	Trainees will learn about the dynamics and importance of cultural competency.	Cultural competency related to children and families.	75%	6	classroom	multiple trainers	long term	child welfare

	B	C	D	E	F	G	H	I	J
14	Domestic Violence - FP	This training will provide the Family Preservation and Child Welfare workers with knowledge about domestic violence, its manifestations and effects on the family. How to identify domestic violence and conduct an assessment of the potential lethality of the situation will be covered, in addition to intervention techniques, the role of the family preservation provider and safety planning with survivors. The training will include use of case scenarios developed based on actual case situations, role playing exercises, handouts and video. The training also focuses on the work, which can be done with perpetrators of domestic violence. Participants will learn to use the guiding principles for work with domestic violence in families, assessment skills and specific interventions developed for working to support the non-offending parent and the children. Attendees will also experience the strength-based perspective as applied to domestic violence.	Social work practice, communication skills required work with children and families, child abuse and neglect issues, impact of child abuse and neglect and the child, family centered practice, activities designed to preserve, strengthen, and reunify the family. Case management and supervision; development of case plan; referral to services	75%	18	Classroom	Multiple trainers	Long term	Child Welfare
15	Domestic Violence Laws 1/2 Day	This training is devoted to an examination of the law related to domestic violence, as well as a review of the Personal Protection Order. Participants will learn how to advocate for women with the legal system, as well as establishing and activating the order of protection. An attorney who is knowledgeable in the area of domestic violence is the presenter for this session.	Preparation for and participation in judicial determinations, communication skills required to work with children and families	75%	3	Classroom	Multiple trainers	Long term	Child Welfare
16	Educational Opportunities for Students from Foster Care (also a 2016 version)	This training will provide attendees with information regarding policy and the education needs of youth in the foster care system. It is presented by Education Planners to child welfare staff, education staff, court staff, foster parents, and/or youth. The following may be covered in the 2-hour training: 1) State and federal education policy and procedure as it applies to youth in foster care. 2) College financial aid and resources. 3) Role and responsibilities of education planners.	Case management and supervision; development of case plan; referral to services	75%	3	classroom	multiple trainers	Long-term	child welfare/ educational planners

	B	C	D	E	F	G	H	I	J
17	Employee Engagement	This will be a classroom training for all of the DHS 1st and 2nd line supervisors. This training derived from the Employee Engagement surveys that suggested our management fell short in the areas of Leadership and Communication. The training teaches leaders at DHS how to gain effective communication and build trust with their team, in addition to managing through change. The class ends with participants creating their own Engagement plans	Team Building; worker retention	50%	3	classroom	multiple trainers	long term	MDHHS Child Welfare
18	Foster Home Certification	Foster Home License Certification Training for child placing agency staff. All staff and supervisors who complete ANY functions related to the licensure of foster homes must attend and pass the three-day class on certifying foster homes.	Recruitment and licensing of foster homes	75%	18	classroom	Division of Child Welfare Licensing staff	long term	licensing
19	Foster Home Complaint	Foster Home License Complaint Training for child placing agency staff. All staff and supervisors who complete ANY functions related to the licensure of foster homes must attend and pass the two-day class for conducting special investigations on foster homes.	investigation of child abuse and neglect	75%	12	classroom	Division of Child Welfare Licensing staff	long term	licensing
20	Human Trafficking	Introduction to the human trafficking protocol. Signs of human trafficking.	social work practice, Development of case plan; referral to services	75%	6	Classroom	Multiple trainers	Long term	child welfare
21	ICWA Refresher	This ½ day training will educate CPS, Foster Care, and Adoption workers on MDHHS policy regarding the Indian Child Welfare Act (ICWA) as well as the Michigan Indian Family Preservation Act (MIFPA) and how the two laws work together to help preserve Native American children and families.	Development of case plan; referral to services; preparation of judicial participation	75%	3	classroom	multiple with support from the Office of Native American Affairs	long term	child welfare
22	Incest-Affected Families I - FP	Designed to assist the in-home worker to utilize techniques in working with incest-affected families within a brief time period. Issues of engagement, assessment, goal setting and structuring for safety are discussed. Workers gain practical knowledge in skills for families through demonstrations case examples and role-plays.	Social work practice, communication skills required to work with children and families, child abuse and neglect issues, family	75%	6	classroom	multiple trainers	long term	child welfare/family preservation

	B	C	D	E	F	G	H	I	J
23	Incest-Affected Families I- FP	This workshop is designed to assist the in-home workers in working with Adult survivors of Incest/Sexual molestation. The focus of "dos and donts" when working with Adult Survivors will be addressed, along with practical techniques for giving support and guidance.	Social work practice, communication skills required to work with children and families, child abuse and neglect issues, family	75%	6	classroom	multiple trainers	long term	child welfare/family preservation
24	Increasing College Outcomes for Foster Youth - 2015	This course is designed to provide workers with education policy, YIT policy, Post-secondary resources for youth from foster care, including Education and Training Voucher (ETV), the application process and other financial opportunities.	Referral to services, Development of case plan	75%	3	classroom	multiple trainers	long term	child welfare
25	Infant Safe Sleep	Safe Sleep training is designed to raise awareness among child welfare staff to assess and address safe sleep with parents/caregivers and to engage them in putting the safe sleep education message in to practice.	How to address/treat child or family behaviors	75%	1.5	classroom	Michigan Public Health Institute	long term	child welfare
26	Influencer	Developing an effective and comprehensive influence strategy to overcome the long-term problems. Influencer training uses a combination of extensive in-class practice, group participation and personal planning to learn and develop the strategies for resolving tough issues.	communication skillsrequired to work with children and families	75%	8	classroom	Doug Finton/Bill Patric	Long term	child welfare
27	Introduction to DV and the Effects on Children	Participants will learn the guiding principles for work with domestic violence in families, assessment skills and ways to support the non-offending parent and the children. Attendees will also experience the strength-based perspective as applied to domestic violence.	Candidates for care	75%	6	classroom	multiple trainers		child welfare
28	Licensing Summit	This is a two-day summit with a focus on recruitment, retention and relevant foster care and licensing topics.	Recruitment and licensing of foster homes	75%	12	classroom	multiple trainers	short term	licensing and child welfare

	B	C	D	E	F	G	H	I	J
29	Mandated Reporter Train the Trainer	Participants will learn skills needed to provide training to Mandated Reporters to both internal and external stakeholders in child welfare to assist with making CPS complaints to Centralized Intake in accordance with the Michigan Child Protection Law.	Training topic not available under IVE but proper for administration of the IVE plan; general skills/knowledge	50%	1.5	classroom	CPS Program Office	long term	child welfare
30	MDHHS Early On Referral Process	Training on the MDHHS Early On referral process, Early On policy, CAPTA, Early On Services, and Early On referral documents.	Case management and supervision; development of case plan; referral to	75%	2	classroom	multiple trainers	Long-term	child welfare
31	Medical Issues in Child Abuse and Neglect	Medical identification of child abuse and neglect, medical needs of children in care, emergency and planned removal of children with medical needs and collecting documentation for adoption purposes are all explored.	social work practice, medical issues in working with children and families.	75%	3	Classroom	multiple trainers	long-term	child welfare
32	Medical/Mental Health: Attachment Theory and Practice	Reactive Attachment Disorder--Participants will develop a basic understanding of diagnostic criteria for Reactive Attachment Disorder and common presentations of same in children within the child welfare system. Participants will be informed of potential risks and barriers involved in working with children with Reactive Attachment Disorder as well as evidence-based treatment approaches for this condition.	social work practice	75%	6	classroom	DHS Medical Director	short term	child welfare
33	Medical/Mental Health: Issues in Child Welfare	Information about a broad array of mental health problems that children and adolescents experience. We will discuss brain-behavior relationships, assessment and diagnosis and treatment approaches (focusing on psychotropic medications but not ignoring other treatment options).	social work practice	75%	6	classroom	DHS Medical Director	short term	child welfare
34	Mental Health I - Interventions - FP	This one day workshop focuses on working with families with mental health issues such as schizophrenia, depression, bipolar disorder, or borderline personality disorder. Workers are given resources to help them protect the rights of family members who may be suffering from mental illness and safety planning	Case management and supervision; development of case plan; referral to services	75%	6	Classroom	Multiple trainers	Long term	Child Welfare

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35	Mental Health II - For Kids - FP	This one-day workshop focuses on providing workers with information regarding the issues of Bi-Polar Personality Disorder and Autism as these conditions relate to children. Teaches ways to assist parents/caretakers in finding resources in regards to treatment and support for their child(ren).	Social work practice, cultural competency, communication skills required to work with children and families, development of the case plan, family centered practice, referral to services, activities designed to preserve, strengthen, and reunify the family	75%	6	classroom	multiple trainers	Long term	child welfare/ family preservation
36	MiTEAM Domestic Violence Enhancement Training	The MiTEAM Domestic Violence Enhancement Training is a perpetrator pattern based, child centered, survivor strengths approach to working with domestic violence. Developed originally for child welfare systems, it has policy and practice implications for a variety of professionals and systems including domestic violence advocates, family service providers, courts, evaluators, domestic violence community collaborative and others. The behavioral focus of the model highlights the "how" of the work, offering practical and concrete changes in practice. The model has a growing body of evidence associated with it including recent correlations with a reduction in out of home placements in child welfare domestic violence cases. This training is designed to provide staff and supervisors with the knowledge and tools to confidently and effectively work with victims, perpetrators, and children of domestic violence	case management and supervision; development of case plan; referral to services	75%	24	classroom	multiple trainers	Long-term	child welfare

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37	Money Whisperer - FP	Information and tools to increase knowledge of money management techniques to Family Preservation staff to assist families in developing short-term and long-term healthy financial management skills.	Tools to provide specific financial services to families.	50%	6	classroom	multiple trainers	long term	child welfare/ family preservation
38	Personal Safety for Workers - FP	Basic safety in urban, rural and suburban areas. Participants will have an opportunity to explore with a home safety nurse the do's and don'ts of safety precautions for communicable diseases.	Worker safety	50%	6	Classroom	Multiple trainers	Long term	Child Welfare
39	Pride - Train the Trainer	PRIDE is a model for the development and support of resource families. It is designed to strengthen the quality of family foster care and adoption services by providing a standardized, structured framework for recruiting, preparing, and selecting resource families. It also provides foster parent inservice training and ongoing professional development.	Recruitment and licensing of foster homes; retention of foster homes, foster parent training.	75%	24	classroom	multiple trainers	Long term	licensing workers/ foster parent trainers
40	Safety By Design	This class is required for all child welfare caseworkers, supervisors, program managers, directors and those in supportive roles to these positions. The Safety by Design training will enhance the trainees' understanding of safety assessment and planning, as well as threatened harm policy and practice. As well as, provide frontline staff the opportunity to identify obstacles to the application of these policies and practices. Thorough and inclusive safety assessment and planning increases immediate child safety, assists in better placement decisions and can enhance worker relationships with families, courts and other community partners.	Case management and supervision; development of case plan; referral to services	75%	3	classroom	multiple trainers	long term	child welfare

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41	<p>Secondary Trauma, Burnout and how MiTeam can help (Note: This class used to be called Secondary Trauma. The curriculum was updated to train it through a MiTEAM lens.</p>	<p>Understanding the difference between secondary trauma and burnout and the importance of addressing these topics in child welfare work. Using Teaming, Engagement, Assessment and Mentoring to build and repair the culture in your office to reduce secondary trauma and burnout.</p>	<p>worker retention, stress management training</p>	50%	3	classroom	multiple trainers	Long term	child welfare/supervisors
42	<p>Self Care for Workers - FP</p>	<p>How to recognize and address stress from working with children and families at risk. The development of a personal care plan will be addressed and time will be given in the course of the day for sharing among participants.</p>	<p>Stress management training; worker retention</p>	50%	6	classroom	multiple trainers	Long term	child welfare/family preservation
43	<p>Self-Awareness</p>	<p>Examining how social workers' cultural background influences their view of different cultures. Participants will gain knowledge on how to individualize services to meet the cultural needs of service recipients.</p>	<p>Cultural competency, job performance enhancement</p>	75%	12	Classroom	Multiple trainers	Long term	Child Welfare
44	<p>Sexual Abuse</p>	<p>To provide child welfare staff with the opportunity to build needed knowledge and skills to define, assess, and provide quality services to identified victims of child sexual abuse and their families.</p>	<p>Case management and supervision; development of case plan; referral to services</p>	75%	3	Classroom	Multiple trainers	Long term	Child Welfare

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45	Solution Focus - FP	Overview of the Solution-Focused Brief Therapy Approach focusing on the five-question technique and interviewing to engage the family from a strength based approach.	social work practice, job performance enhancement	75%	6	classroom	multiple trainers	Long term	child welfare/ family preservation
46	Substance-Affected Families - FP	Working with families with children at imminent risk of removal for abuse, neglect, or delinquent behavior due to the existence of substance abuse within the family system. Methods of intervention are covered using case examples.	Social work practice, cultural competency, communication skills required to work with children and families, child abuse and neglect issues, family centered practice, referral to services. Development of case plan; case management and supervision	75%	12	Classroom	Multiple trainers	Long term	Child Welfare
47	Testifying in Court - FP	An overview of the probate court process involving Families First cases including court preparation, communicating with referring worker and attorneys, developing a legal case before taking the stand. A mock trial gives the opportunity to utilize the skills learned and practice testifying.	social work practice, preparation for and participation in judicial determinations	75%	6	classroom	multiple trainers	multiple trainers	family preservation/child welfare
48	The ABC's of Bullying	Identifying bullying behaviors and the impact on those involved.	social work practice	50%	6	Classroom	Multiple trainers	Long term	child welfare/ family preservation

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49	Trauma Informed Assessment Coaching Lab	This workshop is designed to raise participants' level of skill and confidence in using trauma informed assessments with children, youth and adults; and use the analysis phase of the assessment process to understand the underlying causes of the problem or behaviors.	Impact of child and abuse on children	75%	3	classroom	MiTEAM Consultants	short term	child welfare
50	Trauma Informed Assessment Supervisor Group	Workshop to support the supervisor, for them to support each other and to discuss how they could support their staff around learning and implementing the particular behaviors, skills related to assessment. The small group sessions previewed the competency, lessons taught in the coaching lab and related Quality Service Review practice indicator and fidelity measure.	General supervisory skills; team building & stress management	50%	2	classroom	MiTEAM Consultants	short term	child welfare
51	Trauma Informed Case Plan Implementation Lab	This lab was designed so, each participant could practice identifying strategies to strengthen the implementation of one family's plan – strengthen the collaboration with service providers, strengthen tracking and adjusting and celebrate the small steps of change with families.	Impact of child and abuse on children	75%	3	classroom	MiTEAM Consultants	short term	child welfare
52	Trauma Informed Case Planning Coaching Lab	This coaching lab is designed to raise participants' level of skill – and their confidence – in fostering a family's voice, choice, and resiliency in the case planning process. Participants will examine strategies for capturing family members' voices, enabling them to make empowered choices, and building their resiliency. Participants also will refine the art of brainstorming, a tool they can use to identify quality actions steps with a family and team.	Impact of child and abuse on children	75%	3	classroom	MiTEAM Consultants	short term	child welfare
53	Trauma Informed Case Planning Supervisor Group	Workshop to support the supervisor, for them to support each other and to discuss how they could support their staff around learning and implementing the particular behaviors, skills related to case planning. The small group sessions previewed the competency, lessons taught in the coaching lab and related Quality Service Review practice indicator and fidelity measure.	Impact of child and abuse on children	75%	2	classroom	MiTEAM Consultants	short term	child welfare
54	Trauma Informed Engagement Coaching Lab	This workshop is designed to raise participants' level of skill and confidence in using trauma-informed engagement skills; to practice the core condition of empathy; recognize and acknowledge the power differential that is inherent in our work with families; raise their awareness of personal biases and triggers that impede consistent engagement with families.	Impact of child and abuse on children	75%	3	classroom	MiTEAM Consultants	short term	child welfare
55	Trauma Informed Mentoring Coaching Lab	This lab was designed for staff to practice mentoring through helping those they serve navigate a system or processes, and provide and/or welcome feedback that leads to growth.	Impact of child and abuse on children	75%	3	classroom	MiTEAM Consultants	short term	child welfare

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56	Trauma Informed Mentoring Supervisor Group	Workshop to support the supervisor, for them to support each other and to discuss how they could support their staff around learning and implementing the particular behaviors, skills related to mentoring The small group sessions previewed the competency, lessons taught in the coaching lab and related Quality Service Review practice indicator and fidelity measure.	Impact of child and abuse on children	75%	2	classroom	MiTEAM Consultants	short term	child welfare
57	Trauma Informed Placement Coaching Lab	This lab was designed to connect the content of the skills taught to data (QSR, Outcomes, Fidelity Indicators and Key Performance Indicators). Participants will practice how to communicate small steps at each point of contact that build connections. Key steps to trauma-informed decision making process is also a skill taught. Participants list strategies to lessen trauma for a child in transition or being 'placed'. The impact of placement on workers and supervisors is explored.	Impact of child and abuse on children	75%	3	classroom	MiTEAM Consultants	short term	child welfare
58	Trauma Informed Placement Supervisor Group	Workshop to support the supervisor, for them to support each other and to discuss how they could support their staff around learning and implementing the particular behaviors, skills related to placement. The small group sessions previewed the competency, lessons taught in the coaching lab and related Quality Service Review practice indicator and fidelity measure.	Impact of child and abuse on children	75%	2	classroom	MiTEAM Consultants	short term	child welfare
59	Trauma Informed Prep Session	Designed to provide users with the basic information needed to practice the MiTEAM model using a trauma-informed lens. This session provided staff with the effects of trauma on the brain, the Adverse Childhood Experience (ACE) study regarding long term effects of trauma, the use of the CTAC trauma screen for children and youth, and secondary trauma.	Impact of child and abuse on children	75%	3	classroom	MiTEAM Consultants	short term	child welfare
60	Trauma Informed Teaming Coaching Lab	This workshop is designed to raise participants' level of skill and confidence in forming a meaningful team with children, youth, and adults; practice empowering the family to recruit team members who have cultural competence, technical competence, and time to fulfill commitments to focus on child/youth and family safety, permanence, and well-being.	Impact of child and abuse on children	75%	3	classroom	MiTEAM Consultants	short term	child welfare
61	Trauma Informed Teaming Supervisor Group	Workshop to support the supervisor, for them to support each other and to discuss how they could support their staff around learning and implementing the particular behaviors, skills related to teaming. The small group sessions previewed the competency, lessons taught in the coaching lab and related Quality Service Review practice indicator and fidelity measure.	Impact of child and abuse on children	75%	2	classroom	MiTEAM Consultants	short term	child welfare
62	Verbal De-escalation	Techniques and strategies for defusing verbal aggression and threats.	Worker safety	50%	3	classroom	multiple trainers	Long term	child welfare

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63	Women in Leadership Conference	This one day, women's only training is comprised of two parts and was created for public assistance and child welfare staff and supervisors seeking to gain leadership skills. The morning session is led by an OWDT trainer with group discussion and activities, designed to allow participants to gain/enhance their knowledge and skills in becoming effective leaders. The afternoon session is a panel discussion comprised of local women leaders who share insights and lessons learned about being a women in a leadership role and balancing work and home	job performance enhancement skills	50%	6	classroom	multiple trainers	Long-term	MDHHS staff
64	Working with LGBTQ Clients and Their Families	This course covers definitions of sex/gender, sexual orientation, sexual behavior, sexual identity and gender identity. Participants will use practice exercises to apply concepts. Videos of negative reactions, misguided reactions and positive worker responses are used. Participants learn about the unique needs of and learn tips to being an advocate for LGBTQ youth. Common language pitfalls are reviewed.	Cultural competency related to children and families, candidates for care	75%	6	classroom	multiple trainers	long term	family preservation and child welfare
65	Working With Teens	This ½ day training will educate CPS, Foster Care, and Adoption workers on MDHHS policy regarding working with teens and families. Changes in policy, YAVFC and MYOI will be discussed as well as engagement discussions.	Case management and supervision; development of case plan; referral to services	75%	3	classroom	multiple trainers	Long-term	child welfare
66	Family Engagement, Strength Based Solution Focus and Assessment	A training reinforcing engagement and assessment through a solution based focus.	Communication skills required to work with children and families.	75%	6	classroom	multiple trainers	Long-term	child welfare
67	Critical Thinking	This ½ day training will educate CPS, Foster Care, and Adoption workers on the use of Critical Thinking skills to enhance the use of structured decision making (SDM) tools and improve the accuracy of reports and decision making to improve outcomes for children and families.	Communication skills related to working with children & families, social work practice	75%	3	classroom	multiple trainers	long term	child welfare

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68	Leading Change for Program Managers	This is a training that is delivered to Program Managers within DHHS. The training was designed to allow Program Managers to assess how they adapt to change. Additionally understanding how quickly they are able to adapt to change will affect those that they lead. Participants will be able to identify the ways people will respond to change as well as be able to recognize how to overcome change resistance. Lastly, they will develop a Communication Plan that will assist Program Managers when communicating a change initiative.	job performance enhancement skills	50%	1.5	classroom	multiple trainers	long term	MDHHS staff
69	Building Teams Utilizing The PERMA Model	This course is designed for first line supervisors to identify the best way to apply the PERMA Model when building their team. The PERMA model is based on seeking positive emotion in our day, engagement or flow when completing tasks, building relationships, finding meaning in what we do, supporting staff with goals and rewarding accomplishments. Participants will also be able to recognize ways to offer active constructive feedback with their staff.	job performance enhancement skills	50%	3	classroom	multiple trainers	long term	MDHHS staff
70	Behaviors That Exemplify Your Leadership Skills	The Emerging Leader program is for first line staff. It includes 5 quickknowledge courses courses: Business Writing Basics, Valuing Diversity, Applying Leadership Basics, Building a Successful Team, and Managing Change. Additionally, participants will complete two half days class titled: Behaviors That Exemplify Your Leadership Skills and Communication Techniques for Effective Leadership. A supervisor will serve as a mentor to the participant throughout the program. The mentor role includes but is not limited to discussing the individual trainings with the mentee following a discussion guide, supporting the mentee with implementation goals that will allow the mentee to implement what they have learned on the job, as well as evaluating the mentee at the end of the course on their leadership skills.	job performance enhancement skills	50%	3	classroom	multiple trainers	long term	MDHHS staff
71	* New Trauma Screening Checklist Training 101	This Training prepares Child Welfare staff to complete the Trauma Screening checklist with children/ youth, parents and caregivers in an engaging way. Trauma informed practice is infused in the MiTEAM Practice model. This training also prepares staff to do resiliency case planning, engage partners and make referrals with results of the screens	Impact of child and abuse on children	75%	5	classroom	multiple trainers	long term	child welfare staff
72	Understanding and Navigating Informed Consent	This training describes informed consent, its connection to well-being, safety and permanency and the importance of the foster care worker's role. The majority of the training focuses on the nuts-and-bolts of obtaining consent by working through case vignettes, so supervisors are equipped to support workers' daily practice.	Confidentiality, referral to services,Case management and supervision; development of case plan;	75%	3	classroom	multiple trainers	long term	child welfare staff

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73	Young Adult Voluntary Foster Care (YAVFC)	Young Adult Voluntary Foster Care (YAVFC) is the extension of foster care services until the age of 21 for youth who were in state supervised foster care at the age of 18 or older. This training is a guide to the implementation of the Young Adult Voluntary Foster Care Act. Learners will be informed of federal and state legislation, eligibility criteria, program requirements and case management responsibilities.	Case planning	75%	3	classroom	multiple trainers	long term	child welfare staff
74	Youth Mental Health First Aid	Youth Mental Health First Aid is designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. Youth Mental Health First Aid is primarily designed for adults who regularly interact with young people. The course introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. Topics covered include anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including AD/HD), and eating disorders	How to address/treat child or family behaviors	50%	7	classroom	multiple trainers	long term	child welfare staff

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37	Job Performance enhancement skills	
38	Costs for this course are reduced by the title IV-E ratio to determine the IV-E eligible portion. The eligible portion is allocated between the Foster Care and Adoption Assistance programs by applying the FC/AA ratio. Each portion is claimed at 75% FFP, for the respective programs.	
39	Recruitment and licensing foster families; Retention, foster parent training	
40		

**Additional Ongoing Training**

Below are MDHHS instructor-led classroom trainings and the number of staff who completed each training between October 1, 2016 and December 31, 2017. Refer to the training matrix for courses that are IVE eligible.

<b>Title of Training</b>	<b>Number trained</b>
Adult Interviewing and Investigations	132
Child Welfare Funding Specialist - Refresher trainer	136
Child Welfare Funding Specialist Training (CWFS) - Day 1	100
Child Welfare Funding Specialist Training (CWFS) - Day 2	94
Child Welfare Funding Specialist Training (CWFS) - Day 3	106
CPS Report Writing 101	52
Crucial Accountability for Workers	214
Cultural Competence	230
Domestic Violence - FP	470
DV Laws (1/2 Day) - FP	66
Employee Engagement	58
Forensic Interviewing	79
Foster Home Certification and Complaint Training	347
ICWA Refresher	185
Incest-Affected Families I - FP	23
Incest-Affected Families I I- FP	22
Infant Safe Sleep	1151
Licensing Summit	277
Licensing Workload Study	182
Mandated Reporter Train the Trainer	114
MDHHS Early On Referral Process	156
Medical Issues in Child Abuse and Neglect	27
Mental Health I - Interventions - FP	50
Mental Health II - For Kids - FP	51
MiTEAM Domestic Violence Enhancement Training	2134
Money Whisperer - FP	26
Monitoring Worker Case Review Tool	104
Pathways to Potential Client Log Overview	129
Pediatric Abusive Head Trauma	45
Personal Safety for Workers - FP	97
Pride - Train the Trainer	249
Report Writing Skills for Child Welfare	31
Secondary Trauma	71
Self-Awareness	206
Self Care for Workers - FP	56
Sexual Abuse	28

Solution Focus - FP	88
Substance-Affected Families - FP	310
Testifying in Court - FP	46
Trauma Screening Checklist Training 101	247
Understanding and Navigating Informed Consent	486
Verbal De-escalation	143
Women in Leadership Conference	1498
Working with LGBTQ Clients and Their Families	84
Young Adult Voluntary Foster Care (YAVFC)	76
Youth Mental Health First Aid	53
Critical Thinking	61
Building Successful Teams PERMA Model	142
Emerging Leader	106

**The following computer-based trainings were offered:**

A Guide to Critical Thinking in Child Welfare, DHS-3130a and DHS-588	823
Abbreviated Licensing Training For Child Welfare Workers	766
Absent Parent Protocol	837
Achieving Safety and Self-Sufficiency for Battered Women and Their Children	241
Administrative Hearings Central Registry Expunction	154
Adoption Assistance Negotiation Recorded Webinar	24
Completing the DHS1927 Child Adoption Assessment	152
Complying with the Multiethnic Placement Act MEPA of 1994 and Interethnic Adoption Provisions IEAP of 1996	749
Caseworker-Child Visits	428
Interstate Compact on the Placement of Children (ICPC)	517
Introduction To Mental Health	1104
Introduction to Substance Abuse	1105
Law Enforcement Information Network Security Awareness	2277
Helping Adoptive Parents Apply for Adoption Assistance	144
Indian Child Welfare Act	1032
Management and Data-Driven Decision Making Training - Supervisor	21
Management and Data-Driven Decision Making Training - Worker	101
Mentoring PSI New Hires	83
MiTEAM Specialist and Liaison - Roles and Responsibilities	80
Petition Writing for Child Welfare Workers	205
MiTEAM Domestic Violence Enhancement Introduction	540
Poverty	1137

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Report Writing	546
Sexual Abuse	1066
Working Safe Working Smart (WSWS)	1363
Working with LGBTQ Youth	79
Working with the LGBTQ Community	566
Young Adult Voluntary Foster Care	569



Michigan Department of Health and Human Services  
**In-Service Child Welfare Training Initiative**  
**2017 Cohort**

**Final Evaluation Report**

March 2018

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# Introduction

**W**orking effectively as a child welfare worker or supervisor can be challenging. Keeping families safely together, reuniting families, or supporting new loving families requires a well-trained child welfare workforce. A professional needs to have extensive knowledge about child development, family dynamics, culture and community, trauma, evidence-based or promising approaches to helping children and families, and so much more. In addition to knowledge, multiple skills are required to assure child safety, promote permanency planning, and support the well-being of children and families. Gaining this knowledge and skills requires both initial professional education and training as well as an ongoing commitment and access to learning and improving. This is important work as child welfare professionals have the opportunity to save and transform lives by significantly helping children and families.

The in-service training program reported on in this evaluation report is the product of a dynamic partnership among nine Michigan schools of social work with accredited MSW programs and the Michigan Department of Health and Human Services (DHHS).

We appreciate the commitment and support of DHHS Director Nick Lyon, and his administrative team, particularly Dr. Herman McCall, training team leaders Dr. Stacie Gibson, Laura Schneider, and Kimberly Reese.

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Information for this report was gathered as part of an evaluation project conducted by Michigan State University.

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## Training Initiative Background

In 2009, the Michigan State University School of Social Work spearheaded a collaborative effort to assist the then Michigan Department of Human Services (DHS) to provide the resource for state child welfare workers and supervisors in meeting their in-service training requirements. The initiative was developed to promote professional competence and development, and better serve children and families. This initiative was also responsive to mandates contained in *Dwayne B. v. Granholm*, Civil Action Number 2:06-cv-13548, now named the *Dwayne B. v. Snyder* Modified Settlement Agreement and Consent Order, which was superseded and replaced with the “Implementation, Sustainability, and Exit Plan” in February 2016.

As part of this initiative, the accredited graduate social work programs in Michigan universities collaborated to offer in-service trainings to child welfare workers. In 2017, these universities included: Andrews University, Eastern Michigan University, Ferris State University, Grand Valley State University, the University of Michigan, Spring Arbor University, Wayne State University, Western Michigan University, and Michigan State University, which also coordinated the initiative and evaluated training activities. All trainings are approved for Continuing Education Credits for licensed social workers in Michigan.

The training initiative has evolved over time, expanding the number of professionals who can receive free training, expanding the number of workshops to meet increasing in-service training expectations, and offering workshops to the public when space was available.

**In 2009**, a pilot phase of statewide trainings was supported by Casey Family Programs (Seattle). In the six months these trainings were offered in 2009, more than 460 trainees attended 19 trainings on various topics provided in 13 different locations around the state.

**In 2010**, between January and September, the collaborative again offered in-service trainings to DHHS child welfare workers free of charge. Offered at a reduced rate in 2009, this time, child placement agency and child caring institution employees were also provided trainings for free. More than 640 individuals participated in 23 different trainings conducted at 10 locations around the state. These programs were funded and supported by the Michigan Department of Health and Human Services.

**In 2012**, between January and September, the university collaborative again offered trainings free of charge to DHHS child welfare workers, as well as private agencies that contract with the State of Michigan to provide child welfare services. These trainings continued to be funded by the Michigan Department of Health and Human Services to

“Fantastic! You held my attention. I learned and was provided the skills to continue to help children and families. THANK YOU! I plan to use this information from the training when I present at clinical meetings—can’t wait!”

—Oakland County CPA worker, 2009

“This was a wonderful opportunity to gain more knowledge in many different topics as well as obtain CEs at no cost! The facility and staff were wonderful! Thank you!”

—Ottawa County DHHS worker, 2010

“I felt this training was very beneficial and useful! The information presented was very useful/relevant to a case I am currently working on, so I am very satisfied!”

—Wayne County private child welfare agency worker, 2012

“Thank you for offering this particular training. I was so hungry for this information to use in my work.”

—*Ingham County clinical social worker, 2013*

“I love the topics, timing, and convenience of these SSW CEU programs.”

—*Kalamazoo County clinical social worker, 2014*

“I appreciate the opportunity to attend training through our local Michigan universities. I have found the trainings to be helpful and love the fact that I am able to obtain CEUs toward my social work license at no cost. Thank you!”

—*Genesee County private child welfare agency leadership trainee (supervisor), 2016*

“Very interesting, clear examples and relevant to child welfare.”

—*DHHS CPS worker from Van Buren/Kalamazoo, 2017*

“Great presenter, great training. very interesting topic, learned information that will enhance the direction of our program.”

— *DHHS Supervisor, Washtenaw, 2017*

support workers with the amplified professional development requirements to receive a minimum of 24 hours of in-service training annually. Over 900 individuals participated in 43 training events conducted at 15 locations around the state. Additionally, in 2012, Michigan State University made five one-hour courses available online to all DHHS and private agency child welfare workers.

**In 2013**, the training cohort spanned two years, with trainings being offered between September 2012 and August 2013. These trainings were also funded by the Michigan Department of Health and Human Services. Child welfare caseworkers were now required to receive a minimum of 32 hours of in-service training annually. More than 1,100 individuals participated in 44 trainings conducted in 16 cities around the state. Additionally, five trainings were made available to access free of charge through online course offerings.

**The 2014 Cohort** (between September 2013 and August 2014) provided training for more than 1,026 individuals who participated in 44 trainings conducted in 16 cities around the state. Additionally, five trainings were available to access free of charge through online course offerings.

**The 2015 Cohort** (between September 2014 and August 2015) involved more than 1,283 individuals who participated in 45 trainings conducted in 15 cities around the state. Additionally, five trainings were available to access free of charge through online course offerings (determining number of online participants is imprecise; however, in 2015, 295 workers completed pre-online training surveys).

**2016 Cohort.** Between October 2015 and September 2016, Michigan State University again led the Child Welfare In-Service training program, in partnership with the eight schools of Social Work in Michigan with MSW programs. Ferris State University and Spring Arbor University were the two newest partners to join in this initiative. Trainings were offered free of charge to DHHS child welfare workers and private agencies that contract with MDHHS to provide child welfare services. In addition to the array of in-person training, 19 live webinars that allowed for audience interaction were initiated, and MSU made available to the field a catalog of previously recorded online “On Demand” trainings. Trainings for a specific audience of leaders began and caregiver trainings were also added to the program. A train-the-trainer session was held in September 2016 to develop a network of trainers from across the state in strategies to engage foster, adoptive, and kinship parents, featuring approaches delivered through the caregiver trainings throughout the year. In total, 52 in-person trainings were offered in 23 cities, where more than 1,260 participants attended. An additional 355 child welfare professionals participated in 21 online trainings, and another 110 trainees accessed on demand previously recorded online trainings. Three in-person leadership trainings took place in 3 different cities, as well as two live online trainings and two on demand online trainings for this population. Three in-person caregiver trainings were also provided along with 2 live online trainings and 1 on demand training opportunities for caregivers.

**2017 Cohort.** Between October 2016 and September 2017, Michigan State University again led the Child Welfare In-Service training program, in partnership with the 8 schools of Social Work in Michigan with MSW programs. Trainings were offered free of charge to DHHS child welfare workers, and private agencies that contract with MDHHS to provide child welfare services. In total, 48 in-person trainings were offered in 24 locations, where more than 1,088 participants attended. An additional 510 child welfare professionals participated in 19 online trainings. Three in-person leadership trainings took place in 3 different cities, as well as two live online trainings and two on demand online trainings for this population. Four in-person caregiver trainings were also provided along with 2 live online trainings. Please refer to **Appendix A** for all training topics, locations, and learning objectives.



## The Evaluation Design

An evaluation of the 2017 training cohort was conducted to determine the effectiveness of utilizing the multi-university collaborative to provide in-service training to Michigan's child welfare workers. The results of the summative evaluation are contained in this report, along with demographic information about the trainees and the coordination/implementation of the trainings. A qualitative review gained information regarding the implementation process and trainees' future training needs. This information is also included and has been used to inform lessons learned and recommendations that are contained at the end of this report. The information is provided separately for each of the three training target groups in 2017: child welfare professionals, caregivers, and leaders.

### Evaluation Questions

The evaluation sought to answer the following five key questions:

1. Was the multi-university collaborative model successful in reaching child welfare workers throughout the state of Michigan?
2. Were participants satisfied with the training that they received?
3. Did the trainings increase participants' professional knowledge/skills, and were these trainings useful to their work?
4. Were improvements in training participants' professional knowledge/skills sustained over time?
5. What motivates trainees to participate in in-service trainings and what factors influence their ability to do so?

## Methodology

To evaluate the 2017 cohort, a non-experimental pre/post-test study design was used. Trainees were surveyed three times during the training period: immediately prior to and immediately after they received the training using a self-reporting questionnaire; and finally, through an online follow-up survey administered approximately two months after training. The survey instruments were created by the evaluation team in consultation with Michigan State University (MSU) Continuing Education Program staff members.

**The Pre-training Survey.** A 16-item survey was given to all trainees before each event. It was a self-administered tool to gather trainees' expectations about the training content and demographic information. For the professional trainees, this survey also collected information about their location and position of employment within child welfare, as well as their length of experience in the field. In addition, to help assess trainees' baseline level of competence regarding training subject matter before participating in the trainings, all of the trainees were asked to rate their level of competence on a scale of 1 (Not at All Competent) to 5 (Competent) for several instructor-identified learning objectives related to the course content. Pre-test questions also offered the opportunity for trainees to describe other potential topics of interest and the most convenient days and times for future training events to be held. The questions were both quantitative and qualitative. A sample of the instrument is provided in [Appendix B](#). Caregiver trainees received a slightly modified version of the pre-test consisting of 19 items, which added a few questions about caregiver type and length of time spent as a caregiver in place of the employment items on the traditional pre-test.

**The Post-training Survey.** An 11-item post-training survey instrument was given to all trainees immediately after each event. It was a self-administered tool to gather trainees' perceptions about the training, its usefulness in meeting their needs, assessments of trainees' self-reported competence on the instructor-identified objectives related to the course, and how trainees expected to implement the information from the training in their work with children and families in the child welfare system. A sample of the instrument is provided in [Appendix C](#).

**The Follow-up Survey.** A 7-item follow-up survey was created and distributed electronically by the evaluators two months after each in-person training event in order to assess participants self-rated competency related to the training-specific objectives and how trainees were using the information obtained from the training in their work. This survey was administered online through SurveyMonkey. Both quantitative and qualitative questions were asked. A sample of the instrument is provided in [Appendix D](#). All trainees, including child welfare professionals, leadership trainees, and caregiver trainees received a follow-up survey.

**Data Analysis.** Quantitative data from both surveys was analyzed descriptively using the SPSS statistical program, while qualitative information was examined for themes using a word processing program. The quantitative analysis includes an assessment of pre- to post-training changes in trainees' reported competency with respect to course learning objectives; and, in the case of the 14 MSU trainings, it also includes a pre- to post-training assessment of trainees' scores on content knowledge-based questions related to these learning objectives. The results were shared on an ongoing basis with participating schools.

## Limitations of the Study

The evaluation design for this initiative is non-experimental, meaning study subjects were not selected at random, nor were their outcomes compared to a control group of comparable subjects who did not participate in training. The knowledge and skill transfer findings reported here are based on trainee self-report. The extent to which a caseworker feels more competent in a topic after participating in training is an important indicator of training effectiveness; however, it is possible that some trainees feel more competent after attending training, but do not actually master essential course material (or vice versa). Additionally, not every trainee completed all three surveys (pre-, post-, and follow-up) for each individual training topic and so the evaluation results may be somewhat biased by the imperfect response rate. Consequently, caution must be taken in generalizing findings to the entire population of trainees. Of particular note, **Table 1A** shows that rate of return for the 2-month follow-up survey in the 2017 in-person training cohort was 19.4%. While this is similar to the follow-up survey response rate for the 2015 cohort (23.6%) and better than that of the 2014 cohort (12%), it is still low. Consequently, findings from this instrument should only be used to explore trends and areas of interest. Key findings from this evaluation follow.



## Descriptive Findings

### About the Trainings

**Child Welfare Professional Trainings: In-person.** As Table 1A indicates, the university collaborative provided 48 in-person training events during the 2017 initiative ranging in length from 3 to 6 hours. Training was provided to 1,088 participants, of whom 929 returned pre-training surveys (85.3% response rate), and 985 returned post-training surveys (81.9% response rate). There were a total of 211 follow-up surveys returned (19.4% response rate). In-person training events were offered in 24 different locations within 17 cities spread throughout Michigan and represented a total of 3,477 training hours.

**Child Welfare Professional Trainings: Online.** As Table 1B indicates, Michigan State University provided 19 unique hosted (live) online training opportunities that allowed for audience interaction. MSU has also made available to the child welfare field a catalog of previously recorded online “On Demand” trainings that can be accessed at any time. A total of 510 live online training participants returned 474 pre-training surveys (92.9% response rate) and 365 returned post-training surveys (71.5% response rate). In an online environment, there is no mechanism to determine completion without the participant completing the post-test. There is a larger number of participants who accessed the course than those who completed the course, thus, we are unable to determine with confidence the total number of training participants. There were a total of 111 online training follow-up surveys returned (21.7% response rate).

**Table 1A: Child Welfare Professional Trainings Offered In-person**

	In-person Trainings
Number of training events	48
Number of training locations	24
Number of training participants	1,088
Number of pre-training surveys returned	929 (85.3%)
Number of post-training surveys returned	891 (81.9%)
Number of follow-up surveys returned	211 (19.4%)
<b>Total number of training hours provided</b>	<b>3,477</b>

**Table 1B: Child Welfare Professional Trainings Offered Online**

	Hosted Webinar Trainings
Number of training events	19
Number of training locations	N/A
Number of training participants	510
Number of pre-training surveys returned	474 (92.9%)
Number of post-training surveys returned	365 (71.5%)
Number of follow-up surveys returned	111 (21.7%)
<b>Total number of training hours provided</b>	<b>≥510</b>

**Table 1C: Caregiver Trainings Offered**

	In-person Trainings	Hosted Online Trainings
Number of training events	4	2
Number of training locations	4	N/A
Number of training participants	64	≥105
Number of pre-training surveys returned	28 (43.8%)	100
Number of post-training surveys returned	28 (43.8%)	73
Number of follow-up surveys returned	3 (4.7%)	24
<b>Total number of training hours provided</b>	<b>192</b>	<b>≥105</b>

**Caregiver Trainings.** As Table 1C indicates, the university collaborative provided 4 in-person caregiver training events during the 2017 initiative ranging in length from 3 to 6 hours. Training was provided to 64 participants, of whom 28 returned pre-training surveys (43.8% response rate), and 28 returned post-training surveys (43.8% response rate). There were a total of 3 follow-up surveys returned (4.7% response rate). Additionally, Michigan State University provided 2 sessions of online training for this caregiver group. A total of at least 105 online training participants returned 100 pre-training surveys and 73 returned post-training surveys. In an online environment, there is no mechanism to determine completion without the participant completing the post-test. There is a larger number of participants who accessed the course than those who completed the course, thus, we are unable to determine with confidence the total number of training participants. There were a total of 24 follow-up surveys returned (22.8% response rate).

**Leadership Trainings.** As Table 1D indicates, the university collaborative provided 3 in-person leadership training events during the 2017 initiative ranging in length from 3 to 6 hours. Training was provided to 35 participants, of whom 35 returned pre-training surveys (100% response rate) and 30 returned post-training surveys (85.7% response rate). There were a total of 9 follow-up surveys returned (25.7% response rate). Additionally, Michigan State University provided 2 sessions of online training for this leadership group. A total of at least 82 online training participants returned 55 pre-training surveys and 41 returned post-training surveys. In an online environment, there is no mechanism to determine completion without the participant completing the post-test. There is a larger number of participants who accessed the course than those who completed the course, thus, we are unable to determine with confidence the total number of training participants. There were a total of 9 follow-up surveys returned.

**Table 1D: DHHS Leadership Trainings Offered**

	In-person Trainings	Hosted Online Trainings
Number of training events	3	2
Number of training locations	3	N/A
Number of training participants	35	≥82
Number of pre-training surveys returned	35	55
Number of post-training surveys returned	30	41
Number of follow-up surveys returned	9	4
<b>Total number of training hours provided</b>	<b>105</b>	<b>≥82</b>

## About the Trainees

### Demographics

**Child Welfare Professional Trainees: In-person.** Table 2A provides a description of the 2017 training cohort demographic characteristics. The large majority of in-person trainees were female (85.5%) and were most likely to be between the ages of 25 to 34 (36.1%). With regard to ethnicity, in-person training participants were most likely to identify as non-Hispanic. With regard to race, they were most likely to identify as Caucasian/White (86.7%) followed by African American/Black (4.3%).

In-person training participants were well educated, with (79.7%) reporting that their highest level of education was a bachelor's degree while one fifth (19.5%) reported that their highest level of education was a master's degree. Less than 1% reported other/multiple degrees. The

**Table 2A: Child Welfare Professional Training Participant Demographics (n=1,403)**

Demographics	2017 In-person Cohort (n=929)	2017 Online Cohort (n=474)	2017 Combined Cohort (n=1,403)
Gender			
Female	<b>757 (81.5%)</b>	<b>442 (93.2%)</b>	<b>1,199 (85.5%)</b>
Male	103 (11.1%)	18 (3.8%)	121 (8.6%)
I prefer not to answer	19 (2.0%)	5 (1.1%)	24 (1.7%)
Not provided	50 (5.4%)	9 (1.9%)	59 (4.2%)
Age			
Under 25 years old	46 (5.0%)	24 (5.1%)	70 (5.0%)
<b>25 to 29 years old</b>	154 (16.6%)	63 (13.3%)	<b>217 (15.5%)</b>
<b>30 to 34 years old</b>	<b>204 (22.0%)</b>	85 (17.9%)	<b>289 (20.6%)</b>
<b>35 to 39 years old</b>	110 (11.8%)	<b>90 (19.0%)</b>	200 (14.2%)
40 to 44 years old	91 (9.8%)	53 (11.2%)	144 (10.3%)
45 to 49 years old	94 (10.0%)	64 (13.5%)	158 (11.2%)
50 to 54 years old	66 (7.1%)	17 (3.6%)	83 (5.9%)
55 to 59 years old	34 (3.7%)	37 (7.8%)	71 (5.1%)
60 to 64 years old	47 (5.1%)	20 (4.2%)	67 (4.8%)
65 years old or older	25 (2.7%)	7 (1.5%)	32 (2.3%)
Not provided	58 (6.2%)	14 (2.9%)	72 (5.1%)
Ethnicity			
Spanish, Hispanic or Latino	2 (0.2%)	9 (1.9%)	11 (0.8%)
<b>Not Spanish, Hispanic or Latino</b>	<b>909 (97.8%)</b>	<b>442 (93.2%)</b>	<b>1,351 (96.3%)</b>
I prefer not to answer	9 (1.0%)	14 (3.0%)	23 (1.6%)
Not provided	9 (1.0%)	9 (1.9%)	18 (1.3%)
Race			
American Indian or Alaskan Native	0 (0.0%)	4 (0.8%)	4 (0.3%)
Asian Pacific Islander or Native Hawaiian	1 (0.1%)	9 (2.0%)	10 (0.7%)
Black or African American	19 (2.0%)	40 (8.4%)	59 (4.3%)
Multi-Race	1 (0.1%)	4 (0.8%)	5 (0.3%)
<b>White or Caucasian</b>	<b>822 (88.5%)</b>	<b>395 (83.3%)</b>	<b>1,217 (86.7%)</b>
I prefer not to answer	8 (0.8%)	11 (2.3%)	19 (1.4%)
Others	1 (0.1%)	2 (0.4%)	3 (0.2%)
Not provided	77 (8.4%)	9 (2.0%)	86 (6.1%)
Highest level of education			
BSW	273 (29.4%)	67 (14.1%)	340 (24.2%)
<b>BA/BS</b>	<b>467 (50.3%)</b>	165 (34.8%)	<b>632 (45.0%)</b>
<b>MSW</b>	170 (18.3%)	<b>177 (37.3%)</b>	347 (24.7%)
MA/MS	11 (1.2%)	44 (9.3%)	55 (3.9%)
Other/multiple degrees	5 (0.5%)	7 (1.5%)	12 (0.9%)
I prefer not to answer	0 (0.0%)	5 (1.1%)	5 (0.4%)
Not provided	3 (0.3%)	9 (1.9%)	12 (0.9%)

largest portion of in-person trainees in the 2017 cohort had obtained a Bachelor of Arts or a Bachelor of Science degree (50.3%). Another 29.4% reported that their highest degree obtained was a Bachelor of Social Work degree, and an additional 18.3% had a Master of Social Work degree.

**Child Welfare Professional Trainees: Online.** The large majority of online trainees were female (93.2%) and were most likely to be between the ages of 30 to 39 (36.9%). With regard to ethnicity, in-person training participants were most likely to identify as non-Hispanic. With regard to race, they were most likely to identify as Caucasian/White (83.3%) followed by African American/Black (8.4%).

Online training participants were well educated. Nearly half (46.6%) had a master's degree, and just over one third of the trainees in this group (37.3%) reported specifically having a Master of Social Work degree. Among the remaining trainees, 48.9% had a bachelor's degree.

**Caregiver Trainees: In-person.** Table 2B provides a description of the 2017 training cohort demographic characteristics of caregiver trainees. The majority of in-person trainees were female (71.4%) and were most likely to be between the ages of 35 and 44 (28.5%). With regard to ethnicity, in-person training participants were most likely to identify as non-Hispanic (85.7%). With regard to race, they were most likely to identify as Caucasian/White (84.6%).

In-person training participants most often reported attending some college or earning an associate's degree (57.1%), with an additional 10.7% indicating having a bachelor's degree, 10.7% having a master's degree, and 3.6% having a doctoral degree.

More than half (57.1%) of the trainees who participated in in-person caregiver training events were foster parents, while 42.9% indicated being an adoptive parent, and 28.6% reported being a kinship parent. Trainees indicated that they had been a foster parent for an average of 6.2 years, and an adoptive parent for an average of 6.8 years.

**Caregiver Trainees: Online.** The large majority of online caregiver trainees were female (86.0%) and were most likely to be between the ages of 35 to 44 (41%). With regard to ethnicity, online caregiver training participants were most likely to identify as non-Hispanic. With regard to race, they were most likely to identify as Caucasian/White (91%) followed by African American/Black (5%).

Online caregiver training participants were well educated, with 38.0% having a bachelor's degree and 28.0% having a master's degree. Another 29.0% reported that their highest degree obtained was an associate's degree or some college. Approximately 4% indicated having a high school degree or GED.

Caregiver trainees who participated in online training events were most often foster parents (61.0%), adoptive parents (34.0%) or other caregivers (13.0%). Online caregiver trainees indicated that they had been a foster parent for an average of 2.8 years, and an adoptive parent for an average of 6.3 years.

**Leadership Trainees: In-person.** Table 2C provides a description of the 2017 training cohort demographic characteristics of DHHS leadership trainees. The large majority of in-person leadership trainees were female (86.1%) and were most likely to be between the ages of 30 to 44 (55.5%). With regard to ethnicity, in-person leadership training participants were most likely to identify as non-Hispanic (80.6%). With regard to race, they were most likely to identify as Caucasian/White (61.1%) followed by African American/Black (27.8%).

In-person leadership training participants were well educated, with 72.2% having a master's degree. The largest portion of in-person trainees in the 2017 cohort had obtained a Master of

**Table 2B: Caregiver Training Participant Demographics (n=128)**

Demographics	2017 In-person Cohort (n=28)	2017 Online Cohort (n=100)	2017 Combined Cohort (n=128)
Gender			
<b>Female</b>	<b>20 (71.4%)</b>	<b>86 (86%)</b>	<b>106 (82.8%)</b>
Male	5 (17.8%)	12 (12.0%)	17 (13.2%)
I prefer not to answer	0 (0.0%)	0 (0.0%)	0 (0.0%)
Not provided	3 (10.7%)	2 (2.0%)	5 (3.9%)
Age			
Under 25 years old	0 (0.0%)	3 (3.0%)	3 (2.3%)
25 to 29 years old	0 (0.0%)	8 (8.0%)	8 (6.3%)
30 to 34 years old	1 (3.6%)	5 (5.0%)	6 (4.7%)
<b>35 to 39 years old</b>	<b>5 (17.8%)</b>	<b>26 (26.0%)</b>	<b>31 (24.2%)</b>
40 to 44 years old	3 (10.7%)	15 (15.0%)	18 (14.0%)
<b>45 to 49 years old</b>	<b>7 (25.0%)</b>	<b>18 (18.0%)</b>	<b>25 (19.5%)</b>
50 to 54 years old	2 (7.1%)	9 (9.0%)	11 (8.6%)
55 to 59 years old	1 (3.6%)	9 (9.0%)	10 (7.8%)
60 to 64 years old	3 (10.7%)	4 (4.0%)	7 (5.5%)
65 years old or older	2 (7.1%)	2 (2.0%)	4 (3.1%)
Not provided	4 (14.3%)	1 (1.0%)	5 (3.9%)
Ethnicity			
Spanish, Hispanic or Latino	0 (0.0%)	0 (0.0%)	0 (0.0%)
<b>Not Spanish, Hispanic or Latino</b>	<b>24 (85.7%)</b>	<b>97 (97.0%)</b>	<b>121 (94.5%)</b>
I prefer not to answer	2 (14.2%)	3 (3.0%)	7 (5.5%)
Race			
American Indian or Alaskan Native	1 (3.6%)	1 (1.0%)	2 (1.6%)
Asian Pacific Islander or Native Hawaiian	0 (0.0%)	1 (1.0%)	1 (0.8%)
Black or African American	2 (7.1%)	5 (5.0%)	7 (5.5%)
Multi-Race	0 (0.0%)	1 (1.0%)	1 (0.8%)
<b>White or Caucasian</b>	<b>22 (78.5%)</b>	<b>91 (91.0%)</b>	<b>113 (88.2%)</b>
I prefer not to answer	0 (0.0%)	1 (1.0%)	1 (0.8%)
Others	0 (0.0%)	0 (0.0%)	0 (0.0%)
Not provided	3 (10.7%)	0 (0.0%)	3 (2.3%)
Highest level of education			
High school diploma/GED	2 (7.1%)	4 (4.0%)	6 (4.7%)
<b>Some college or associate's degree</b>	<b>16 (57.1%)</b>	<b>29 (29%)</b>	<b>45 (35.1%)</b>
<b>Bachelor's degree</b>	<b>3 (10.7%)</b>	<b>38 (38.0%)</b>	<b>41 (32.0%)</b>
Master's degree	3 (10.7%)	28 (28.0%)	31 (24.2%)
Doctoral degree	1 (3.6%)	0 (0.0%)	1 (0.8%)
I prefer not to answer	0 (0.0%)	0 (0.0%)	0 (0.0%)
Not provided	3 (10.7%)	1 (1.0%)	4 (3.1%)
Type of caregiver*			
<b>Foster parent caregiver</b>	<b>16 (57.1%)</b>	<b>61 (61.0%)</b>	<b>77 (60.1%)</b>
Adoptive parent caregiver	12 (42.9%)	34 (34.0%)	46 (35.9%)
Kinship/relative caregiver	8 (28.6%)	7 (7.0%)	15 (11.7%)
Other caregiver	3 (10.7%)	13 (13.0%)	16 (12.5%)
Not provided	5 (10.7%)	24 (24.0%)	29 (22.6%)
Mean number of years as foster parent caregiver	6.2 years (n=16)	2.8 years (n=61)	3.6 years (n=77)
Mean number of years as adoptive parent caregiver	6.8 years (n=12)	6.3 years (n=34)	6.5 years (n=46)

\*These percentages will not add up to 100% because caregivers could be more than one type of caregiver.

Social Work degree (58.3%). Another 13.9% reported that their highest degree obtained was a Master of Arts or a Master of Science degree. Nearly 17% indicated having a bachelor's degree.

**Leadership Trainees: Online.** The majority of online leadership trainees were female (92.7%) and were most likely to be between the ages of 35 to 44 (47.3%). With regard to ethnicity, in-person leadership training participants were most likely to identify as non-Hispanic (90.9%). With regard to race, they were most likely to identify as Caucasian/White (85.5%) followed by African American/Black (7.3%).

Online leadership training participants were well educated, with 69.1% having a master's degree. The largest portion of in-person trainees in the 2017 cohort had obtained a Master of Social Work degree (56.4%). Another 21.8% reported that their highest degree obtained was a Bachelor of Arts degree.

**Table 2C: Leadership Training Participant Demographics (n=91)**

Demographics	2017 In-person Cohort (n=36)	2017 Online Cohort (n=55)	2017 Combined Cohort (n=91)
Gender			
Female	<b>31 (86.1%)</b>	<b>51 (92.7%)</b>	<b>82 (90.1%)</b>
Male	1 (2.8%)	2 (3.6%)	3 (3.3%)
I prefer not to answer	1 (2.8%)	2 (3.6%)	3 (3.3%)
Not provided	3 (8.3%)	0 (0.0%)	3 (3.3%)
Age			
Under 25 years old	0 (0.0%)	0 (0.0%)	0 (0.0%)
25 to 29 years old	3 (8.3%)	4 (7.3%)	7 (7.7%)
<b>30 to 34 years old</b>	<b>8 (22.2%)</b>	10 (18.2%)	18 (19.8%)
35 to 39 years old	4 (11.1%)	12 (21.8%)	16 (17.6%)
<b>40 to 44 years old</b>	<b>8 (22.2%)</b>	<b>14 (25.5%)</b>	<b>22 (24.2%)</b>
45 to 49 years old	4 (11.1%)	3 (5.4%)	7 (7.7%)
50 to 54 years old	1 (2.8%)	6 (10.9%)	7 (7.7%)
55 to 59 years old	2 (5.5%)	4 (7.3%)	6 (6.6%)
60 to 64 years old	0 (0.0%)	2 (3.6%)	2 (2.2%)
65 years old or older	1 (2.8%)	0 (0.0%)	1 (1.1%)
Not provided	5 (13.9%)	0 (0.0%)	5 (5.5%)
Ethnicity			
Spanish, Hispanic or Latino	0 (0.0%)	0 (0.0%)	0 (0.0%)
<b>Not Spanish, Hispanic or Latino</b>	<b>29 (80.6%)</b>	<b>50 (90.9%)</b>	<b>79 (86.8%)</b>
I prefer not to answer	4 (11.1%)	5 (9.1%)	9 (9.9%)
Not provided	3 (8.3%)	0 (0.0%)	3 (3.3%)
Race			
American Indian or Alaskan Native	0 (0.0%)	0 (0.0%)	0 (0.0%)
Asian Pacific Islander or Native Hawaiian	0 (0.0%)	2 (3.6%)	2 (2.2%)
Black or African American	10 (27.8%)	4 (7.3%)	14 (15.4%)
Multi-Race	0 (0.0%)	0 (0.0%)	0 (0.0%)
<b>White or Caucasian</b>	<b>22 (61.1%)</b>	<b>47 (85.5%)</b>	<b>69 (75.8%)</b>
Not provided	4 (11.1%)	2 (3.6%)	6 (6.6%)
Highest level of education			
BSW	0 (0.0%)	3 (5.5%)	3 (3.3%)
BA/BS	6 (16.7%)	12 (21.8%)	18 (19.8%)
<b>MSW</b>	<b>21 (58.3%)</b>	<b>31 (56.4%)</b>	<b>52 (57.1%)</b>
MA/MS	5 (13.9%)	7 (12.7%)	12 (13.2%)
Other/multiple degrees	1 (2.8%)	2 (3.6%)	3 (3.3%)
I prefer not to answer	3 (8.3%)	0 (0.0%)	3 (3.3%)

## Employment Characteristics

**Child Welfare Professional Trainees: In-person.** Table 3A provides a description of the 2017 training cohort by employer, position at the time of the training, and number of years working in child welfare and with their current employer. As the data indicate, the largest category of in-person trainees in 2017 were employed by Michigan DHHS (55.5%) and a little more than a quarter of the trainees (28.1%) were employed by private child welfare agencies. The remaining 16.4% were clinicians in private practice (2.0%) employed by mental health agencies (1.4%), schools or intermediate school districts (ISDs) (1.6%), “other” agencies/ organizations (6.8%), or failed to answer the question (4.6%).

In regard to in-person child welfare professional trainees’ positions at the time of training, a large portion were , foster care workers, child protective service workers, and adoption workers (21.3%, 13.5% and 5.0% respectively). There were 112 child welfare licensing staff (12.1%) and 95 supervisors (10.2%). Additionally, there were 66 participants (7.1%) who indicated working in mental health and 16 who identified as teaching or school personnel (1.7%). Approximately 24% of these trainees indicated that they were employed with some “other” area of focus.

In-person child welfare professional trainees most commonly identified as having worked in child welfare between 5 and 10 years (32.7%) and having worked for their current employer between 5 and 10 years (31.5%).

**Child Welfare Professional Trainees: Online.** The largest category and majority of child welfare professional online trainees in 2017 were employed by the Michigan Department of Health and Human Services (45.6%) or by private child welfare agencies (40.9%). Additionally, 1.7% were clinicians in private practice while 0.4% were employed by school systems or universities and 0.4% were employed by mental health agencies. The remaining 11.0% either did not respond to the question (4.0%) or were employed by “other” agencies/organizations (7.0%). The types of employers represented in the “other” category predominantly include non-contract private child and family service organizations.

In regard to online child welfare professional trainees’ position at the time of training, 14.8% were supervisors while others were foster care workers, adoption workers or child protective service workers (18.8%, 8.2% and 8.2% respectively). There were 27 mental health workers (5.7%), 52 Licensing Specialists (11.0%), and 4 teaching/school personnel (0.8%) who attended online training.

Online child welfare professional trainees most commonly identified as having worked in child welfare between 5 and 10 years (31.0%) and having worked at their current employer between 5 and 10 years (26.4%).

**Caregiver Trainees: In-person.** Almost 54% of caregiver trainees who attended training in-person reporting being employed full time while 7.1% reported being employed part time. Three caregivers (10.7%) who attended in person training indicated being retired and 10.7% indicated being unemployed and not looking for work.

**Caregiver Trainees: Online.** The largest category and majority of 2017 caregiver trainees who attended training online reporting being employed full time (73.0%), while 11.0% indicated being employed part time.

**Leadership Trainees: In-person.** Table 3C provides a description of the 2017 leadership training cohort by employer, position at the time of the training, and number of years working in child welfare and with their current employer. As the data indicate, the largest category of in-person leadership trainees in 2017 were employed by Michigan DHHS (55.5%) and 27.8% were employed by private child welfare agencies. An additional 8.4% indicated

**Table 3A: Child Welfare Professionals Training Participant Employment Characteristics (n=1,403)**

Employment Characteristics	2017 In-person Cohort (n=929)	2017 Online Cohort (n=474)	2017 Combined Cohort (n=1,403)
Employer at time of training			
Michigan Department of Health and Human Services	516 (55.5%)	216 (45.6%)	732 (52.2%)
Private child welfare agency	261 (28.1%)	194 (40.9%)	455 (32.4%)
Clinician in private practice	19 (2.0%)	8 (1.7%)	27 (1.9%)
CMH/mental health agency	13 (1.4%)	2 (0.4%)	15 (1.1%)
School/ISD/university	15 (1.6%)	2 (0.4%)	17 (1.2%)
Other	63 (6.8%)	33 (7.0%)	96 (6.8%)
Multiple roles	0 (0.0%)	0 (0.0%)	0 (0.0%)
Healthcare/hospital	0 (0.0%)	0 (0.0%)	0 (0.0%)
Retired	0 (0.0%)	0 (0.0%)	0 (0.0%)
Unemployed	0 (0.0%)	0 (0.0%)	0 (0.0%)
I prefer not to answer	42 (4.6%)	19 (4.0%)	61 (4.4%)
Position at time of training			
Child Protective Services (CPS) worker	125 (13.5%)	39 (8.2%)	164 (11.7%)
Foster care worker	198 (21.3%)	89 (18.8%)	287 (20.4%)
Adoption worker	46 (5.0%)	39 (8.2%)	85 (6.6%)
Supervisor	95 (10.2%)	70 (14.8%)	165 (11.7%)
Licensing staff	112 (12.1%)	52 (11.0%)	164 (11.7%)
Mental health	66 (7.1%)	27 (5.7%)	93 (6.6%)
Teaching/school personnel	16 (1.7%)	4 (0.8%)	20 (1.4%)
Other	222 (23.9%)	125 (26.4%)	347 (24.7%)
Multiple roles	0 (0.0%)	0 (0.0%)	0 (0.0%)
Retired	0 (0.0%)	0 (0.0%)	0 (0.0%)
Not provided	46 (5.2%)	27 (6.1%)	73 (5.2%)
Years in child welfare			
Less than 1 year	226 (24.3%)	33 (7.0%)	259 (18.5%)
1 - 2 years	182 (19.6%)	70 (14.8%)	252 (18.0%)
3 - 4 years	70 (7.5%)	50 (10.5%)	120 (8.5%)
5 - 10 years	303 (32.7%)	147 (31.0%)	450 (32.1%)
11 - 15 years	12 (1.3%)	50 (10.5%)	72 (5.1%)
16 - 20 years	92 (9.9%)	59 (12.4%)	151 (10.8%)
21 - 25 years	5 (0.5%)	14 (3.0%)	19 (1.5%)
More than 25 years	22 (2.4%)	39 (8.2%)	61 (4.3%)
Not provided	17 (1.8%)	12 (2.6%)	29 (2.1%)
Years with current employer			
Less than 1 year	117 (12.6%)	63 (13.3%)	180 (12.8%)
1 - 2 years	143 (15.4%)	97 (20.5%)	240 (17.1%)
3 - 4 years	134 (14.4%)	66 (13.9%)	200 (14.2%)
5 - 10 years	293 (31.5%)	125 (26.4%)	418 (29.8%)
11 - 15 years	58 (6.2%)	38 (8.0%)	96 (6.8%)
16 - 20 years	62 (6.7%)	42 (8.9%)	104 (7.4%)
21 - 25 years	20 (2.2%)	6 (1.3%)	26 (1.9%)
More than 25 years	43 (4.6%)	22 (4.6%)	65 (4.7%)
Not provided	59 (6.4%)	15 (3.1%)	74 (5.3%)

**Table 3B: Caregiver Training Participant Employment Characteristics (n=128)**

Employment Characteristics	2017 In-person Cohort (n=28)	2017 Online Cohort (n=100)	2017 Combined Cohort (n=128)
Employment status			
Employed full-time	15 (53.5%)	73 (73.0%)	88 (68.7%)
Employed part-time	2 (7.1%)	11 (11.0%)	13 (10.1%)
Retired	3 (10.7%)	5 (5.0%)	8 (6.3%)
Unemployed - not looking for work	3 (10.7%)	10 (10.0%)	13 (10.1%)
Not provided	5 (17.8%)	1 (1.0%)	6 (4.6%)

**Table 3C: Leadership Training Participant Employment Characteristics (n=91)**

Employment Characteristics	2017 In-person Cohort (n=36)	2017 Online Cohort (n=55)	2017 Combined Cohort (n=91)
Employer at time of training <b>Michigan Department of Health and Human Services</b>	<b>20 (55.5%)</b>	<b>31 (56.4%)</b>	<b>51 (56.0%)</b>
Private child welfare agency	10 (27.8%)	22 (40.0%)	32 (35.2%)
Clinician in private practice	1 (2.8%)	0 (0.0%)	1 (1.1%)
CMH/mental health agency	1 (2.8%)	1 (1.8%)	2 (2.2%)
School/ISD/university	0 (0.0%)	0 (0.0%)	0 (0.0%)
Other	1 (2.8%)	1 (1.8%)	2 (2.2%)
Multiple roles	0 (0.0%)	0 (0.0%)	0 (0.0%)
Healthcare/hospital	0 (0.0%)	0 (0.0%)	0 (0.0%)
Retired	0 (0.0%)	0 (0.0%)	0 (0.0%)
Unemployed	0 (0.0%)	0 (0.0%)	0 (0.0%)
Not provided	3 (8.3%)	0 (0.0%)	3 (3.3%)
Position at time of training			
Child Protective Services (CPS) worker	0 (0.0%)	0 (0.0%)	0 (0.0%)
Foster care worker	3 (8.3%)	0 (0.0%)	3 (3.3%)
Adoption worker	0 (0.0%)	0 (0.0%)	0 (0.0%)
<b>Supervisor</b>	<b>23 (63.9%)</b>	<b>41 (74.5%)</b>	<b>64 (70.3%)</b>
Licensing staff	0 (0.0%)	0 (0.0%)	0 (0.0%)
Mental health	2 (5.6%)	1 (1.8%)	3 (3.3%)
Teaching/school personnel	0 (0.0%)	1 (1.8%)	1 (1.1%)
Other	5 (13.9%)	12 (21.9%)	17 (18.9%)
Multiple roles	0 (0.0%)	0 (0.0%)	0 (0.0%)
Retired	0 (0.0%)	0 (0.0%)	0 (0.0%)
Not provided	3 (8.3%)	0 (0.0%)	3 (3.3%)
Years in child welfare			
Less than 1 year	0 (0.0%)	2 (3.6%)	2 (2.2%)
1 - 2 years	0 (0.0%)	2 (2.6%)	2 (2.2%)
3 - 4 years	1 (2.8%)	3 (5.4%)	4 (4.4%)
<b>5 - 10 years</b>	<b>17 (47.2%)</b>	<b>19 (34.5%)</b>	<b>36 (39.6%)</b>
11 - 15 years	5 (13.9%)	13 (23.6%)	18 (19.8%)
16 - 20 years	4 (11.1%)	7 (12.7%)	11 (12.1%)
21 - 25 years	5 (13.9%)	6 (10.9%)	11 (12.1%)
More than 25 years	1 (2.8%)	3 (5.4%)	4 (4.4%)
Not provided	3 (8.3%)	0 (0.0%)	3 (3.3%)
Years with current employer			
Less than 1 year	0 (0.0%)	3 (5.4%)	3 (3.3%)
1 - 2 years	2 (5.6%)	2 (3.7%)	4 (4.4%)
3 - 4 years	4 (11.1%)	9 (16.4%)	13 (14.3%)
<b>5 - 10 years</b>	<b>13 (36.1%)</b>	<b>20 (36.4%)</b>	<b>33 (36.2%)</b>
11 - 15 years	4 (11.1%)	10 (18.2%)	14 (15.4%)
16 - 20 years	5 (13.9%)	5 (9.1%)	10 (11.0%)
21 - 25 years	2 (5.6%)	3 (5.4%)	5 (5.5%)
More than 25 years	3 (8.3%)	3 (5.4%)	6 (6.6%)
Not provided	3 (8.3%)	0 (0.0%)	3 (3.3%)

working as clinicians in private practice (2.8%), in mental health agencies (2.8%), or “other” agencies/organizations (2.8%).

In regard to in-person trainees’ positions at the time of training, a large majority (63.9%) reporting being supervisors. Three in-person trainees indicated being foster care workers (8.3%) while 2 trainees (5.6%) indicated being a mental health worker. In-person trainees most commonly identified as having worked in child welfare between 5 and 10 years (47.2%) and having worked for their current employer between 5 and 10 years (36.1%).

**Leadership Trainees: Online.** Based on survey findings, more than half of leadership trainees who attended online training in 2017 were employed by Michigan DHHS (56.4%) and 40.0% were employed by private child welfare agencies. An additional 1.8% indicated working in a mental health agency or “other” agencies/organizations (1.8%).

With regard to online trainees’ positions at the time of training, 74.5% reporting being supervisors. Online trainees most commonly identified as having worked in child welfare between 5 and 10 years (34.5%) and having worked for their current employer between 5 and 10 years (36.4%).

## How Trainees Heard About the Training

**Child Welfare Professional Trainees: In-person.** Further analysis was conducted on the 2017 Child Welfare Training Cohort to determine how they heard about the in-service trainings. As reported in Table 4A, the largest group of in-person trainees (47.4%) indicated that they learned about it through a special in-service catalog that was specifically designed for, and distributed to, state child welfare offices and private agencies currently contracted with the state to provide child welfare services. Email was the second most common way trainees reported learning about the training, with 1.2% indicating hearing about the training through this method of marketing. Table 4 provides additional response details.

**Child Welfare Professional Trainees: Online.** As reported in Table 4A, the largest group of online trainees (48.1%) indicated that they learned about it through the DHHS in-service training catalog. The Michigan State University School of Social Work’s Continuing Education website was the second most common way that online trainees reported learning about training (23.0%).

**Table 4A: Child Welfare Training Participants: How Did You Hear About the Training? (n=1,403)**

	2017 In-person Cohort (n=929)	2017 Online Cohort (n=534)	2017 Combined Cohort (n=1,403)
How did you hear about the training?			
<b>DHHS In-service Training Catalog</b>	<b>440 (47.4%)</b>	<b>288 (48.1%)</b>	<b>1,188 (81.2%)</b>
University newsletter/website	91 (9.8%)	52 (11.0%)	54 (3.7%)
Continuing Education website	133 (14.3%)	111 (23.4%)	116 (7.8%)
Email	134 (14.4%)	48 (10.1%)	60 (4.1%)
Word of mouth	45 (4.8%)	18 (3.8%)	23 (1.6%)
Other	40 (4.3%)	6 (1.3%)	10 (0.7%)
Not provided	46 (4.9%)	11 (2.3%)	12 (0.9%)

**Caregiver Trainees: In-person.** Further analysis was conducted on the 2017 Caregiver Cohort to determine how they heard about the in-service trainings. As reported in Table 4B, the largest group of in-person trainees (42.8%) indicated that they learned about it through a child welfare professional, while 17.3% learned about the training through an electronic flyer or DHHS in-service catalog. Table 4B provides additional response details.

**Caregiver Trainees: Online.** Child welfare professionals were the most commonly mentioned source of learning about the caregiver training, with 55% of trainees indicating this group was how they heard about the training. Email was mentioned by 13% of online trainees as how they learned about training while 9% of online trainees learned about training through an electronic flyer and 5% learned about the training through the Michigan State University School of Social Work’s Continuing Education website or other university newsletter/website (4%).

**Table 4B: Caregiver Training Participants: How Did You Hear About the Training? (n=128)**

	2017 In-person Cohort (n=28)	2017 Online Cohort (n=100)	2017 Combined Cohort (n=128)
How did you hear about the training?			
<b>Child welfare professional</b>	<b>12 (42.8%)</b>	<b>55 (55.0%)</b>	<b>67 (52.3%)</b>
Electronic flier/DHHS In-service Catalog	5 (17.9%)	9 (9.0%)	14 (10.9%)
University newsletter/website	1 (3.6%)	4 (4.0%)	5 (3.9%)
Continuing Education website	0 (0.0%)	5 (5.0%)	5 (3.9%)
Email	2 (7.1%)	13 (13.0%)	15 (11.5%)
Word of mouth	0 (0.0%)	5 (5.0)	5 (4.4%)
Other	4 (14.3%)	4 (4.0%)	8 (6.2%)
Not provided	4 (14.3%)	5 (5.0%)	9 (7.0%)

**Leadership Trainees: In-person.** Further analysis was conducted on the 2017 Leadership Cohort to determine how they heard about the in-service trainings. As reported in Table 4C, the largest group of in-person trainees (38.9%) indicated that they learned about it through a special in-service catalog that was specifically designed for, and distributed to, state child welfare offices and private agencies currently contracted with the state to provide child welfare services. Another 25.0% reported learning about leadership training opportunities through email. A continuing education website (5.6%), a university newsletter or website (5.6%), word of mouth (5.6%) were also indicated as ways that trainees learned about the training. Table 4C provides additional response details.

**Leadership Trainees: Online.** The largest group of online trainees (43.6%) indicated that they learned about leadership training through the DHHS in-service training catalog while 34.6% indicated hearing about the training via email.

**Table 4C: Leadership Training Participants: How Did You Hear About the Training? (n=91)**

	2017 In-person Cohort (n=36)	2017 Online Cohort (n=55)	2017 Combined Cohort (n=91)
How did you hear about the training?			
<b>DHHS In-service Training Catalog</b>	<b>14 (38.9%)</b>	<b>24 (43.6%)</b>	<b>38 (41.7%)</b>
University newsletter/website	2 (5.6%)	1 (1.8%)	3 (3.3%)
Continuing Education website	2 (5.6%)	6 (10.9%)	8 (8.8%)
Email	9 (25.0%)	19 (34.6%)	28 (30.8%)
Word of mouth	2 (5.6%)	2 (3.6%)	4 (4.4%)
Other	3 (8.3%)	3 (5.5%)	6 (6.6%)
Not provided	4 (11.0%)	0 (0.0%)	4 (4.4%)



## Evaluation Findings

### **Evaluation Question 1: Was the multi-university collaborative model successful in reaching child welfare workers throughout the state of Michigan?**

To facilitate access to professional development for child welfare professionals located throughout the state, trainings were offered at 24 separate locations in 16 different cities. Tables 5A and 5B detail these locations and lists the corresponding number of events and trainees associated with each site. A total of 1,088 trainees attended these events.

**Table 5A: Locations of 2017 Child Welfare Professionals Trainings (n=1,088)**

Host University	Training Site	City	# Training Events
Andrews University	Chan Shun Hall, 4185 E. Campus Circle Drive	Berrien Springs	5
Andrews University	Lory's Place, 445 Upton Drive	St. Joseph	1
Eastern Michigan University	Eastern Michigan University, 38777 W, Six Mile Road, Suite 400	Livonia	3
Ferris State University	Ferris State University, The University Center, 805 Campus Drive	Big Rapids	1
Ferris State University	West Campus Community Center	Big Rapids	1
Grand Valley State University	GVSU Pew Campus, Bicycle Factory, 201 Front Avenue SW	Grand Rapids	4
Grand Valley State University	GVSU Pew Campus, DeVos Center, Loosemore Auditorium, 401 Fulton Street West	Grand Rapids	1
Michigan State University	Kellogg Hotel and Conference Center	East Lansing	1
Michigan State University	Western Michigan University Beltline Conference Center, 2333 Beltline Avenue SE	Grand Rapids	1
Michigan State University	Greater Lansing Association of Realtors, 4309 Legacy Parkway	Lansing	2
Michigan State University	Houghton/Keweenaw Department of Health and Human Services	Houghton	1
Michigan State University	Ford Community and Performing Arts Center	Dearborn	1
Michigan State University	County Inn and Suites East By Carlson	Grand Rapids	1
Michigan State University	Great Wolf Lodge, 3575 North US Highway 31	Traverse City	2
Michigan State University	MSU Federal Credit Union	East Lansing	1
Michigan State University	VisTaTech Center, Schoolcraft College	Livonia	1
Michigan State University	Troy Community Center, 3179 Livernois	Troy	2
Spring Arbor University	Spring Arbor University	Lansing	1
University of Michigan	U of M School of Social Work, 1080 South University	Ann Arbor	5
Western Michigan University	Western Michigan University College of Health and Human Services, 1240 Oakland Drive	Kalamazoo	5
Wayne State University	Wayne State University Oakland Education Center, 33737 West 12 Mile Road	Farmington Hills	2
Wayne State University	Wayne State University Schoolcraft College Education Center, 18600 Haggerty Road	Livonia	1
Wayne State University	Wayne State University Advanced Technology Education Center, 14601 East 12 Mile Road	Warren	2
Wayne State University	DHHS, Western Wayne District Office	Inskter	1
<b>Total Number of Locations: 24</b>			

**Table 5B: 2017 Child Welfare Professionals In-Person Trainings (n=1,088)**

In-Person Training Date	Training Title	Host University	# of Participants
10.06.16	Claiming Shame Resilience and Self-Compassion in Adoption and Foster Care	Michigan State University	29
10.07.16	Collaborating with Schools to Enrich the Lives of Children and Families	Wayne State University	19
10.14.16	Engaging Resistant Clients	Spring Arbor University	5
10.14.16	Cultural Competence and Cultural Humility	University of Michigan	6
10.21.16	Overcoming Unconscious Bias in Child Welfare	Grand Valley State University	21
10.21.16	Social Work Ethics and Social Media More Than a Friend Request	Andrews University	23
10.26.16	Common Diagnosis and Essentials of Medication Management	Michigan State University	12
10.28.16	Understanding and Meeting Needs of Relative Caregivers	Western Michigan University	25
10.28.16	Navigating the Special Education System	Eastern Michigan University	24
11.03.16	Post-adoption Strategies and Services Designed to Avoid Broken Adoptions	Michigan State University	12
11.04.16	Formulation on Child Trauma: Developmental Effects and Intervention Strategies	Wayne State University	24
11.11.16	Supporting Gay and Lesbian Youth Living in Care	Eastern Michigan University	5
11.17.16	Not Going It Alone: The Role of Reflective Supervision in Increasing Staff Efficacy and Coping	University of Michigan	24
12.02.16	Adolescent Suicide Prevention and Intervention	Grand Valley State University	30
01.13.17	When Children Get Removed: Using Play to Reduce the Effects of Trauma	Grand Valley State University	35
01.20.17	Effective Recruitment and Retention Strategies for Foster and Adoptive Families	Michigan State University	26
01.20.17	Holding Them While They Grieve	University of Michigan	22
02.09.17	Making Trauma Informed Transitions for Children and Families	Michigan State University	27
02.10.17	Building Resiliency: Family Approaches to Surviving Substance Abuse	Wayne State University	24
02.17.17	Understanding Sexuality and Gender Expression	Western Michigan University	31
02.17.17	Infant Mental Health: The Importance of Attachment	Eastern Michigan University	31
03.10.17	Making a Difference: Open, Direct, and Honest TALK About Suicide	Andrews University	21
03.10.17	Loss and Grief for Children and Youth in Care	Eastern Michigan University	39
03.10.17	No Time for Goodbye: When a Loved One's Death Is Traumatic	Wayne State University	25
03.10.17	Workers' Cultural Identities, Values, and Beliefs: Where Do They Fit in Our Jobs?	Western Michigan University	28
03.17.17	Assessing and Treating Mental Health Concerns in Very Young Children	Wayne State University	25
03.24.17	Domestic Violence and Trauma-informed Services	Western Michigan University	46
04.07.17	Integrated Self-care for Helping Professionals	Western Michigan University	37
04.21.17	"ARMBandS" for Effective Treatment	Andrews University	19
04.21.17	MiTEAM Supervision and Mentoring	Grand Valley State University	19

Continued on next page

**Table 5B: 2017 Child Welfare Professionals In-Person Trainings (n=1,088) – Continued**

In-Person Training Date	Training Title	Host University	# of Participants
04.21.17	Impact of Childhood Neglect on Early Development: An Interdisciplinary Approach	Western Michigan University	34
04.28.17	Perspectives on Youth Substance Abuse	Wayne State University	26
05.05.17	Understanding Emotional and Mental Health Concerns of Youth	Spring Arbor University	7
05.11.17	Working with Children Who Have Attachment Issues	Michigan State University	32
05.11.17	Taking a Pulse: Examining Compassion Fatigue in Child Welfare	University of Michigan	16
05.19.17	Effective Placement Strategies for Children in Foster Care	Ferris State University	10
05.26.17	Did You Hear What I Said? Culture, Communication, and Conflict	Grand Valley State University	36
06.02.17	Addressing Suicide: A Culturally Responsive Approach to Prevention and Intervention	University of Michigan	30
06.09.17	Supporting African-American Youth in Schools	Eastern Michigan University	21
06.16.17	Helping the Helper! Recognizing and Treating Compassion Fatigue	Andrews University	20
06.22.17	Early Education and Child Welfare Services: Working Together	Michigan State University	18
06.23.17	Moving Toward Cultural Intelligence	Grand Valley State University	34
07.12.17	Putting Your Own Mask on First: Understanding Secondary Traumatic Stress and Self-care in the Workplace	Michigan State University	32
08.04.17	Transitioning to Higher Education: Improving Outcomes for Youth from Foster Care	Michigan State University	13
08.11.17	“¿Qué? Help Me Understand! Latino or Hispanic? Implications for Practice That Go Beyond the Spanish Language	Andrews University	3
09.08.17	Supporting Children Through Trauma and Grief	Andrews University	27
09.15.17	Trauma and Crisis Management for Children in Placement	Ferris State University	2
09.21.17	Promoting Healing Health and Wellness in Youth Who Have Been Sexually Abused and Experienced Other Trauma	Michigan State University	13
<b>Total Child Welfare Professional Trainees Across 48 Events</b>			<b>1,088</b>

**Table 5C: 2017 Child Welfare Professionals Webinar Trainings (n=510)**

Online Training Date	Training Title	Host University	# of Participants
10.21.16	Child Welfare: Your Role in Making Medicaid Happen	Michigan State University	16
10.24.16	Mindfulness Tools to Combat Secondary Trauma and Build Well-being Among Child Welfare Professionals	Michigan State University	22
11.08.16	Dissociative Coping in Traumatized Children	Michigan State University	39
12.08.16	Child Abuse and Neglect: The Signs, Symptoms and Consequences	Michigan State University	14
01.24.17	Fetal Alcohol Syndrome Disorder: What You Should Know	Michigan State University	32
02.10.17	Involving Fathers to Create Functional Families	Michigan State University	38
02.23.17	Promoting Health and Wellness for Foster Youth	Michigan State University	35
03.21.17	Teen Parents in Foster Care	Michigan State University	27
04.06.17	Intergenerational Trauma and Our Work with Birth Parents: Understanding the Bridge to Success	Michigan State University	29
05.02.17	Engagement, Readiness for Change, and Transition Planning	Michigan State University	29
05.12.17	Transitioning Youth Out of Foster Care	Michigan State University	22
05.12.17	Post Adoption Services: Assisting Adoptive Families to Avoid Disruption/Dissolution	Michigan State University	19
05.19.17	The Welfare of Children with Autism Spectrum Disorders and Their Families	Michigan State University	21
06.06.17	Understanding and Supporting Adoptive Families	Michigan State University	21
06.08.17	Accessing Special Education Supports for Children in Foster Care	Michigan State University	28
06.15.17	Psychological and Emotional Trauma in Children and Its Impact on Adoption/Foster Care and Family Development	Michigan State University	31
06.19.17	Child Welfare Workers: The Ethical Obligation and Opportunities to Advocate for Social Justice	Michigan State University	26
06.23.17	Honoring and Empowering Adolescents	Grand Valley State University	32
08.01.17	Having the Tough Conversations About Race with Your Clients	Michigan State University	29
<b>Total Child Welfare Professional Trainees Across 19 Webinar Events</b>			<b>510</b>

**Table 5D: On Demand Trainings (n=106)**

Course #	Title of On Demand Training	# of Participants
310	Finding and Utilizing Services for Adoptive Families	11
311	Hope and Resilience: Moving Past Secondary Traumatic Stress in Child Welfare Practice	6
312	Suicide Assessment, Management, and Intervention	8
313	Safety Planning	4
314	Effective Courtroom Advocacy	2
315	Children of Parents with Mental Illness	3
322	Parent-Child Attachment Relationships and the Effects of Attachment Disruption	8
324	Detection and Diagnosis of Substance Use Conditions	5
325	Working with Immigrant Children and Their Families	1
327	The Power of Peer Support for Foster and Adoptive Families	1
328	Creating Safety for Children	3
329	The Kinship Conundrum (and Ways to Address)	1
339	Leadership Principles of a Mobile Workforce	11
340	Positive Parenting with Very Young Children	4
346	When Addiction Trumps Relationships: Working with Mothers and Addiction	5
347	Working with Families Affected by Substance Abuse	1
349	Extending the Welcome Mat to Our Newest Americans	1
350	Never Too Old: Adoption as an Option for Older Youth	1
352	Cognitive Behavioral Therapy for Social Anxiety in Children	2
355	Indicators and Trends of Domestic Violence and Intervention Services	2
358	Through A Baby's Eyes: Foster Care, Parenting Time, and Transitions	1
359	The Healing Breath: Practicing Meditation and Self-Care as a Child Welfare Professional	1
362	Your Role in Making Medicaid Happen	3
363	Mindfulness Tools to Combat Secondary Trauma and Build Well-being Among Child Welfare Professionals	2
365	Dissociative Coping in Traumatized Children	4
371	Child Abuse and Neglect: The Signs, Symptoms, and Consequences	2
372	Trauma-Informed Caregiving (Part 1) Becoming Trauma Informed Parents	6
373	Fetal Alcohol Syndrome Disorder: What You Should Know	1
376	Promoting Health and Wellness for Foster Youth	1
381	Intergenerational Trauma and Our Work with Birth Parents: Understanding the Bridge to Success	2
390	Honoring and Empowering Adolescents	3
<b>Total</b>		<b>106*</b>

\*On Demand training events were not available during the entire period September 2017–February 2018 due to a transition in software. As a result, training attendance is likely significantly less than it would be if these events had been available all year.

**Table 5E: Location of 2017 Caregiver Trainings (n=169)**

Training Type	Training Title	Host University	Training Location	Reported Attendance
In Person	Claiming Shame Resilience and Self Compassion for Foster, Adoptive, Kin, and Birth Parents (10.22.16)	Michigan State University	Mt. Pleasant Comfort Inn and Suites Hotel and Conference Center, 224 South Mission, Mt. Pleasant MI 48858	6
In Person	Raising Traumatized Children (11.12.16)	Michigan State University	2125 University Park Drive, Okemos, MI 48864	12
In Person	True Grit of Self Care: Thriving in Foster, Adoptive and Kinship Families (05.05.17)	Michigan State University	Jackson College Maher Campus, 3000 Blake Road, Jackson, MI 49201	42
In Person	Parenting Youth Who Have Been Sexually Abused and Have Experienced Other Trauma (09.21.17)	Michigan State University	47420 State Highway M26, Suite 62, Houghton, MI 49931	4
Webinar	Becoming Trauma Informed Parents (01.19.2017)	Michigan State University	Online	79
Webinar	Is That Your REAL Mom? (03.07.17)	Michigan State University	Online	26
<b>Total Number of Caregiver Trainees Across 6 Events</b>				<b>169</b>

There were a total of 4 in-person caregiver training events and 2 online trainings offered to the 2017 cohort. Table 5E details these training topics and lists the corresponding number of trainees associated with each training. A total of 169 trainees attended these events.

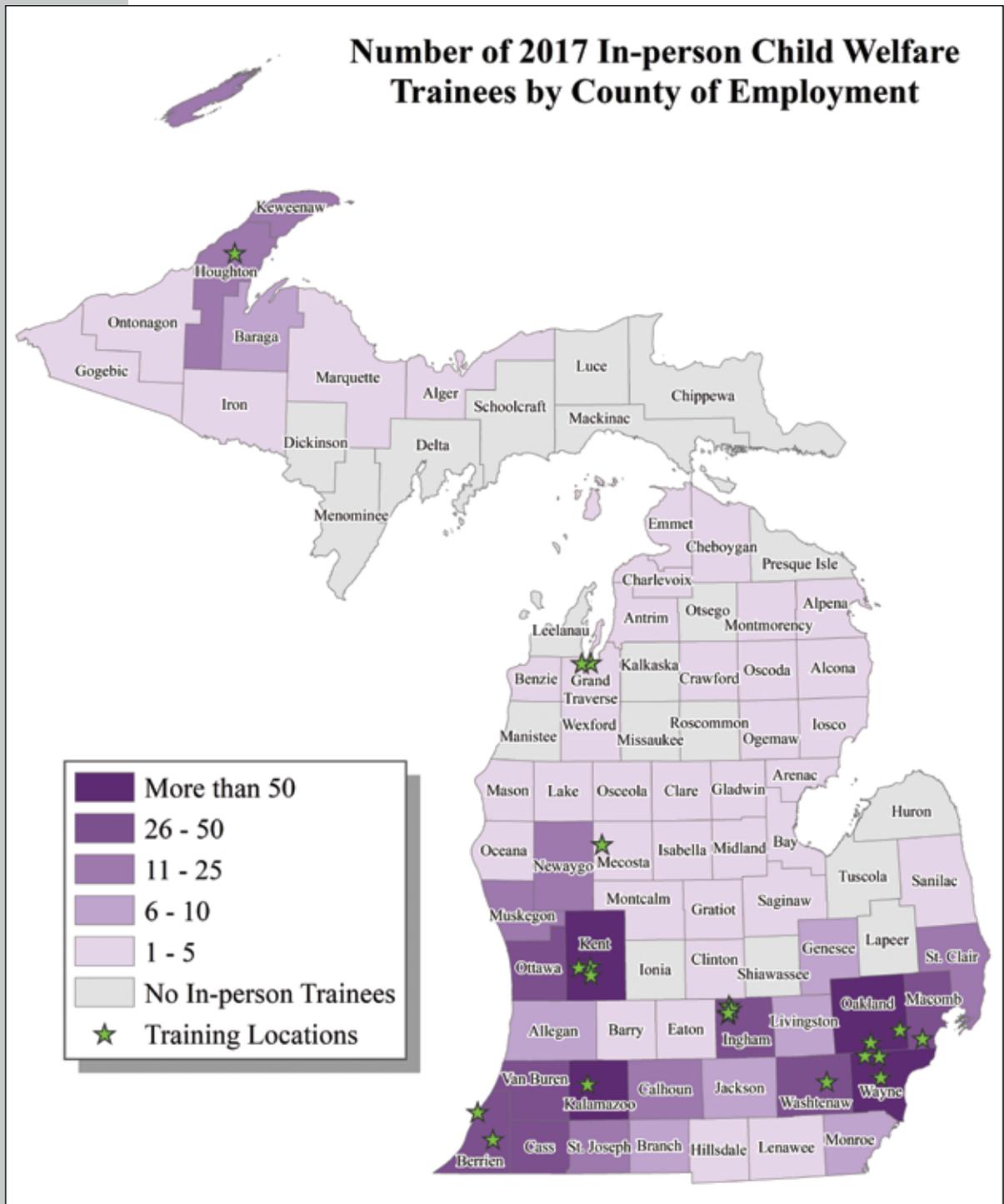
There were a total of 3 in-person leadership training events and 2 online trainings offered to the 2017 cohort. Table 5F details these training topics and lists the corresponding number of trainees associated with each training. A total of 117 trainees attended these events.

**Table 5F: Location of 2017 Leadership Trainings (n=117)**

Trainings Type	Training Title	Host University	Training Location	Reported Attendance
Webinar	Making the Case for Retention-Focused Supervision (10.14.16)	Michigan State University	Online	60
Webinar	Making the Case for Retention-Focused Supervision (03.16.17)	Michigan State University	Online	22
In person	Operationalizing Retention-focused Management (11.10.16)	Michigan State University	MSU Federal Credit Union 4825 E. Mt. Hope Road, East Lansing, MI 48824	18
In person	Operationalizing Retention-focused Management (04.28.17)	Michigan State University	Troy Community Center, 3179 Livernois, Troy, MI 48083	11
In person	Operationalizing Retention-focused Management (07.14.17)	Michigan State University	Great Wolf Lodge 3575 US-31 South, Traverse City, MI 49684	6
<b>Total Number of Leadership Trainees Across 5 Events</b>				<b>117</b>

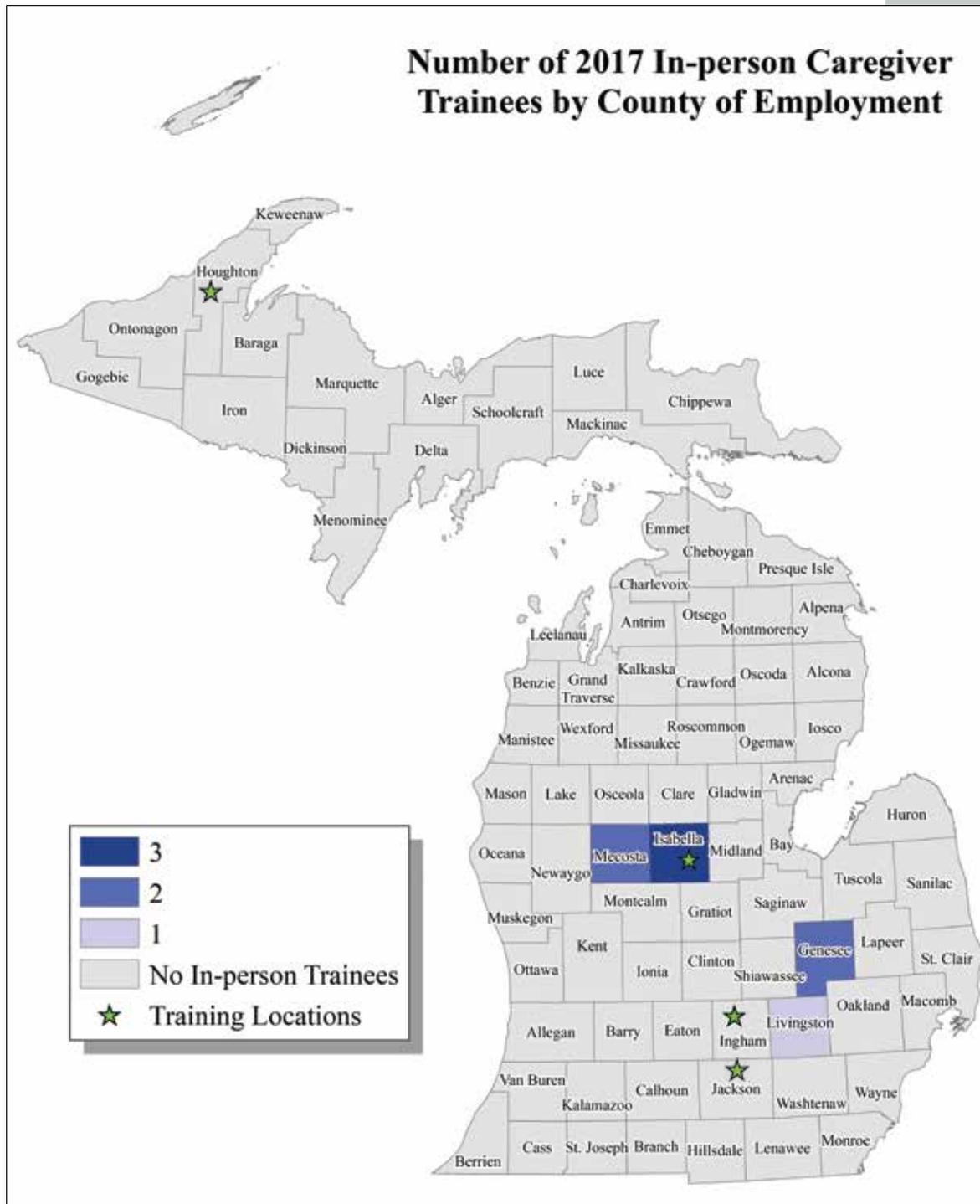
**Child Welfare Training Participants: In-person.** As reflected in the figure that follows, the 2017 initiative was largely successful in providing accessible training for child welfare professional employees located throughout the state. Regionally based in-person trainees reported employment in 64 of Michigan's 83 counties. This represents more than three quarters (77%) of the counties in the state. Non-regionally assigned trainees, such as those who work at the state level, are not reflected in this statistic.

**Child Welfare Training Participants: Online.** Regionally based in-person trainees reported employment in 72 of Michigan's 83 counties. This represents more than two-thirds (87%) of the counties in the state.



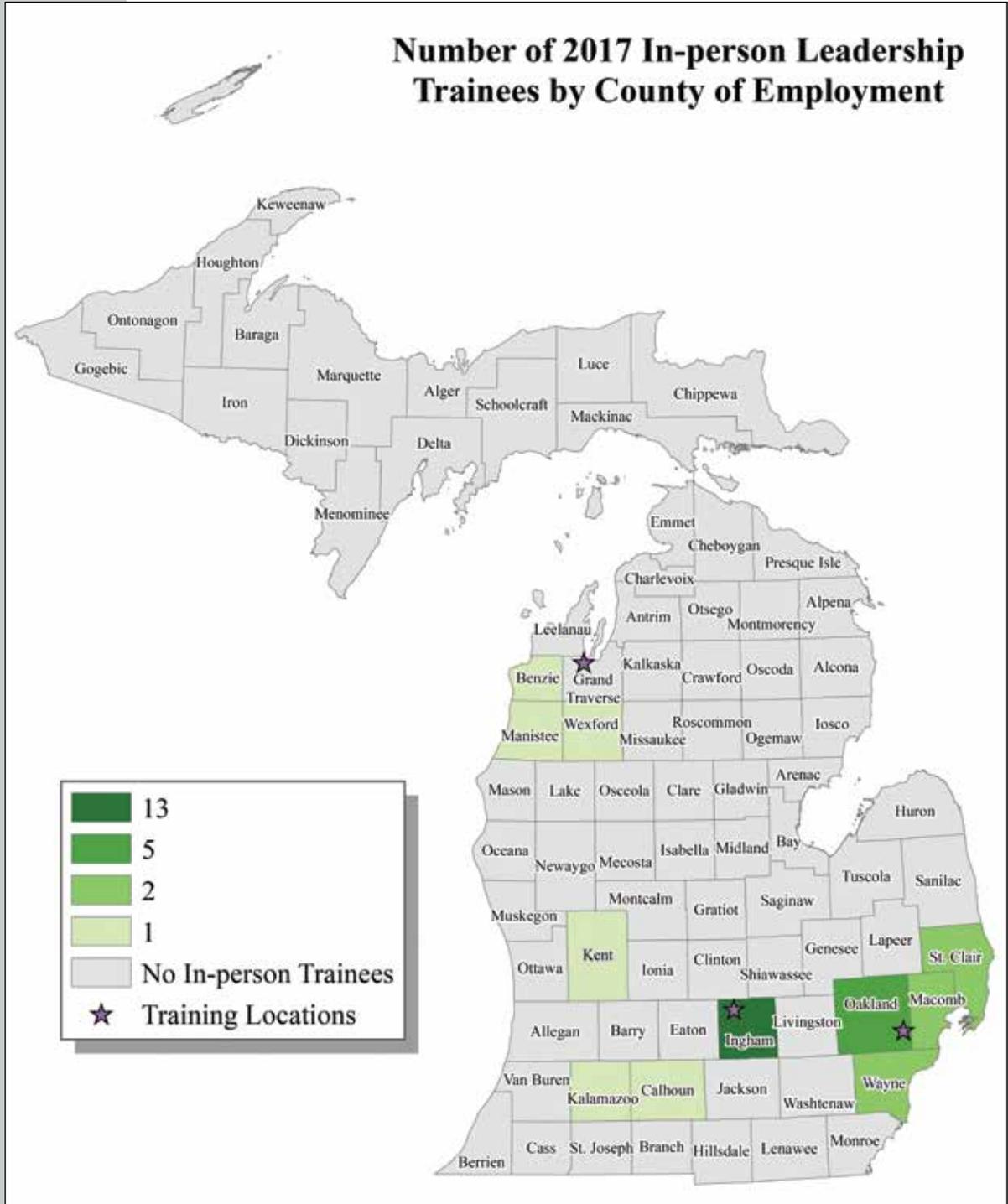
**Caregiver Training Participants: In-person.** This year, training included caregivers (including but not limited to foster, adoptive, and kinship caregivers), and 4 in-person training events were offered to this group. Attendees of these training events represented 9 different counties across the state: Genesee, Hillsdale, Houghton, Isabella, Jackson, Kalamazoo, Kent, Livingston, and Mecosta. This represents 9 of 83 (10.8%) counties in the state.

**Caregiver Training Participants: Online.** Training for caregivers was also available online in the form of 2 online training events. Trainees representing a total of 31 different counties in Michigan (37%) completed online training related to caregiving.



**Leadership Training Participants: In-person.** Leadership training was attended by trainees from 11 (13%) of Michigan's 83 counties in a traditional in-person environment.

**Leadership Training Participants: Online.** Leadership training was also made available in an online format. This version of training was attended by trainees from 33 (40%) of Michigan's 83 counties in an online environment.



## Evaluation Question 2: Were participants satisfied with the training that they received?

### Training Content as Advertised?

To help assess participants' satisfaction with the trainings, the post-test survey administered immediately after completion of trainings asked them to rate the correspondence between the knowledge/skills the trainings provided and those advertised in the course learning objectives. Trainees were also queried about how effectively the trainer delivered the material and whether they would recommend the training to coworkers.

**Child Welfare Professionals.** Trainees reported that the training courses were being marketed accurately with respect to the advertised learning objectives (Table 6A). This was the case for both the in-person and online trainings provided. When asked about the extent to which trainings provided participants with the knowledge and/or skills that were identified in the course objectives, in-person events received an average rating of 8.3 and online events received an average rating of 8.5 from trainees on a scale ranging from 1=Strongly Disagree to 10=Strongly Agree.

**Table 6A: Child Welfare Professional Trainees' Rating of Correspondence Between Knowledge/Skills Provided and Those Identified in Course Objectives (n=1,158)**

This training provided me with the knowledge and/or skills that were identified in the course objective. (1=Strongly Disagree, 10=Strongly Agree)	# Responses	Mean Score
In-person training events	798	8.3
Online training events	360	8.5

**Caregivers.** When caregiver trainees were asked about the extent to which trainings provided participants with the knowledge and/or skills that were identified in the course objectives, in-person events received an average rating of 8.7 and online events received an average rating of 8.6 from trainees on a scale ranging from 1=Strongly Disagree to 10=Strongly Agree. See Table 6B.

**Table 6B: Caregiver Trainees' Rating of Correspondence Between Knowledge/Skills Provided and Those Identified in Course Objectives (n=97)**

This training provided me with the knowledge and/or skills that were identified in the course objective. (1=Strongly Disagree, 10=Strongly Agree)	# Responses	Mean Score
In-person training events	26	8.7
Online training events	71	8.6

**Leadership.** When leadership trainees were asked about the extent to which trainings provided participants with the knowledge and/or skills that were identified in the course objectives, in-person events received an average rating of 8.5 and online events received an average rating of 8.2 from trainees on a scale ranging from 1=Strongly Disagree to 10=Strongly Agree. See Table 6C.

**Table 6C: Leadership Trainees' Rating of Correspondence Between Knowledge/Skills Provided and Those Identified in Course Objectives (n=70)**

This training provided me with the knowledge and/or skills that were identified in the course objective. (1=Strongly Disagree, 10=Strongly Agree)	# Responses	Mean Score
In-person training events	31	8.5
Online training events	39	8.2

## Facilitators' Delivery of Training Material

**Child Welfare Professionals.** Training facilitators for child welfare professionals training also received high scores from trainees for material delivery (Table 7A). On a scale ranging from 1=Poor to 10=Excellent, trainers for in-person events received a mean rating of 8.7 and online trainers received a mean rating of 7.8.

**Table 7A: Child Welfare Professional Trainees' Rating of Facilitator for Material Delivery (n=1,174)**

How well did the facilitator deliver the material? (1=Poor, 10=Excellent)	# Responses	Mean Score
In-person training events	811	8.7
Online training events	363	7.8

**Caregivers.** Training facilitators for caregiver training also received high scores from trainees for material delivery (Table 7B). On a scale ranging from 1=Poor to 10=Excellent, trainers for in-person events received a mean rating of 8.9, and online trainers received a mean rating of 8.1.

**Table 7B: Caregiver Trainees' Rating of Facilitator for Material Delivery (n=96)**

How well did the facilitator deliver the material? (1=Poor, 10=Excellent)	# Responses	Mean Score
In-person training events	26	8.9
Online training events	70	8.1

**Leadership.** Training facilitators for leadership training also received high scores from trainees for material delivery (Table 7C). On a scale ranging from 1=Poor to 10=Excellent, trainers for in-person events received a mean rating of 8.3 and online trainers received a mean rating of 7.4.

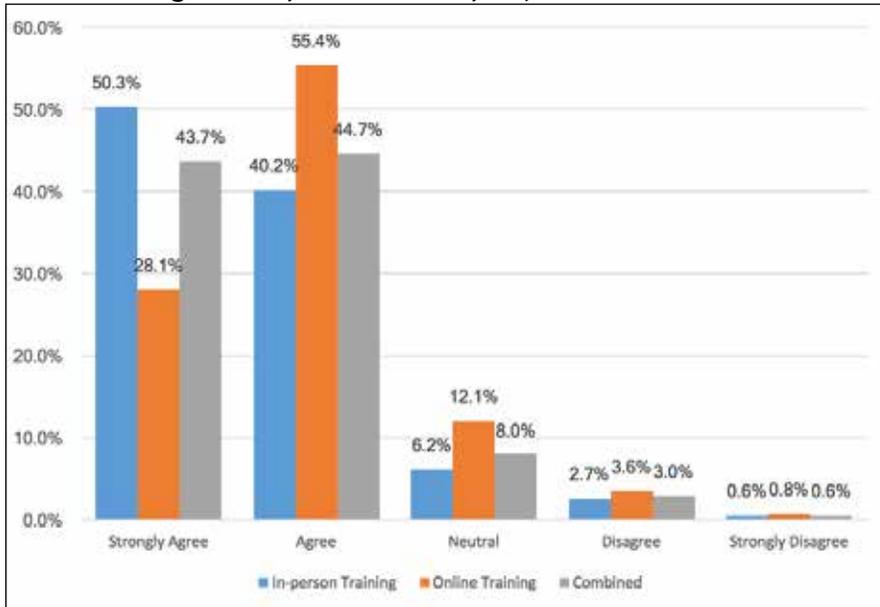
**Table 7C: Leadership Trainees' Rating of Facilitator for Material Delivery (n=67)**

How well did the facilitator deliver the material? (1=Poor, 10=Excellent)	# Responses	Mean Score
In-person training events	28	8.3
Online training events	39	7.4

## Would Trainees Recommend Training to Coworkers?

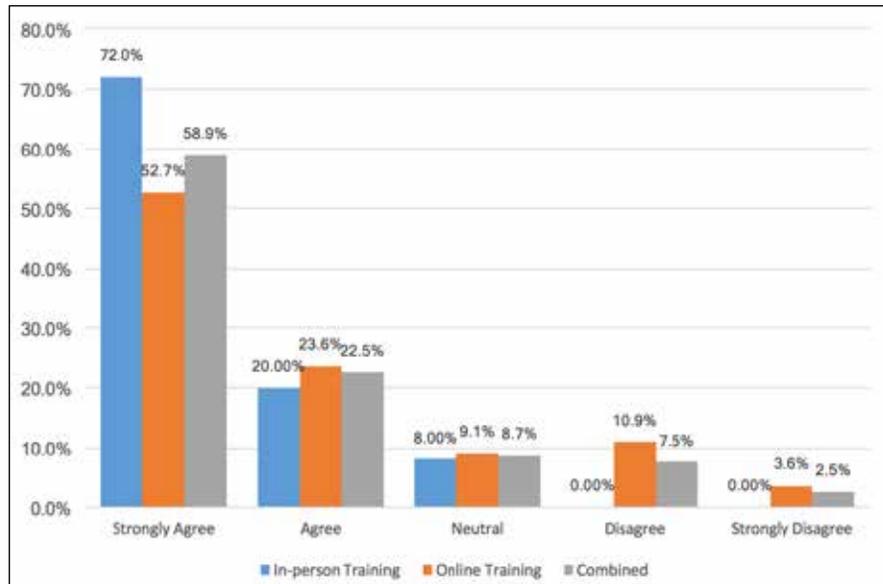
**Child Welfare Professionals.** As Chart 1A shows, the vast majority of trainees in the 2017 Cohort responded with “Agree” or “Strongly Agree” when asked whether they would recommend the training to coworkers. In-person trainees tended to respond slightly more enthusiastically than online trainees, as reflected by a lower percentage of online trainees “Strongly Agreeing” and a slightly higher percentage “Agreeing.”

**Chart 1A: I Would Recommend This Training to Co-workers**  
(Child Welfare Professionals In-person Training: n=844;  
Online Trainings: n=363; Combined n=1,207)



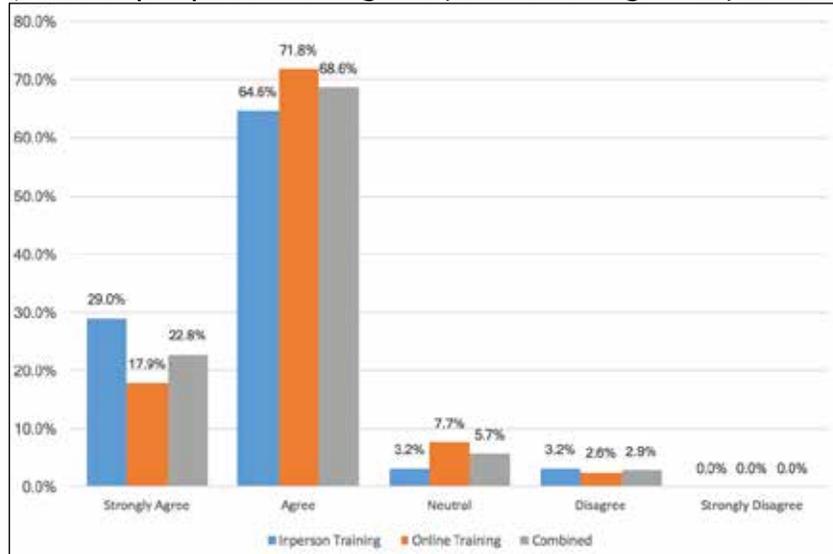
**Caregivers.** As Chart 1B shows, the vast majority of trainees in the 2017 Cohort responded with “Agree” or “Strongly Agree” when asked whether they would recommend the training to caregivers. In-person trainees tended to respond slightly more enthusiastically than online trainees, as reflected by a lower percentage of online trainees “Strongly Agreeing” and a higher percentage “Agreeing.”

**Chart 1B: I Would Recommend This Training to other Caregivers**  
(Caregivers In-person Training: n=25; Online Trainings: n=55; Combined n=80)



**Leadership.** As Chart 1C shows, the vast majority of trainees in the 2017 Cohort responded with “Agree” or “Strongly Agree” when asked whether they would recommend the training to coworkers. In-person trainees tended to respond slightly more enthusiastically than online trainees, as reflected by a lower percentage of online trainees “Strongly Agreeing” and a higher percentage “Agreeing.”

**Chart 1C: I Would Recommend This Training to Co-workers**  
 (Leadership In-person Training: n=31; Online Trainings: n=39; Combined n=70)



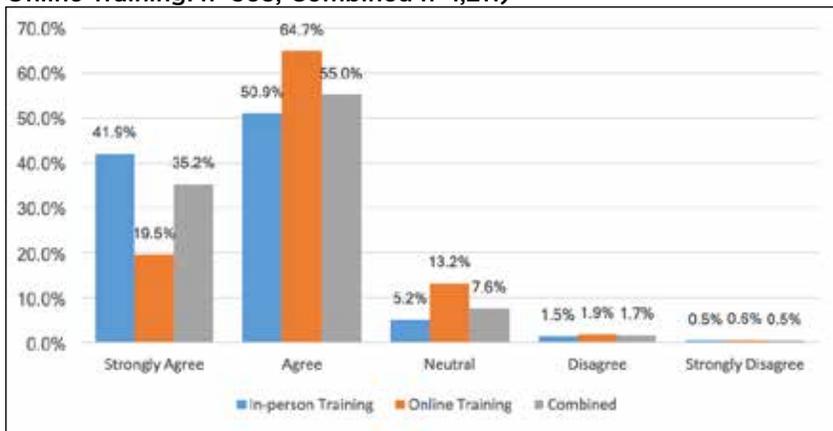
**Evaluation Question 3: Did the trainings increase participants’ professional knowledge/skills and were they useful to their work?**

## Training Effectiveness, Relevance, and Utility

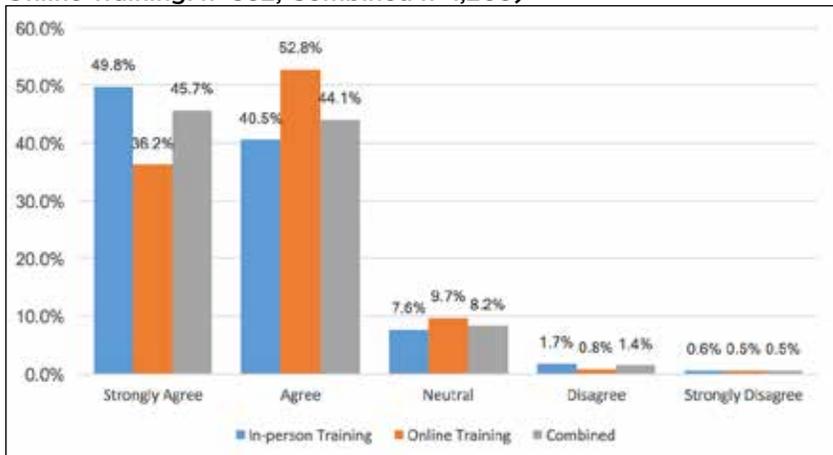
During the post-test survey administered immediately after completion of trainings, trainees were asked to rate the effectiveness of the training in helping them to understand the topic, whether the training was relevant to the work trainees were currently engaged in, and whether they would use the information learned in the training. Charts 2-4 show the results of these questions.

**Child Welfare Professionals.** As Charts 2A, 2B and 2C show, the vast majority of trainees in the 2017 Cohort responded with “Agree” or “Strongly Agree” when asked whether the trainings that they participated in increased their understanding of the topic(s) and whether they were relevant to their current work. Also, the vast majority of respondents selected “Agree” or “Strongly Agree” when asked whether they would use the information in their current work. In-person trainees tended to respond slightly more enthusiastically than online trainees, as reflected by a lower percentage of online trainees “Strongly Agreeing” with these items and a higher percentage responding neutrally.

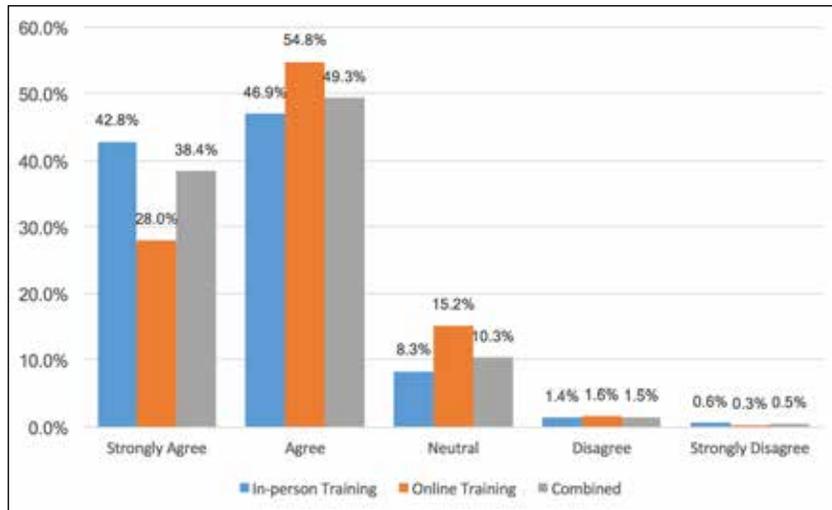
**Chart 2A: This Training Has Increased My Understanding of the Topic (Child Welfare Professionals In-person Training: n=848; Online Training: n=363; Combined n=1,211)**



**Chart 2B: This Topic is Relevant to the Work I Do Currently (Child Welfare Professionals In-person Training: n=847; Online Training: n=362; Combined n=1,209)**

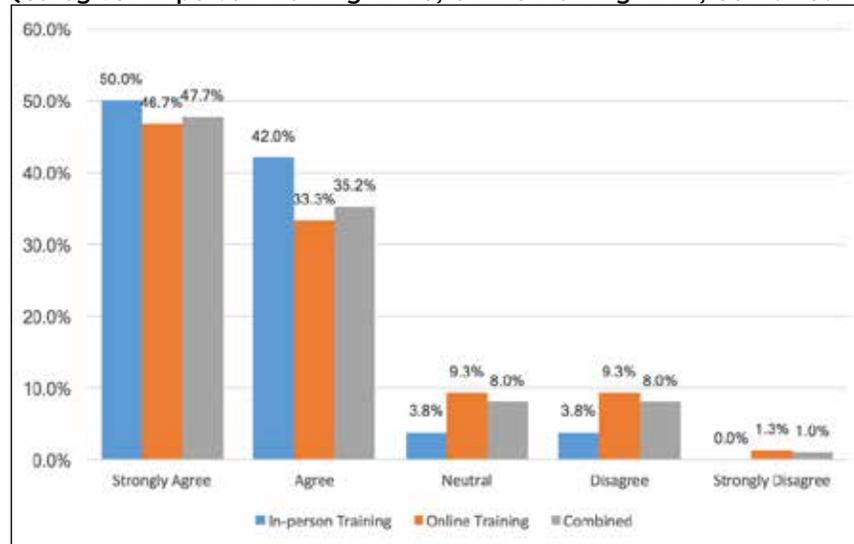


**Chart 2C: I Will Use the Information From This Training in My Current Employment (Child Welfare Professionals' In-person Training: n=846; Online Training: n=363, Combined n=1,209)**

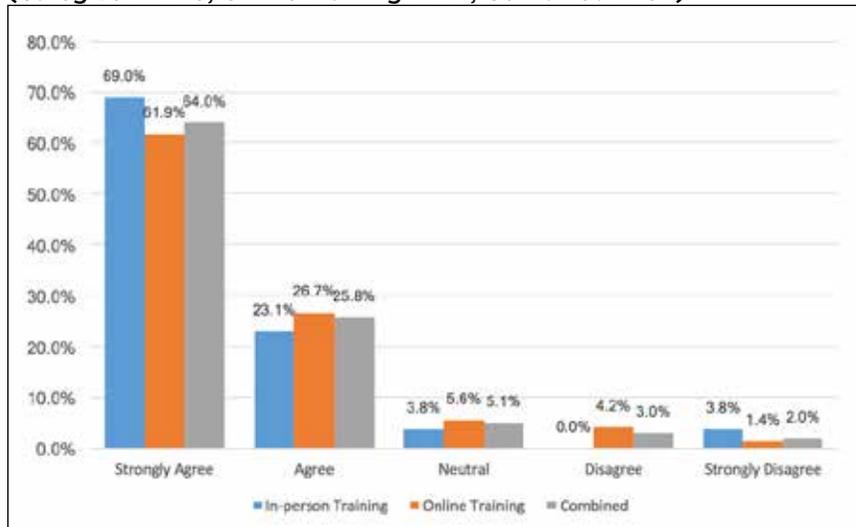


**Caregivers.** As Charts 3A, 3B and 3C show, the vast majority of trainees in the 2017 Cohort responded with “Agree” or “Strongly Agree” when asked whether the trainings that they participated in increased their understanding of the topic(s) and whether they were relevant to their current roles as caregivers. Also, the vast majority of respondents selected “Agree” or “Strongly Agree” when asked whether they would use the information in their current role as caregivers. In-person and online caregiver trainees rated the trainings similarly on these items.

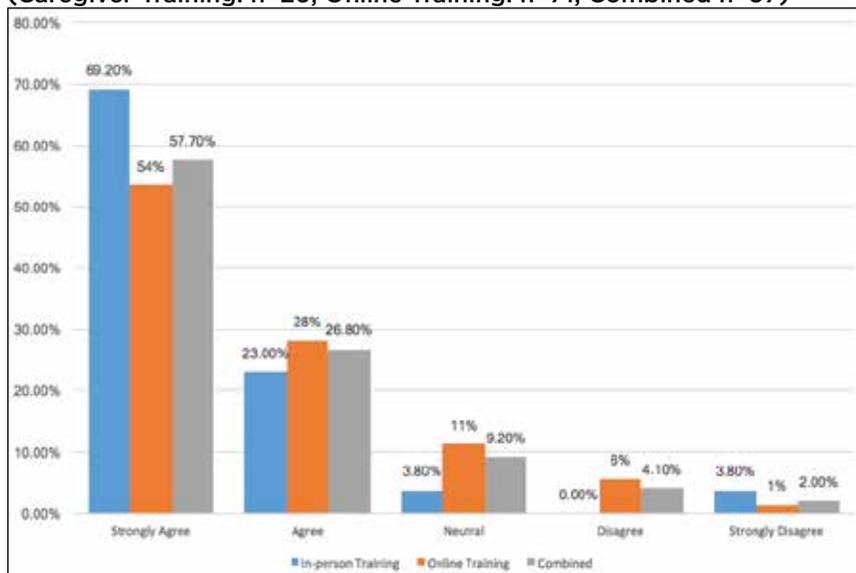
**Chart 3A: This Training Has Increased My Understanding of the Topic (Caregiver In-person Training: n=26; Online Training: n=71, Combined n=97)**



**Chart 3B: This Topic is Relevant to the My Role as Caregiver (Caregiver: n=26; Online Training: n=71, Combined n=97)**



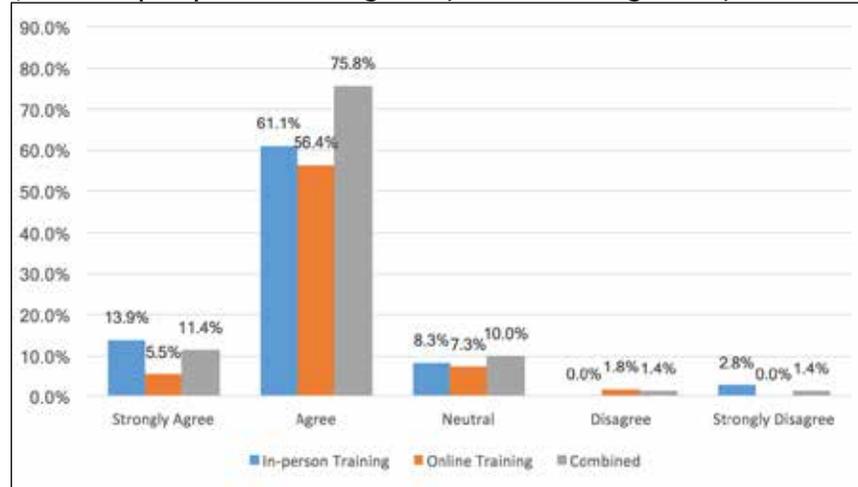
**Chart 3C: I Will Use the Information From This Training in My Role as a Caregiver (Caregiver Training: n=26; Online Training: n=71; Combined n=97)**



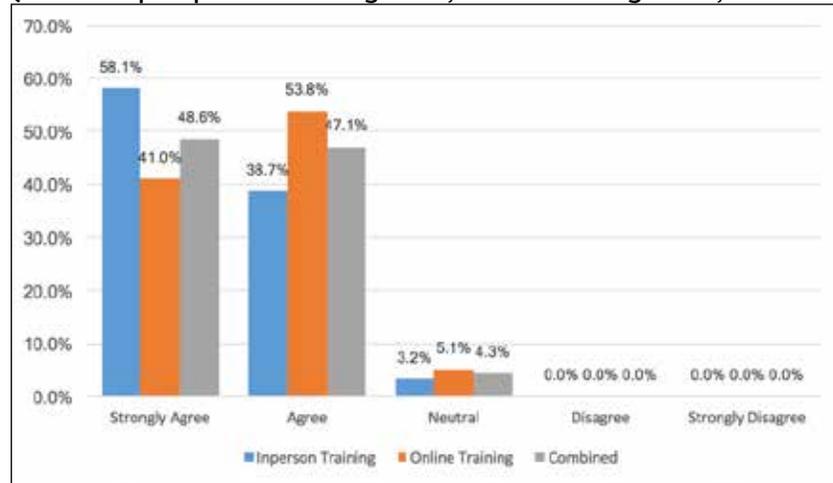
**Leadership.** As Charts 4A, 4B and 4C show, the vast majority of trainees in the 2017 Cohort responded with “Agree” or “Strongly Agree” when asked whether the trainings that they participated in increased their understanding of the topic(s) and whether they were relevant to their current work. Also, the vast majority of respondents selected “Agree” or “Strongly Agree” when asked whether they would use the information in their current work. In general, across these three items, in-person trainees tended to respond slightly more enthusiastically than online trainees, as reflected by a lower percentage of online trainees

“Strongly Agreeing” with these items and a higher percentage “Agreeing.”

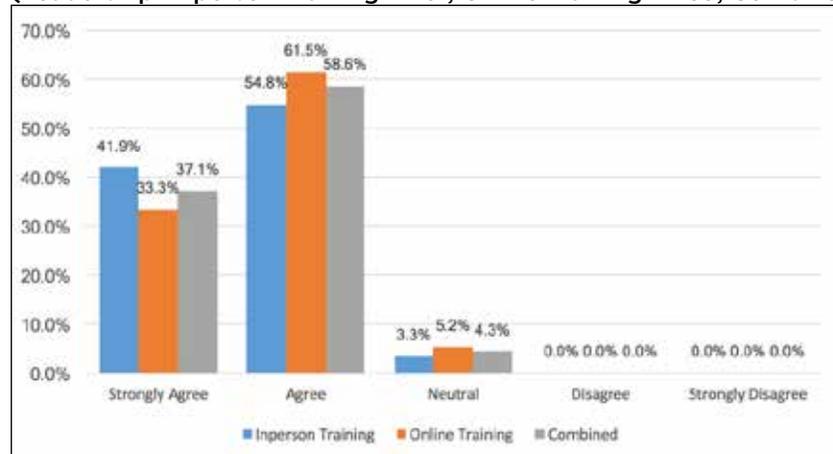
**Chart 4A: This Training Has Increased My Understanding of the Topic**  
(Leadership In-person Training: n=31; Online Training: n= 39, Combined n=70)



**Chart 4B: This Topic is Relevant to the Work I Do Currently**  
(Leadership In-person Training: n=31; Online Training: n=39, Combined n=70)



**Chart 4C: I Will Use the Information From This Training in My Role as a Professional**  
(Leadership In-person Training: n=31; Online Training: n=39; Combined n=70)



## Trainee Improvement in Self-assessed Competencies

**Child Welfare Professional Trainees.** When the data were analyzed to determine whether trainees perceived that they had increased their knowledge and/or skills related to the training topic(s), most showed a positive change (see Tables 8A–8F). Training facilitators created a short list of between 3-6 learning objectives reflecting the anticipated knowledge or skills that participants would gain by participating in their training. Trainees were asked both before (pre-test survey) and immediately after the training (post-test survey) to rate their knowledge/skill level related to each of the specific course objectives associated with the training that they participated in on a scale of 1=Not at All Competent to 5=Competent. These questions were asked of both trainees who engaged in in-person training events as well as those who participated in trainings that were conducted entirely online. The average competency rating across all objectives for the in-person child welfare professional training events before receiving the training was 3.2. For online training, this pre-test objective rating score was 3.0. After receiving training, the mean assessment of competencies increased for both training formats (1.1 points and 1.2 points, respectively). Demonstrating a particularly substantial level of improvement, only 13.7% of trainees who participated in in-person training events rated themselves as “Competent” with regard to a specific learning objective before the training, while 53.6% rated themselves as “Competent” after receiving training. For the online trainings, 12.2% of the trainees rated themselves as “Competent” with regard to a specific learning objective before the training, and 48.6% rated themselves as “Competent” after receiving training.

Reports of competence by trainees for in-person training events indicate that the vast majority (93.5%) of trainees considered themselves to be either “Moderately Competent” or “Competent” in the learning objectives after participating in the training. As detailed in Table 8A, this is a substantial increase when compared to the 51.9% of trainees who indicated that they felt “Moderately Competent” or “Competent” prior to participating in the training. The mean report of competence by trainees for all objectives across all in-person training events increased 1.1 points, from 3.2 before training to 4.3 after training. These results suggest that the training had a positive effect on the level of knowledge as perceived by the trainees.

Similarly, reports of competence by trainees for online training events (Table 8B) indicate that the vast majority (88.0%) of trainees considered themselves to be either “Moderately Competent” or “Competent” in the learning objectives after participating in the training. This is a substantial increase when compared to the 45.6% of trainees who indicated that they felt “Moderately Competent” or “Competent” prior to participating in the training. The mean report of competence by trainees for all objectives across all online training events increased 1.2 points, from 3.0 before training to 4.2 after training. These results suggest that the online trainings also had a positive effect on the level of knowledge as perceived by the trainees.

**Table 8A: Child Welfare Professional Trainees  
Self-Assessment of Competence on Training Objectives  
(In-Person Training Events, n=2,904)**

Rate your current level of competence regarding learning objective...	Before Training (Number/Percentage) n=2,904	After Training (Number/Percentage) n=2,741	Change
1 = Not at all Competent	174 (1.9%)	4 (0.0%)	-170 (-1.8%)
2 = Minimally Competent	473 (10.2%)	35 (0.6%)	-438 (-9.6%)
3 = Somewhat Competent	1,116 (36.1%)	237 (6.0%)	-879 (-30.1%)
4 = Moderately Competent	867 (38.2%)	1,188 (39.9%)	+301 (+1.7%)
5 = Competent	254 (13.7%)	1,277 (53.6%)	+1,023 (+39.9%)
Average Score (on 1-5 scale)	Mean=3.2	Mean=4.3	(+1.1)

**Table 8B: Child Welfare Professional Trainees  
Self-Assessment of Competence on Training Objectives  
(Online Training Events, n=1,630)**

Rate your current level of competence regarding learning objective...	Before Training (Number/Percentage) n=1,630	After Training (Number/Percentage) n=1,265	
1 = Not at all Competent	149 (3.0%)	5 (0.1%)	
2 = Minimally Competent	319 (12.9%)	46 (0.9%)	
3 = Somewhat Competent	629 (38.3%)	585 (11.0%)	
4 = Moderately Competent	412 (33.4%)	2,100 (39.4%)	
5 = Competent	121 (12.2%)	2,585 (48.6%)	
Average Score (on 1-5 scale)	Mean=3.0	Mean=4.2	

**Caregiver Trainees.** Reports of competence by caregiver trainees for in-person training events indicate that the vast majority (85.1%) of trainees considered themselves to be either “Moderately Competent” or “Competent” in the learning objectives after participating in the training. As detailed in Table 8C, this is a substantial increase when compared to the 52.1% of trainees who indicated that they felt “Moderately Competent” or “Competent” prior to participating in the training. The mean report of competence by trainees for all objectives across all in-person training events increased 1.1 points, from 3.0 before training to 4.1 after training. These results suggest that the training had a moderately positive effect on the level of knowledge as perceived by the trainees.

Similarly, reports of competence by caregiver trainees for online training events (Table 8D) indicate that the vast majority (92.2%) of trainees considered themselves to be either “Moderately Competent” or “Competent” in the learning objectives after participating in the training. This is a substantial increase when compared to the 56.6% of trainees who indicated that they felt “Moderately Competent” or “Competent” prior to participating in the training. The mean report of competence by trainees for all objectives across all online training events increased 1.2 points, from 3.2 before training to 4.4 after training. These results suggest that the online trainings had a very positive effect on the level of knowledge as perceived by the trainees.

**Table 8C: Caregiver Trainees  
Self-Assessment of Competence on Training Objectives  
(In-Person Training Events, n=83)**

Rate your current level of competence regarding learning objective...	Before Training (Number/Percentage) n=83	After Training (Number/Percentage) n=90	Change
1 = Not at all Competent	14 (5.5%)	0 (0.0%)	-14 (-5.5%)
2 = Minimally Competent	10 (7.9%)	2 (1.1%)	-8 (-6.8%)
3 = Somewhat Competent	29 (34.4%)	17 (13.70%)	-12 (-20.7%)
4 = Moderately Competent	18 (28.4%)	39 (42.0%)	+21 (+13.6%)
5 = Competent	12 (23.7%)	32 (43.1%)	+20 (+19.4%)
Average Score (on 1-5 scale)	Mean=3.0	Mean=4.1	(+1.1)

**Table 8D: Caregiver Trainees  
Self-Assessment of Competence on Training Objectives  
(Online Training Events, n=294)**

Rate your current level of competence regarding learning objective...	Before Training (Number/Percentage) n=294	After Training (Number/Percentage) n=216	Change
1 = Not at all Competent	18 (1.9%)	3 (0.3%)	-15 (-1.6%)
2 = Minimally Competent	54 (11.3%)	5 (1.1%)	-49 (-10.2%)
3 = Somewhat Competent	96 (30.2%)	20 (6.4%)	-76 (-23.8%)
4 = Moderately Competent	91 (38.2%)	77 (32.9%)	-14 (-5.3%)
5 = Competent	35 (18.4%)	111 (59.3%)	+76 (+40.9%)
Average Score (on 1-5 scale)	Mean=3.2	Mean=4.4	(+1.2)

**Leadership Trainees.** Reports of competence by caregiver trainees for in-person training

events indicate that the vast majority (92.4%) of trainees considered themselves to be either “Moderately Competent” or “Competent” in the learning objectives after participating in the training. As detailed in Table 8E, this is a substantial increase when compared to the 37.2% of trainees who indicated that they felt “Moderately Competent” or “Competent” prior to participating in the training. The mean report of competence by trainees for all objectives across all in-person training events increased 1.3 points, from 3.1 before training to 4.4 after training. These results suggest that the training had a positive effect on the level of knowledge as perceived by the trainees.

Similarly, reports of competence by caregiver trainees for online training events (Table 8F) indicate that the vast majority (90.2%) of trainees considered themselves to be either “Moderately Competent” or “Competent” in the learning objectives after participating in the training. This is a substantial increase when compared to the 46.0% of trainees who indicated that they felt “Moderately Competent” or “Competent” prior to participating in the training. The mean report of competence by trainees for all objectives across all online training events increased 1.1 points, from 3.0 before training to 4.1 after training. These results suggest that the online trainings also had a moderately positive effect on the level of knowledge as perceived by the trainees.

**Table 8E: Leadership Trainees  
Self-Assessment of Competence on Training Objectives  
(In-Person Training Events, n=99)**

Rate your current level of competence regarding learning objective...	Before Training (Number/Percentage) n=99	After Training (Number/Percentage) n=93	Change
1 = Not at all Competent	6 (1.9%)	0 (0.0%)	6 (-1.9%)
2 = Minimally Competent	6 (3.9%)	2 (1.0%)	-4 (-2.9%)
3 = Somewhat Competent	59 (56.9%)	9 (6.6%)	-50 (-50.2%)
4 = Moderately Competent	24 (30.8%)	34 (33.4%)	+10 (+2.5%)
5 = Competent	4 (6.4%)	48 (59.0%)	+44 (+52.5%)
Average Score (on 1-5 scale)	Mean=3.1	Mean=4.4	(+1.3)

**Table 8F: Leadership Trainees  
Self-Assessment of Competence on Training Objectives  
(Online Training Events, n=110)**

Rate your current level of competence regarding learning objective...	Before Training (Number/Percentage) n=110	After Training (Number/Percentage) n=79	Change
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1 = Not at all Competent	6 (1.8%)	0 (0.0%)
2 = Minimally Competent	31 (18.7%)	4 (2.45%)
3 = Somewhat Competent	37 (33.4%)	8 (7.3%)
4 = Moderately Competent	27 (32.5%)	41 (50.3%)
5 = Competent	9 (13.5%)	26 (39.9%)
Average Score (on 1-5 scale)	Mean=3.0	Mean=4.1

### Interpretation of Findings for Evaluation Question #3

The charts and tables above demonstrate that the majority of trainees were positively impacted by the in-service trainings they attended. Most indicated that training increased their understanding of the topic, that training topics were relevant to their work, and that they planned to use the information gained during training in their work. Additionally, trainees' self-assessed competency regarding course learning objectives improved after completing training. Moreover, scores on knowledge tests that were included in the evaluation of the 9 MSU-sponsored in-person trainings support these positive self-assessment findings by demonstrating that trainees were more knowledgeable about core course content after participating in training. Lastly, trainees' responses to the open-ended post-training survey question about how they planned to implement the knowledge gained from attending the child welfare in-service training in their professional work reflected a strong intention to carry forward the knowledge and skills gained through the training into their professional practice.

1 = Not at all Comp
2 = Minimally Comp
3 = Somewhat Com
4 = Moderately Cor
5 = Competent
Average Score (on

### Evaluation Question 4: Were improvements in training participants' professional knowledge/skills sustained over time?

#### Sustainment of In-Person Child Welfare Professional Trainees' Self-Assessed Competency in Course Training Objectives

The training collaborative wanted to determine whether improvements in child welfare professional trainees' professional knowledge and skills were sustained over time; therefore, a follow-up survey was administered to training participants via a SurveyMonkey link emailed approximately 2 months after each training event. It asked them to once again rate their knowledge/skill level related to the specific course objectives associated with the training they participated in according to the same scale used in the prior surveys: 1=Not At All Competent to 5=Competent. Tables 10A-10B summarize in-person child welfare trainees' average follow-up survey response to this question, comparing it to both their pre-training and post-training survey responses. We do not provide the follow-up survey results for the in-person caregiver and leadership trainees because the response rates were so low as to render the findings unreliable and potentially misleading.

Reports of competence by in-person child welfare professional trainees indicate that the vast majority (86.1%) continued to consider themselves to be either "Moderately Competent" or "Competent" in the learning objectives two months after participating in the training. As detailed in Table 10A, this remains a substantial increase when compared to the 51.9% of trainees who indicated that they felt "Moderately Competent" or "Competent" prior to participating in the training. The mean report of competence by trainees for all objectives across all in-person training events increased 0.9 points, from 3.2 before training to 4.1 at follow up. This is only 0.2 less than the mean report of in-person child welfare professional trainee competence for all objectives as measured immediately following completion of training via the post-training survey. These results suggest that in-person child welfare professional trainees perceived that the training they received had a positive effect on their learning and that this effect was generally sustained during the two month period following the training.

Table 10A: In-Person Child Welfare Professional Trainees Self-Assessment of Competence on Training Objectives Over Time (In-Person Training Events, n=2,904)			
	Before Training (Number/Percentage) n=2,904	After Training (Number/Percentage) n=2,741	Follow Up Survey (Number/Percentage) n=689
Not at all competent	174 (1.9%)	4 (0.0%)	5 (0.2%)
Minimally competent	473 (10.2%)	35 (0.6%)	28 (1.0%)
Somewhat competent	1,116 (36.1%)	237 (6.0%)	363 (12.7%)
Moderately competent	867 (38.2%)	1,188 (39.9%)	1,140 (39.9%)
Competent	254 (13.7%)	1,277 (53.6%)	1,320 (46.2%)
Average Score (on 1-5 scale)	Mean=3.2	Mean=4.3	Mean=4.1

## Sustainment of Online Child Welfare Professional Trainees' Self-assessed Competency in Course Training Objectives

Reports of competence by online child welfare professional trainees indicate that the vast majority (85.6%) of online trainees continued to consider themselves to be either “Moderately Competent” or “Competent” in the learning objectives two months after participating in the training. As detailed in Table 10B, this remains a substantial increase when compared to the 45.6% of trainees who indicated that they felt “Moderately Competent” or “Competent” prior to participating in the training. The mean report of competence by trainees for all objectives across all in-person child welfare professional training events increased 1.1 points, from 3.0 before training to 4.1 at follow up. This is only 0.1 less than the mean report of in-person child welfare professional trainee competence for all objectives as measured immediately following completion of the training via the post-training survey. These results suggest that in-person child welfare professional trainees perceived that the training they received had a positive effect on their learning and that this effect was largely sustained during the two month period following the training.

**Table 10B: Online Child Welfare Professional Trainees Self-Assessment of Competence on Training Objectives Over Time (Online Training Events, n=1,630)**

Rate your current level of competence regarding learning objective...	Before Training (Number/Percentage) n=1,630	After Training (Number/Percentage) n=1,265	Follow Up Survey (Number/Percentage) n=474
1 = Not at all Competent	149 (3.0%)	5 (0.1%)	0 (0.0%)
2 = Minimally Competent	319 (12.9%)	46 (0.9%)	15 (1.5%)
3 = Somewhat Competent	629 (38.3%)	585 (11.0%)	84 (12.8%)
4 = Moderately Competent	412 (33.4%)	2,100 (39.4%)	194 (39.5%)
5 = Competent	121 (12.2%)	2,585 (48.6%)	181 (46.1%)
Average Score (on 1-5 scale)	Mean=3.0	Mean=4.2	Mean=4.1

## How Was Training Information Implemented in Your Professional Work?

Two months after completion of the training, child welfare professional in-person trainees were asked how they had implemented the knowledge or skills gained during training in their professional work with children and families. They indicated that they had applied the knowledge gained in a variety of ways. Trainees reported being able to better communicate with the populations they serve, being more skilled in understanding the perspective of clients, and being able to more effectively address their clients' needs. Trainees indicated that they were taking steps toward better organization and self-care within their agency and that they had shared the knowledge gained with their coworkers. Additional specific examples of

implementation of training knowledge are included below:

- Birthday cards for foster parents, appreciation dinner, nomination of foster parents, strategies for getting name out in the community.
- Additional considerations to safety planning.
- As a second line supervisor, I am working closely with my staff to ensure they are utilizing retention focused techniques, including providing breaks, back-up and extra support.
- Asking, "How was that for you?"
- Assisting grandparents with supports in their community and also with computer skills to complete forms and applications related to the grandchild they are caring for.
- At this time, I have not implemented any particular techniques as I am the licensing specialist and not a foster care worker.
- Being able to explain risks and signs for parents to be aware of. Sharing the knowledge of how residential treatment works with families who are considering it.
- Being able to link the client's life experience to their well-being and level of functioning. See the world from their point of view and their reaction to their environment.
- Being better about listening and letting clients know I am hearing what they are saying.
- Being more conscious of not talking about work on my personal social media. Ensuring my personal social media settings are private.
- Coming from the perspective that the worker does not know the solution.
- Creating MiTEAM cue cards to use during team meetings for MiTEAM review.
- Cultural humility.
- Developing my story and letting my clients choose a saying or song lyrics to talk about.
- Different types of medications that are utilized for various diagnoses, to pay attention to side effects.
- Discussion with leaders about the various forms of stress, i.e., accountability stress.
- Educating families about how to help minimize the trauma and how traumatic it is to replace a child.
- Encouraging parents to advocate for their children and providing direction on how to do so.
- Engaging with relative caregivers. Sharing how the court process works, as well as different financial resources.
- Focusing on secondary trauma and self-care, as well as reflective supervision.
- Give them the time they need; reinforce that with them (there is no time line for grief).
- Helping families understanding bonding, infant mental health, etc.
- Helping parents be curious, not judgmental. Thinking about neglect as being worse than abuse, "I don't even care enough to take care of you."
- How to improve child safety in domestic violence situations.
- How to interact with the families during a removal. How to prepare for a removal.
- How to practice self-compassion, how to recognize and name thoughts.
- How to reach out to families and children, different areas to look for services, make contact before the problem ruins the adoption.
- I am more aware of what people say and how they say it. I try to definitely listen more!!
- I am not working right now, but when I am working I will create the open setting where the person be comfortable in sharing of their thoughts.
- I am retired.
- I approach supervision differently. I see it more as a chance to check in with how my staff is doing instead of a list of tasks to get through. I still need to work on this, but now I am aware of needing to add in questions about their overall work health.
- I didn't implement anything new. The training just reinforced what I do!
- I do not do direct service with children and families.
- I do not work directly with children. I am a manager. My staff does not work directly with children and families. We audit agencies for compliance with Child Welfare

#### Licensing Rules.

- I do not work in the child welfare system. I have shared the training information with the staff I supervise at the Alzheimer's Association.
- I don't work with children/families or welfare. I do use it in work with adults and also in supervision of my social work intern and staff.
- I encourage families to discuss all medication concerns and side effects with their medical provider.
- I feel that due to this training I have a better self-understanding of the ways that vicarious trauma can impact me as a service provider.
- I have advised individual staff about the differences between a 504 and an IEP.
- I have become more aware of reflective listening skills and make it a point to use them with staff.
- I have been able to meet them where they are at now more than just telling them where they need to get. This has helped my clients be more engaging in the process of change and allowed us to have a better working relationship.
- I have been more aware of informing foster parents and host providers that children that come into foster care might exhibit certain types of behaviors, because of the trauma or experiences that have happened in their lives.
- I have implemented self-care activities such as cooking and baking after a day of work.
- I have used the "stay" question with my staff to help determine their specific areas of interest and attempt to connect them with opportunities in those areas.
- I have used this knowledge to help assess young children for trauma.
- I have worked on understanding and loving my own story so that I can teach others in doing the same and support them in that journey.
- I no longer have a regular case load, but I work with and train workers who do. I keep what I learned in mind when I talk with workers and their clients, and I have probably used the info. I learned, although I cannot think of a specific instance.
- I practice the parallel process of modeling MiTEAM competencies with my staff and throughout my interactions with internal as well as external customers.
- I primarily work with adults.
- I review adoption cases daily so I am always putting this knowledge to good use.
- I work with this more commonly in my private practice and I uphold the same standards working at DHHS.
- I've suggested many of the tips presented, and I really liked that this training included real ideas and suggestions I could share with parents.
- Identifying suicidal ideation in child welfare.
- If possible to have the new foster parents meet the child in a familiar setting such as their house.
- Implementing some of the reflective supervision techniques in supervising our interns and supporting our staff members.
- In general, I have been able to talk more knowledgeably about needs and services. However, a more specific example does not come to mind.
- Increased listening.
- Involve the entire family.
- I remember being inspired and experiencing having all my past training coming back to the front of my memory.
- It has helped me to write better safety plans, understand trauma and the effect it has on clients and their ability to be safe, and to continue to focus on strength based strategies.
- It helps in my review of cases.
- It helps me understand now the steps to getting an IEP or whether or not a child even qualifies for one. What an IEP might look like, who would participate, etc. I found the training very informative, even though I might not use the content in everyday work.
- It was a great training, useful information.
- It was helpful to know terminology used, short hand used by doctors. It was helpful to

better understand how the medication affects the function of the brain. It was a very helpful training overall.

- Listening to and following up with staff and families regarding any issues that may arise.
- McKinney-Vento Act, advocating for youth
- Measuring individuals' (staff member's) compassion fatigue simple exercises to address compassion fatigue during the course of the day
- Mindful conversations and honest questions and conversations.
- More aware of domestic violence resources in my community.
- More careful of the language that I use.
- My current position is working with my team, so I try to use the skills in the office to facilitate comfort and compassion within the team.
- My staff, who are supervisors, are using the Stay Interview with each of their staff. We all also did the Staff Retention Competency Inventories to evaluate ourselves.
- My work is removed from direct service; however, I do interact with direct workers and supervisors. We conference and reach out for wisdom, and this training was very valuable.
- Nice training!
- None. Due to the nature of my work, it has not been applicable.
- Nothing at this time since I am not a direct worker. But I have information that I can provide to staff that I work with to assist them in understanding and helping families and children they service.
- Our agency was already using the tools presented.
- Provided the training and info to my staff to implement with their families.
- Reality with hope and comfort which equal stability.
- School responsibility to collect data on child to determine if evaluation should occur, understanding of ability of school/district to provide specific services as a result of IEP, who can request IEP, new legislation, services other than IEP services.
- Self-care activities.
- Self-compassion is different than self-care.
- Self-compassion break.
- So far I am not in any positions to implement any of these skills other than watching for signs in family and friends.
- Stressing how attachment starts as an infant, and children who do not have secure attachment as an infant feel the effects throughout life and will take work and therapy and time to overcome.
- Support to pursue options, inquire about what is available.
- Talking with children though play, using puppets.
- Teach caregivers on the side effects of essential medications.
- Terminology and how to communicate needs of the child with schools.
- The "stay interview" has been used to demonstrate to my staff that I am interested in their thoughts and experiences. Encouraging staff to build relationships with one another on our unit. Brainstormed with staff simple inexpensive ideas that can be utilized to show appreciation.
- The knowledge of self-care and self-compassion techniques have assisted me in stress management for my job. I have also encouraged my staff to utilize them.
- The training more or less caused me to take more time to think about how certain things associated with this line of work affect people.
- The training was a good overall reminder of where these youth in foster care are coming from and how we, as workers, can best communicate and support them. Motivational interviewing is a technic that was reviewed in this training that I have since used in my profession.
- The use of familiar objects when transitioning children to/from placements, understanding and being aware of trauma triggers during transitions, minimizing conditions that might traumatize the child.
- There was nothing from this training that I implemented that I was not already

practicing.

- This topic was not explicitly addressed in the training. The trainer spent the majority of the class time talking about his own experiences with race. There was very little mention of the child welfare system.
- This training was a very good reminder that while family members do step up when children are removed from their parents, they are taking on a major burden. Often, these relative caregivers have already raised children into grown adults and are thinking about retiring, which they then have to put on hold because of someone else's mistakes.
- This training was a very good training. It allows one to think about their own grief and loss situations and be able to understand and empathize with the children that we work with.
- To listen to how others interpret culture and cultural biases vs. have my own agenda on how they're defined.
- To really know how to discern what should be acceptable to post or not to post and to keep professional and personal boundary lines clear/evident so that mistakes can be avoided as much as possible.
- Trainer was very comfortable with her knowledge and sharing of knowledge with the audience.
- Treating trauma first when it comes to developing a support system for parents and children in need of mental health services, assessing and accessing services immediately to kick start a trusting and up-front relationship with the families.
- Understanding more of the challenges of grandparents.
- Updated and revised agency Confidentiality and Disclosure Policy. Changed personal social media practices.
- Using the hand out as a guide, can speak with families and ask them questions, help them come up with questions to ask service providers, help them better understand medications and side effects, help them learn about the different medications, learn how to look up medication, brainstorm, maybe more than medication is needed such as routine, additional counseling, OT/PT, etc.
- Using the warning signs to identify adolescents who may be at risk. Being aware of common misconceptions, especially providing this information to relative caregivers.
- Utilizing retention events to incorporate recruitment by allowing current families to invite interested families to learn more about foster care and adoption.
- Was able to de-escalate a parent who was suicidal/homicidal and get her the help she needed.
- Watch better for compassion fatigue with my staff and provide them with coping strategies to combat.
- We now use the exercises with interns to help them develop personal use practices related to social media.
- What is appropriate to post online and what isn't.
- Why children have a break in attachment, providing information to relatives for placements on working with the children to help build/re-establish attachment, explain why attachment is important.
- Workers treat the families they work with, the same as they are treated by managers. Managers must be the example for listening and being flexible.
- You don't have to have the same rules for all your children. You can cater your parenting style to the needs of each of your children. Be confident in your decision.

## Interpretation of Findings for Evaluation Question #4

These results suggest that training-related learning was largely sustained in the two months following trainees' participation in-person training events. Not only did the vast majority of trainees continue to feel competent in the training course learning objectives, they were also able to articulate a variety of ways in which they had already applied knowledge and skills that they learned during training.

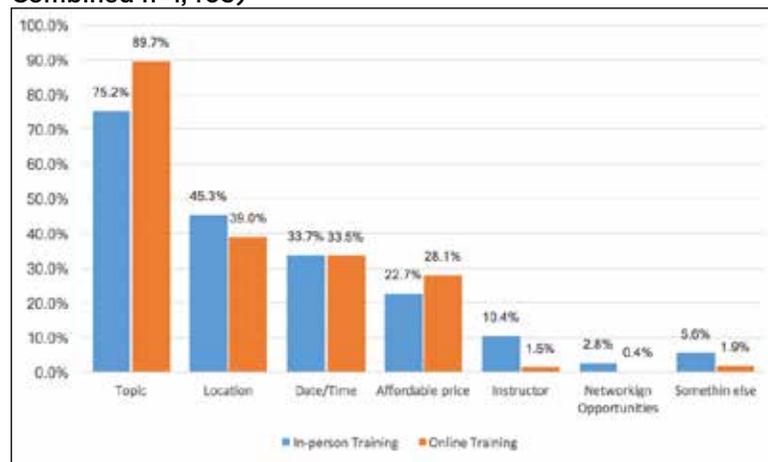
## Evaluation Question 5: What motivates trainees to participate in in-service trainings and what factors influence their ability to do so?

Lastly, in order to aid continuous quality improvement efforts, the post-evaluation included four survey questions designed to illuminate trainees' motivations for participating in in-service trainings and to identify facilitators and barriers to their participation.

### Factors That Influenced Participants to Attend Trainings

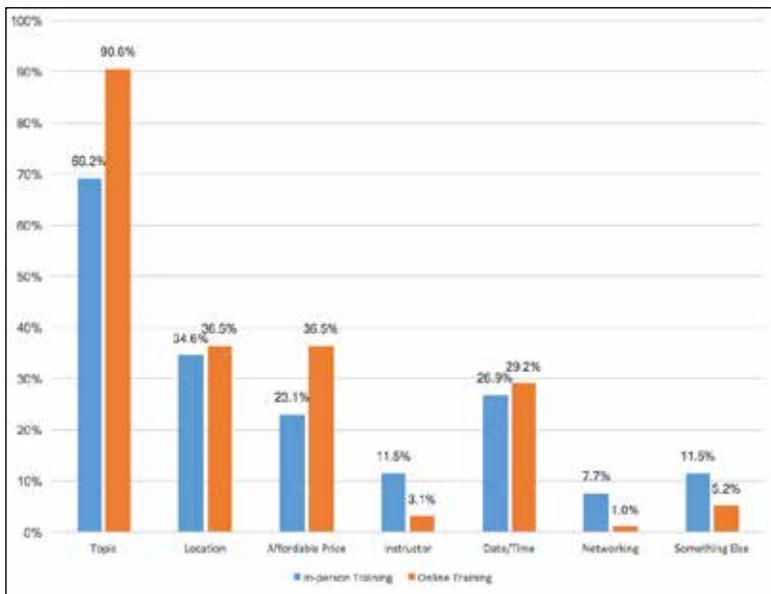
All trainees were asked to identify which of seven factors (identified in Charts 5A, 5B and 5C) influenced them to attend the training in which they participated. The predominant factor cited by child welfare trainees was the training topic (75% for in-person trainees, 90% for online trainees). Additionally, where the training was located was a key factor for almost half the child welfare trainees queried (45% for in-person trainees, 39% for online trainees), and close to a third cited the date/time of the training (34% for in-person trainees, 34% for online trainees) and its affordability (23% for in-person trainees, 28% for online trainees). The relative importance of these factors as motivators for attending a specific training varied little between the three groups of targeted trainees (child welfare professionals, caregivers, and leaders) nor between in-person and online trainees.

**Chart 5A: What influenced you to attend this Training Workshop?**  
(Child Welfare Professionals In-person: n=929; Online Training; n=474; Combined n=1,403)



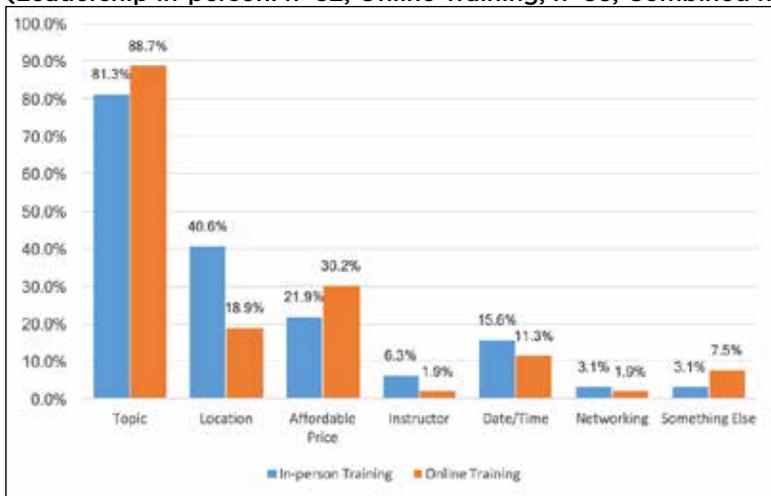
The predominant factor cited by caregiver trainees was the training topic (69% for in-person trainees, 91% for online trainees). Additionally, approximately 35% of online trainees indicated that the training location was a factor that influenced attendance, while 23% of trainees indicated that affordable price influenced training attendance. A few in-person trainees mentioned that a teacher or spouse influenced their attendance at the training.

**Chart 5B: What influenced you to attend this training workshop?**  
(Caregivers In-person: n=26; Online Training; n=96; Combined n=122)



The predominant factor cited by leadership trainees was the training topic (81% for in-person trainees, 89% for online trainees). More in person trainees were influenced by the training location than online trainees (41% and 19%, respectively) while the affordable price was a stronger predictor for online trainees than for in person trainees (30% and 22%, respectively). A few leadership trainees mentioned that the training was required or that a supervisor suggested they attend the training.

**Chart 5C: What influenced you to attend this training workshop? (Leadership In-person: n=32; Online Training; n=53; Combined n=85)**



### Potential Barriers to Attending Trainings

Lastly, trainees were asked about several potential barriers to their attending training. For each of the five statements listed in Table 13A, trainees indicated on a 5-point scale the extent to which they “Agreed” (1-Strongly Agree, 2-Agree, 3-Neutral, 4-Disagree, or 5-Strongly Disagree). We did not ask caregivers about the barriers listed in Table 13A because they primarily had to do with training events offered through the workplace, something not likely to be offered by a majority of caregivers’ employers.

**Child Welfare Professional Trainees: In-person Training.** The vast majority (80.6%) of child welfare professional in-person trainees indicated that they “Strongly Agreed” or “Agreed” that it was easy to get paid time off of work from their employer to attend outside training events, and just over half (57.1%) indicated that they “Strongly Agreed” or “Agreed” that it was easy to get unpaid time off of work from their employer to attend outside training events. The vast majority of trainees also indicated that their agency/organization encouraged its employees to attend outside training events (87.8%). When asked about the extent to which trainees’ own agencies/organizations provided enough in-service trainings during working hours to meet their professional development needs, trainees’ responses were varied. Less than half (47.5%) “Strongly Agreed” or “Agreed” with this statement. However, when trainings were offered through their employers, most trainees considered them to be helpful, as indicated by 64.6% “Strongly Agreeing” or “Agreeing” with this idea.

**Child Welfare Professional Trainees: Online Training.** The majority (72.4%) of child welfare professional online trainees indicated that they “Strongly Agreed” or “Agreed” that it was easy to get paid time off of work from their employer to attend outside training events, and just over half (59.2%) indicated that they “Strongly Agreed” or “Agreed” that it was easy to get unpaid time off of work from their employer to attend outside training events. The vast majority of trainees also indicated that their agency/organization encouraged its employees to attend outside training events (83.1%). When asked about the extent to which trainees’ own agencies/organizations provided enough in-service trainings during working hours to meet their professional development needs, trainees’ responses were varied. Less than half (47.3%) “Strongly Agreed” or “Agreed” with this statement. However, when trainings were offered through their employers, most trainees considered them to be helpful, as indicated by 71.8% “Strongly Agreeing” or “Agreeing” with this idea.

**Table 13A: Child Welfare Professionals Barriers to Attending Trainings**

Survey Questions and Response Options	2017 Child Welfare In-person Cohort	2017 Child Welfare Online Cohort
It is easy to get paid time off work from my employer to attend outside training events. <b>Strongly agree</b> <b>Agree</b> Neutral Disagree Strongly disagree	n=832 <b>368 (44.2%)</b> 303 (36.4%) 108 (12.9%) 25 (3.0%) 28 (3.4%)	n=363 92 (25.3%) <b>171 (47.1%)</b> 69 (19.0%) 14 (3.9%) 17 (4.7%)
It is easy to get unpaid time off work from my employer to attend outside training events. Strongly agree <b>Agree</b> <b>Neutral</b> Disagree Strongly disagree	n=801 243 (30.3%) 215 (26.8%) 242 (30.2%) 52 (6.5%) 49 (6.1%)	n=363 80 (22.0%) 135 (37.2%) 109 (30.0%) 23 (6.3%) 16 (4.4%)
My agency/organization encourages its employees to attend outside training events. <b>Strongly agree</b> <b>Agree</b> Neutral Disagree Strongly disagree	n=828 <b>424 (51.2%)</b> 303 (36.6%) 69 (8.3%) 22 (2.7%) 10 (1.2%)	n=362 126 (34.8%) 175 (48.3%) 50 (13.8%) 7 (1.9%) 4 (1.1%)

My agency/organization provides enough in-service trainings during working hours to meet my professional development needs.	n=830	n=362
Strongly agree	154 (18.6%)	60 (16.6%)
<b>Agree</b>	240 (28.9%)	111 (30.7%)
Neutral	213 (25.6%)	107 (29.5%)
Disagree	150 (18.1%)	66 (18.2%)
Strongly disagree	73 (8.8%)	18 (5.0%)
The majority of trainings offered at work are helpful in my job.	n=813	n=362
Strongly agree	182 (22.3%)	66 (18.2%)
<b>Agree</b>	343 (42.2%)	194 (53.6%)
Neutral	180 (22.1%)	77 (21.3%)
Disagree	76 (9.3%)	20 (5.5%)
Strongly disagree	32 (3.9%)	5 (1.4%)

**Child Welfare Professional Trainees: In-person Training.** Child welfare professional trainees were also invited to comment on the barriers they face in attending training. Comments were grouped into themes and a few common themes emerged such as workload responsibilities (40.8%), location (27.1%), time constraints (21.6%), cost (13.3%) and lack of relevant training offered (7.3%).

**Child Welfare Professional Trainees: Online Training.** Online trainees were also asked to identify barriers to attending training. Comments were grouped, and a few common themes emerged such as location/distance (40.2%), time constraints (33.3%), workload responsibilities (28.4%), cost (14.7%), and not enough training offered (5.8%). Results appear in Table 13B, followed by some specific comments provided by trainees.

**Table 13B: Child Welfare Professionals Barriers to Attending Trainings - Comments in Qualitative Feedback**

Survey Questions and Response Options	2017 Child Welfare In-person Cohort n=218*	2017 Child Welfare Online Cohort n=102*
Barriers listed in qualitative feedback		
<b>Workload responsibilities</b>	89 (40.8%)	29 (28.4%)
Location or distance	59 (27.1%)	41 (40.2%)
<b>Time constraints</b>	47 (21.6%)	34 (33.3%)
Cost	29 (13.3%)	15 (14.7%)
Not enough training offered	16 (7.3%)	6 (5.8%)
Something else	26 (11.9%)	9 (8.8%)
*Some comments listed more than one barrier, so percentages are calculated out of total respondents and may exceed 100%		

### Workload responsibilities

- Having caseloads so high that finding time to attend training is becoming very difficult.
- May not attend if court/other mandated scheduling conflicts occur.
- Last minute work schedule changes.
- Work caseload.
- Difficult to juggle my caseload/ work responsibility to take time off for trainings.
- Employer discourages dues to caseloads and not having other/ enough staff to cover.
- Getting coverage in the office so we can attend trainings.
- Too many tasks to do in the office that have a higher priority than trainings—too high of caseloads + demands.
- Being away from your office created time from your daily job that is waiting for you.
- Staffing shortages have made it impossible to get paid training time off. For the past year ,I have had to take vacation time to attend training despite the fact the state requires

child welfare staff to complete 32 hours annually.

- Amount of employees that can be off at one time.
- The obstacle I have in attending outside training is work responsibility and work deadline or emergency.
- It can be difficult to attend outside training events depending on what is going on with my caseload.
- Preparing staff/ work for time away.
- Scheduling around client appointments.

**Location or distance:**

- Distance. I work in Muskegon so sometimes, I'm late to trainings in GR due to the distance and road conditions.
- I commute to my office and daycare is located by my office. It is tough to attend trainings that aren't local due to childcare.
- Too far away—more in Detroit area!
- Snow! I-94! Distance between workplace + training location.
- Distance from Flint, MI for short (3 hours) training.
- Not enough offered in Kalamazoo.
- Distance to travel and time of training.
- At times are too far away.

**Time constraints:**

- Scheduling time with changing environments.
- Day/Time offered.
- When they start before 9, can be challenging for parents of school-age children.
- Schedule conflicts.
- Schedule, multiple day trainings are more difficult to get approved as are ones that are out of state.
- More offerings during the week.
- We needed more time 4 more hours.
- time: need morning/ early afternoon.
- The job has a meeting on training scheduled at the same time that is mandatory.

**Cost**

- Costs to attend training events.
- No paid training offered.
- Travel: Accommodation approval/ reimbursement.
- Price (Distance suggests need for hotel but cost not likely covered by agency).
- If there is a cost, I usually have to pay.
- Cost vs. number of CEUs, example: \$100 conference to get 6 CEUs = 16.66 per CEU. This conference \$49/3 = \$16.33 + travel, gas, time. Internet site = \$59.99 unlimited cost.

**Not enough training offered:**

- Repeat topics that are not an advanced from last time offered. Sometimes, not enough sessions/topics to sign up for.
- Lack of relevant, child welfare trainings.
- There aren't enough.
- A lot of the same topics, not enough variety.
- Content - needs more training on leadership and not just population specific.
- Not enough on various topics.

**Something else:**

- Good directions.
- Events trainings fill up really quickly.
- Director not feeling trainings are important (outside trainings).
- Parking in Ann Arbor.
- Limited capacity/waiting lists.

- I need state employee trainings to consistently offer social work CEUs. Too many mandatory trainings for DHHS do not.

**Other notable comments:**

- Consistently thought provoking, current and relevant topics which are easily accessible and affordable. I believe that MSU’s School of SW provides a ‘gold standard’ in higher education not just to students seeking a degree, but also in providing ongoing professional development support to those of us working in the community. Very nice job, everyone! (and thanks!)
- I especially appreciated the distinction between learning disabilities and educational impairments vs.. trauma responses. It makes a lot of sense that issues could be related to trauma and not an educational setback.
- My employer does not have flexible hours in which to attend trainings. It is hard to get time off. In addition, when trainings are held, the CEU’s are only offered to RN’s or physicians, not social workers.

**Leadership Trainees: In-person Training.** Leadership trainees were asked about several potential barriers to their attending training. For each of the five statements listed in Table 13C, trainees indicated on a 5-point scale the extent to which they “Agreed” (1-Strongly Agree, 2-Agree, 3-Neutral, 4-Disagree, or 5-Strongly Disagree). Some trainees (42%) indicated that they “Strongly Agreed” or “Agreed” that it was easy to get paid time off of work from their employer to attend outside training events, and more than half (64.6%) indicated that they “Strongly Agreed” or “Agreed” that it was easy to get unpaid time off of work from their employer to attend outside training events. Most trainees also indicated that their agency/organization encouraged its employees to attend outside training events 70.9%). When asked about the extent to which trainees’ own agencies/organizations provided enough in-service trainings during working hours to meet their professional development needs, trainees’ responses were varied. More than half (54.8%) “Strongly Agreed” or “Agreed” with this statement. When trainings were offered through their employers, most trainees considered them to be helpful, as indicated by 70.6% “Strongly Agreeing” or “Agreeing” with this idea.

**Leadership Trainees: Online Training.** Leadership trainees were asked about several potential barriers to their attending training. For each of the five statements listed in Table 13C, trainees indicated on a 5-point scale the extent to which they “Agreed” (1-Strongly Agree, 2-Agree, 3-Neutral, 4-Disagree, or 5-Strongly Disagree). Most (80.0%) indicated that they “Strongly Agreed” or “Agreed” that it was easy to get paid time off of work from their employer to attend outside training events, and (40.0%) indicated that they “Strongly Agreed” or “Agreed” that it was easy to get unpaid time off of work from their employer to attend outside training events. The vast majority of trainees also indicated that their agency/organization encouraged its employees to attend outside training events 82.5%). When asked about the extent to which trainees’ own agencies/organizations provided enough in-service trainings during working hours to meet their professional development needs, trainees’ responses were varied. Just over half (55.0%) “Strongly Agreed” or “Agreed” with this statement. When trainings were offered through their employers, most trainees considered them to be helpful, as indicated by 62.5% “Strongly Agreeing” or “Agreeing” with this idea.

**Table 13C: Leadership Training Barriers to Attending Trainings**

Survey Questions and Response Options	2017 Child Welfare In-person Cohort n=31	2017 Child Welfare Online Cohort n=40
It is easy to get paid time off work from my employer to attend outside training events.		
Strongly agree	7 (22.6%)	8 (20.0%)
<b>Agree</b>	6 (19.4%)	<b>24 (60.0%)</b>
<b>Neutral</b>	<b>14 (45.1%)</b>	6 (15.0%)
Disagree	1 (3.2%)	2 (5.0%)
Strongly disagree	3 (9.7%)	0 (0.0%)

It is easy to get unpaid time off work from my employer to attend outside training events. <b>Strongly agree</b> <b>Agree</b> <b>Neutral</b> Disagree Strongly disagree	<b>10 (32.3%)</b> <b>10 (32.3%)</b> 8 (25.8%) 1 (3.2%) 2 (6.5%)	6 (15.0%) 10 (25.0%) <b>19 (47.5%)</b> 3 (7.5%) 2 (5.0%)
My agency/organization encourages its employees to attend outside training events. <b>Strongly agree</b> <b>Agree</b> Neutral Disagree Strongly disagree	<b>13 (41.9%)</b> 9 (29.0%) 5 (16.1%) 4 (12.9%) 0 (0.0%)	10 (25.0%) <b>23 (57.5%)</b> 3 (7.5%) 3 (7.5%) 1 (2.5%)
My agency/organization provides enough in-service trainings during working hours to meet my professional development needs. Strongly agree <b>Agree</b> Neutral Disagree Strongly disagree	5 (16.1%) <b>12 (38.7%)</b> 8 (25.8%) 5 (16.1%) 1 (3.2%)	1 (2.5%) <b>21 (52.5%)</b> 6 (15.0%) 12 (30.0%) 0 (0.0%)
The majority of trainings offered at work are helpful in my job. Strongly agree <b>Agree</b> Neutral Disagree Strongly disagree	10 (29.4%) <b>14 (41.2%)</b> 7 (20.6%) 2 (5.9%) 1 (2.9%)	1 (2.5%) <b>24 (60.0%)</b> 10 (25.0%) 5 (12.5%) 0 (0.0%)

**Leadership Professional Trainees: In-person Training.** Comments were grouped into themes and a few common themes emerged such as time constraints (50.0%), location, cost (33.3%), and location/distance (16.7%).

**Leadership Professional Trainees: Online Training.** Leadership trainees were also asked to identify barriers to attending training. Comments were grouped, and a few common themes emerged such as cost (26.6%), location (26.6%), lack of agency support (26.6%), time constraints (13.3%), workload responsibilities (6.6%), Results appear in Table 13D, followed by some specific comments provided by trainees. Note: there were a relatively small number of leadership trainees who responded to this question, so there are some limitations to the generalizability of the percentages of the information contained in the tables below.

**Table 13D: Leadership Training Barriers to Attending Trainings – Comments in Qualitative Feedback**

Survey Questions and Response Options	2017 Child Welfare In-person Cohort n=6*	2017 Child Welfare Online Cohort n=21*
Barriers listed in qualitative feedback		
Workload responsibilities	0 (0.0%)	8 (38.1%)
Location or distance	1 (16.7%)	3 (14.3%)
<b>Time constraints</b>	<b>3 (50.0%)</b>	1 (4.8%)
<b>Cost</b>	<b>2 (33.3%)</b>	<b>9 (42.9%)</b>
Not enough training offered	0 (0.0%)	0 (0.0%)
Something else	0 (0.0%)	0 (0.0%)
*Some comments listed more than one barrier, so percentages are calculated out of total respondents and may exceed 100%		

**Workload responsibilities:**

- Distractions in the office.
- We're short-staffed, so it's hard to find coverage when folks go to trainings.
- Workload builds as I am away.
- Regular workload and time.
- Scheduled meetings/court hearings.
- My workload in the office.
- Too much work to do.

**Location or distance:**

- Location.
- Distance at times can be a barrier.
- Travel time would be #1 as I am in the Upper Peninsula.
- Drive time and parking.

**Time constraints:**

- I am in private practice, so rescheduling clients is problematic.
- Just making sure that when trainings are set up that it's not on Fridays afternoon times.
- No barriers other than scheduling conflicts.
- Time and money constraints.

**Cost:**

- Finances. If it costs, there is not a large budget to pay for a training. The free DHHS trainings are always encouraged.
- Funding - most are located downstate and often requires travel to/from - either taking up the whole day or requiring overnight stay.
- We have no training budget so outside training is discouraged.
- Financial costs.
- Costs for relevant training can stand in the way of attendance.
- Payment when there are fees and travel reimbursement when there is significant travel.

**Proposed Topics for Future Training Events**

As part of the evaluation materials completed at the conclusion of each training event, child welfare trainees were asked to provide suggestions for future topics on which they would be interested in receiving training. The responses have been organized in **Table 14** by most frequently cited response.

**Table 14: Top 19 Suggested Training Topics (Child Welfare)**

n=191	Professional Skills/ Responsibilities	n=5	Human Trafficking
n=156	Trauma	n=16	Ethics
n=112	General Mental Health	n=29	Physical/ Sexual Abuse or Neglect
n=40	Substance Abuse	n=16	Domestic Violence
n=17	Cultural Diversity	n=10	Pain Management
n=63	Youth	n=24	Autism
n=167	Foster Care	n=31	Special Education Needs
n=50	Self-care/Burnout Prevention/ Secondary Trauma	n=5	Older Adults
n=16	Cultural Diversity	n=5	Engaging Fathers
n=26	Medication	n=19	Management
n=37	Grief	n=22	Supporting families
n=44	Working with Children with Physi- cal Disabilities		

## Best Training Day and Time

**Child Welfare Professionals: In-person Training.** Trainees were also invited to provide comments about their experience attending the in-service training events. Trainees were asked which days and times were most convenient to attend training, and trainees overwhelmingly indicated that attending training during the morning hours was preferable. The most commonly suggested response was Friday morning with 69.0% of respondents indicating this as their most preferred day and time to attend training. Wednesday morning (46.1%), Thursday morning (46.5%) and Monday morning (43.8%) were also selected as highly preferable by trainees. See Table 15A. (Note: trainees were allowed to select several responses, so percentages are calculated based on the total number of trainees who selected that time slot divided by the total number of trainees in the child welfare in-person trainee cohort).

Time	Monday
Morning	294 (46.1%)
Afternoon	217 (34.1%)
Evening	57 (9.0%)

**Table 15A**  
**Child Welfare Professional: In-person Training (n=785)**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning	344 (43.8%)	316 (40.3%)	362 (46.1%)	365 (46.5%)	542 (69.0%)	71 (9.0%)
Afternoon	175 (22.3%)	169 (21.5%)	176 (22.4%)	185 (23.6%)	254 (32.4%)	35 (4.5%)
Evening	66 (8.4%)	81 (10.3%)	73 (9.3%)	88 (11.2%)	84 (10.7%)	20 (2.6%)

**Child Welfare Professionals: Online Training.** Tuesday morning (54.3%), Wednesday morning (52.7%), Thursday morning (55.2%) and Friday morning (49.7%) received strong support as a preferred training day and time from trainees who attending

child welfare online training. See Table 15B.

**Table 15B**  
**Child Welfare Professional: Online Training (n=634)**

Day	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
33%	344 (54.3%)	334 (52.7%)	350 (55.2%)	315 (49.7%)	54 (8.5%)	38 (6.0%)
22%	258 (40.7%)	244 (38.5%)	269 (42.4%)	227 (35.8%)	51 (8.0%)	40 (6.3%)
45%	67 (10.5%)	55 (8.6%)	64 (10.1%)	52 (8.2%)	35 (5.5%)	32 (5.0%)

## Interpretation of Findings for Evaluation Question #5

The information presented here offers helpful insights for continuous quality improvement of this in-service child welfare training initiative. Of particular note, it highlights the importance of continuing to offer trainings on subjects of interest to the targeted audience, which include professional skills/responsibility, trauma, mental health, foster care/adoption, abuse, youth, physical/sexual abuse and neglect, self-care/burnout prevention/trauma. Continuing to make in-person trainings geographically accessible, the geographic accessibility of leadership trainings, and ensuring that all available is also valuable. Offering trainings on Fridays, and to a lesser extent, and Thursday mornings, may facilitate greater participation. Lastly, it appears that the training initiative has done a good job of reaching out to professionals working in environments that support employees' participation in outside training events. This raises a question about what the initiative and DHHS might be able to do to encourage less accommodating child welfare sector employers to facilitate their employees participation in these trainings.

Day	Sunday
9.0%)	25 (3.1%)
4.5%)	11 (1.4%)
2.5%)	7 (0.9%)

# Conclusions

## Key Findings

- The vast majority of all three targeted training populations—child welfare professionals, caregivers, and leaders—reported high levels of satisfaction with the trainings. They indicated that the trainings they participated in increased their knowledge of the topic(s), were relevant to their current work, and that they would recommend them to coworkers.
- Responses from the in-person child welfare professional training surveys indicate that the vast majority of the 1,088 in-person trainees in the 2017 Cohort were regionally based; together they served 64 (77%) of the counties in Michigan. The number of counties represented may even be higher, as individuals who serve in a dual or tri-county region may have only reported one county.
- A minimum of 510 child welfare professionals from 72 Michigan counties (87%) participated in online training via hosted online trainings. Combined with the representation from the in-person training series, only 4 counties in Michigan (5%) were not represented by child welfare professional trainees.
- A total of 36 Michigan counties (43%) were represented by the trainees who attended in-person and online leadership trainings. This reflects strong geographic representation across the state given that this was the second year that this series of trainings for child welfare leadership was made available.
- Trainees were asked to assess their competency in the learning objectives for the training (s) that they attended both immediately prior to completing the training (pre-test) and immediately after completion (post-test). Analysis of this data indicated an increase

in trainees' self-assessed competency in the learning objectives, and follow-up survey results for in-person trainees indicate that this increase was typically sustained during the two months following training completion.

- Both in-person and online trainees expressed a high level of satisfaction with the trainings. In-person trainees were slightly more enthusiastic.

The following recommendations are based primarily on the quantitative data presented in the body of this report and the resulting Key Findings noted above. They are also informed by qualitative responses to four training participant survey questions regarding: (1) What trainees most hoped to learn from the training, (2) Suggested topics for future training events, (3) Best training days and times, and (4) How trainees planned to implement training information in their professional work.

## Lessons Learned and Recommendations

1. The In-Service program continues to meet its intended purposes and provide crucial training for public and private child welfare workers in Michigan. Increased funding would help develop more intensive and numerous workshops on critical topics—such as responding to the opioid crisis—and would help support the delivery of training to more remote geographic areas so that there is a regular opportunity to attend a face-to-face training (as well as webinars across the state), particularly in underserved areas.
2. The leadership training and caregiver training continue to be successful and are building audiences in both areas. It will take consistent offerings and outreach to make these opportunities known across the state. Given that the primary source of information about caregiver training is child welfare professionals, our outreach to caregivers needs to include agency workers. We need to continue to engage workers and inform workers about training opportunities for foster, kin and adoptive parents. The train-the-trainer event each fall continues to be a great success with solid attendance (approximately fifty participants) and strong positive evaluations. This could be expanded to semi-annual; or even quarterly training with additional support.
3. Given the challenges of child care and geography, our emphasis will increasingly be on webinars and other accessible learning events and less so on face-to-face workshops for both caregivers and leaders/supervisors.
4. Overall, online education is increasingly popular for workers, too. It is difficult to know the exact number of participants because if people do not fill out questionnaires, we do not know they are participating in the training. Also, multiple people may be attending at the same computer but only one site is reported. Although only small numbers, it is interesting that African American and other non-white participants seem more likely to be using online formats (19 in-person African American and 40 on-line; 2.2% of in-person and 10% on-line including other non-white racial categories). Our efforts to offer and increase online learning opportunities will continue.
5. Although we have been worried about lower training numbers of workers in their earliest years of employment, this year's evaluation shows that there are 70 participants under the age of 25. There also seems to be a better distribution with regard to length of child welfare service with 28% of participants under 2 years of service (in-person) and 34% under two years of service on-line. We need to continue to aim for newer and younger workers as this is a vulnerable time of employment. This may require stronger coordination with new worker training and outreach to agency training directors.
6. A small number and simple finding but significant: 10% of participants learned about the in-service training from university newsletters—this is a benefit of the partnership between universities and the Department. The catalog continues to be a primary marketing instrument and will be continued.
7. Motivation for participating in in-service training is primarily the training topic. Choosing relevant, timely and diverse topics remains our top priority. For example, introducing more evidence-based practices into training would be an asset. In addition,

# Appendix A • 2017 Child Welfare In-service Training for the Michigan Department of Health and Human Services and DHHS-contracted Private Agencies

## Child Welfare Professionals Events

Training Title, Date and Provider	Training Objectives As a result of this workshop, participants will be prepared to:
<p><b>Claiming Shame Resilience and Self Compassion in Adoption and Foster Care</b></p> <p>Michigan State University 10/07/16 9:00am - 12:15pm WMU Beltline Conference Center, Grand Rapids</p>	<ul style="list-style-type: none"> <li>Describe the universal experience of shame and its adverse impact on healthy functioning.</li> <li>Recognize that the way our brain and nervous system function underpins self-compassion and shame resilience and that it relates to healing and a sense of well-being.</li> <li>Discuss/practice various strategies that support self-compassion and shame resilience.</li> </ul>
<p><b>Collaborating with Schools to Enrich the Lives of Children and Families</b></p> <p>Wayne State University 10/07/16 9:00am - 12:15pm DHHS, Western Wayne District Office, Inkster</p>	<ul style="list-style-type: none"> <li>Recall basic special education law, rights, and process.</li> <li>Promote the rights of homeless youth under the McKinney-Vento Act.</li> <li>Identify strategies to form positive working relationships with school personnel.</li> </ul>
<p><b>Engaging Resistant Clients</b></p> <p>Spring Arbor University 10/14/16 8:45am - 12:00pm Northwest Michigan College University Center, Traverse City</p>	<ul style="list-style-type: none"> <li>Assess client readiness to change.</li> <li>Understand ways to meet clients where they are at.</li> <li>Utilize new techniques to engage with resistant clients.</li> </ul>
<p><b>Cultural Competence and Cultural Humility</b></p> <p>University of Michigan 10/14/16 1:00pm - 4:15pm UoM School of Social Work, Ann Arbor</p>	<ul style="list-style-type: none"> <li>Differentiate cultural competence from cultural humility.</li> <li>Describe skills for culturally responsive relationship building.</li> <li>Identify strategies to promote cultural humility in practice.</li> </ul>
<p><b>Overcoming Unconscious Bias in Child Welfare</b></p> <p>Grand Valley State University 10/21/16 8:45am - 12:00pm GVSU Pew Campus, Bicycle Factory, Grand Rapids</p>	<ul style="list-style-type: none"> <li>Identify at least two ways to adapt to a changing workplace and customer demographics.</li> <li>Describe at least two common value clashes that occur in the workplace and how to prevent these conflicts.</li> <li>Identify at least one skill to effectively communicate with individuals from different backgrounds.</li> </ul>
<p><b>Social Work Ethics and Social Media: More than a Friend Request</b></p> <p>Andrew University 10/21/16 9:00am - 12:15pm Andrew University, Chan Shun Hall, Berrien Springs</p>	<ul style="list-style-type: none"> <li>Recognize and process ethical dilemmas regarding using social media for personal and professional use.</li> <li>Develop a personal social media policy that governs personal use of social media to uphold the social work profession's ethical responsibilities to clients, colleagues, and organization.</li> <li>Recognize and process ethical dilemmas regarding using social media for personal and professional use.</li> <li>Develop a professional social media policy that governs professional use of social media to uphold the social work profession's ethical responsibilities to clients, colleagues, and organization.</li> <li>Develop a personal social media policy that governs personal use of social media to uphold the social work profession's ethical responsibilities to clients, colleagues, and organization.</li> </ul>
<p><b>Common Diagnosis and Essentials of Medication Management for Adopted Children</b></p> <p>Michigan State University 10/26/16 1:00pm - 4:15pm Troy Community Center, Troy</p>	<ul style="list-style-type: none"> <li>Describe the basic pharmacology of commonly used medications.</li> <li>Identify proper administration guidelines.</li> <li>Identify unintended side effects of medication for children in care.</li> <li>Summarize methods for maximizing caregiver medication compliance.</li> <li>Integrate information learned, as a basis to advocate for children in care to receive appropriate medication.</li> </ul>

<p><b>Understanding and Meeting Needs of Relative Caregivers</b></p> <p>Western Michigan University 10/28/16 8:45am - 12:00pm WMU College of Health and Human Services, Kalamazoo</p>	<ul style="list-style-type: none"> <li>• Describe the specific unique challenges facing grandparent/relative caregivers.</li> <li>• Identify specific needs of grandparent/relative caregivers for specific supports/resources.</li> <li>• Describe a current list of existing supports and resources for grandparent/ relative caregivers and recognize the appropriate use of these resources.</li> </ul>
<p><b>Navigating the Special Education System</b></p> <p>Eastern Michigan University 10/28/16 9:00am - 12:15pm EMU-Livonia</p>	<ul style="list-style-type: none"> <li>• Identify where they can access information about special education laws and policies in Michigan.</li> <li>• Describe strategies for navigating the special education system.</li> <li>• Name at least three resources in Michigan related to special education, including organizations that support students' rights.</li> </ul>
<p><b>Post-adoption Strategies and Services Designed to Avoid Broken Adoptions</b></p> <p>Michigan State University 11/03/16 9:00am - 12:15pm VisTaTech Center Schoolcraft College, Livonia</p>	<ul style="list-style-type: none"> <li>• Describe an effective approach to intervening with adoptive families in crisis.</li> <li>• Identify three common post-adoption service needs of families and children.</li> <li>• List three specific post-adoption resources at the local, state, and national levels.</li> </ul>
<p><b>Formulations on Child Trauma: Developmental Effects and Intervention Strategies</b></p> <p>11/04/16 9:00am - 12:15pm Macomb Advanced Technology Educational Center, Warren</p>	<ul style="list-style-type: none"> <li>• Apply information about the emerging research on the effects of abuse and neglect on children and adolescents.</li> <li>• Recognize the developmental effects of domestic violence and threatened harm.</li> <li>• Recognize the developmental effects of domestic violence and threatened harm.</li> </ul>
<p><b>Supporting Gay and Lesbian Youth Living in Care</b></p> <p>Eastern Michigan University 11/11/16 9:00am - 12:15pm EMU-Livonia, Livonia</p>	<ul style="list-style-type: none"> <li>• Identify unique layers of trauma common to gay and lesbian foster youth.</li> <li>• Identify common elements in the child welfare system that compound the vulnerability of sexual minority youth in care.</li> <li>• Develop a plan for adjusting practices with youth in care to increase sensitivity to gay and lesbian foster youth.</li> </ul>
<p><b>Operationalizing Retention-focused Management</b></p> <p>Michigan State University 11/10/16 1:00pm - 4:15pm MSU Federal Credit Union, East Lansing</p>	<ul style="list-style-type: none"> <li>• Identify two concepts that underpin the supervisor's role in building a culture of retention.</li> <li>• Name three strategies designed to develop and retain child welfare staff.</li> <li>• Implement two techniques to increase the intentional use of supervision for staff within the first year of employment.</li> </ul>
<p><b>Not Going It Alone: The Role of Reflective Supervision in Increasing Staff Efficacy and Coping</b></p> <p>University of Michigan 11/17/16 1:00pm - 4:15pm UoM School of Social Work, Ann Arbor</p>	<ul style="list-style-type: none"> <li>• Describe the theoretical underpinnings of reflective supervision.</li> <li>• Explain the value of increasing reflective functioning in staff.</li> <li>• Identify key behaviors exhibited in reflective supervision.</li> </ul>
<p><b>Adolescent Suicide Prevention and Intervention</b></p> <p>Grand Valley State University 12/02/16 8:45am - 12:00pm GVSU Pew Campus, Bicycle Factory, Grand Rapids</p>	<ul style="list-style-type: none"> <li>• Coach (foster) parents on warning signs and high-risk periods.</li> <li>• Identify risk factors and other attitudinal obstacles to prevention.</li> <li>• Communicate common myths and misperceptions about juvenile suicide.</li> </ul>
<p><b>When Children Get Removed: Using Play to Reduce the Effects of Trauma</b></p> <p>Grand Valley State University 01.13.17 8:45am - 12:00pm GVSU Pew Campus, Bicycle Factory, Grand Rapids</p>	<ul style="list-style-type: none"> <li>• Identify two ways that removal from the home is traumatic for the child.</li> <li>• Identify two roles that workers play in supporting the child through the process.</li> <li>• Demonstrate two play techniques that can be used to help reduce the effect of trauma.</li> </ul>

<p><b>Effective Recruitment and Retention Strategies for Foster and Adoptive Families</b></p> <p>Michigan State University 01/20/17 8:45am - 12:00pm Greater Lansing Association of REALTORS®, Lansing</p>	<ul style="list-style-type: none"> <li>• Identify three types of foster and adoptive parent recruitment strategies.</li> <li>• Utilize data to identify their agency's foster and adoptive home recruitment and retention needs.</li> <li>• Identify three methods to retain successful resource families.</li> </ul>
<p><b>Holding Them While They Grieve</b></p> <p>University of Michigan 01/20/17 1:00pm - 4:15pm UoM School of Social Work, Ann Arbor</p>	<ul style="list-style-type: none"> <li>• List three key indicators of infant/toddler grief.</li> <li>• Describe parenting behaviors that assist in supporting a child to grieve.</li> <li>• Identify key parenting behaviors that assist young children to form a new, secure attachment.</li> </ul>
<p><b>Building Resiliency: Family Approach to Surviving Substance Abuse</b></p> <p>Wayne State University 02/10/17 9:00am - 12:15pm WSU Oakland Center, Farmington Hills</p>	<ul style="list-style-type: none"> <li>• Strengthen resiliency in children and youth to reduce the harmful effects of parental substance abuse.</li> <li>• Identify family interventions to initiate treatment, support recovery, and help other family members.</li> <li>• Develop safety planning that uses family and community resources to protect children in homes with parental substance abuse.</li> </ul>
<p><b>Understanding Sexuality and Gender Expression</b></p> <p>Western Michigan University 02/17/17 8:45am - 12:00pm WSU College of Health and Human Services, Kalamazoo</p>	<ul style="list-style-type: none"> <li>• Describe the terms sexuality and gender expression.</li> <li>• Gain competence in understanding the different terms for sexuality and/or gender expression and how they are used in the LGBTQ community.</li> <li>• Gain competence in understanding the different terms for sexuality and/or gender expression and how they are used in the LGBTQ community.</li> </ul>
<p><b>Infant Mental Health: The Importance of Attachment</b></p> <p>Eastern Michigan University 02/17/17 9:00am - 12:15pm EMU-Livonia, Livonia</p>	<ul style="list-style-type: none"> <li>• Describe the central role of attachment in overall development.</li> <li>• Describe both insecure and secure attachment types and their associated relational behaviors.</li> <li>• Identify ways to support caregivers in creating a secure attachment with infants and toddlers.</li> </ul>
<p><b>Making a Difference: Open, Direct, and Honest TALK About Suicide</b></p> <p>Andrews University 03/10/17 9:00am - 12:15pm Chan Shun Hall, Berrien Springs</p>	<ul style="list-style-type: none"> <li>• Recognize that motivation is the key to learning suicide alertness skills.</li> <li>• Recognize that safeTALK unfolds wisdom about alertness and better integration.</li> <li>• Recognize the importance of open and direct talk about suicide.</li> <li>• Recognize people with thoughts of suicide.</li> <li>• Apply the Talk steps (Tell, Ask, Listen, and KeepSafe) to connect a person with thoughts of suicide to a suicide first-aid intervention caregiver.</li> </ul>
<p><b>Loss and Grief for Children and Youth in Care</b></p> <p>Eastern Michigan University 03/10/17 9:00am - 4:30pm EMU-Livonia, Livonia</p>	<ul style="list-style-type: none"> <li>• Articulate an understanding of attachment and separation as critical developmental issues in relation to loss and grief.</li> <li>• Articulate the unique cognitive and developmental stages and challenges for children and teens.</li> <li>• Explore the many losses experienced by children and youth within the child welfare system.</li> <li>• Apply principles of assessment of the grieving process, differentiating between adaptive and maladaptive responses.</li> <li>• Recognize practice considerations and opportunities to support children and teens.</li> </ul>
<p><b>No Time for Goodbye: When a Loved One's Death Is Traumatic</b></p> <p>Wayne State University 03/10/17 9:00am - 12:15pm WSU Oakland Center, Farmington Hills</p>	<ul style="list-style-type: none"> <li>• Identify behaviors characteristic of traumatic death.</li> <li>• Recognize normal versus complicated grief (how traumatic grief reactions are different from normal grief reactions).</li> <li>• Assess therapeutic interventions most conducive to the healing process.</li> <li>• Utilize a multi-disciplinary team approach in the healing process.</li> <li>• Distinguish beneficial therapeutic tools, tasks and exercises that reduce stressors relevant to a traumatic event.</li> </ul>

<p><b>Workers' Cultural Identities, Values, and Beliefs: Where Do you fit in Our Jobs?</b></p> <p>Western Michigan University 03/10/17 8:45am -12:00pm WMU College of Health and Human Services, Kalamazoo</p>	<ul style="list-style-type: none"> <li>• Identify core personal values and beliefs and appropriate ways to integrate them into practice.</li> <li>• Identify personal unconscious biases, how they impact personal values and beliefs, and the implications for practice.</li> <li>• During the workshop participants will develop a personalized plan that will outline appropriate ways to include their values and beliefs, their professions values and beliefs, and their clients' values and beliefs into their practice.</li> </ul>
<p><b>Assessing and Treating Mental Health Concerns in Very Young Children</b></p> <p>Wayne State University 03/17/17 9:00am -12:15pm WSU Schoolcraft Center, Livonia</p>	<ul style="list-style-type: none"> <li>• Recognize the importance of early child-caregiver relationships in assessing and treating mental health concerns in very young children.</li> <li>• Utilize trauma-informed care in treating young children who have been exposed to violence.</li> <li>• Identify treatment techniques when providing services to very young children with mental health concerns.</li> </ul>
<p><b>Domestic Violence and Trauma-informed Services</b></p> <p>Western Michigan University 03/24/17 8:45am -12:00pm WMU College of Health and Human Services, Kalamazoo</p>	<ul style="list-style-type: none"> <li>• Identify the many different ways in which trauma can impact survivors of domestic violence, focusing on beliefs, emotions, feelings, and behaviors of individuals.</li> <li>• Understand and develop safety options with clients.</li> <li>• Utilize trauma-informed delivery skills</li> </ul>
<p><b>Integrated Self-care for Helping Professionals</b></p> <p>Western Michigan University 04/07/17 8:45am -12:00pm WMU College of Health and Human Services, Kalamazoo</p>	<ul style="list-style-type: none"> <li>• Understand body-brain concepts related to stress.</li> <li>• Increase personal awareness of how stress manifests in the body.</li> <li>• Utilize body-based stress management techniques to practice scenarios.</li> <li>• Utilize body-based stress management techniques to practice scenarios.</li> </ul>
<p><b>"ARMBands" for Effective Treatment</b></p> <p>Andrews University 04/21/17 8:45am -12:00pm Chan Shun Hall, Berrien Springs</p>	<ul style="list-style-type: none"> <li>• Promote parenting practices that create strong, healthy emotional bonds.</li> <li>• Help teach parents on their caseload how to read their child's cues and behaviors to help him/her stay regulated and calm.</li> <li>• Assist parents on their caseload to learn the importance of spending time everyday playing with their child to create a connection, build the relationship, and provide a loving, secure environment.</li> <li>• Utilize tips, techniques, and practical skills to promote attachment and bonding.</li> </ul>
<p><b>MiTEAM Supervision and Mentoring</b></p> <p>Grand Valley State University 04/21/17 8:45am - 12:00pm GVSU Pew Campus, Bicycle Factory, Grand Rapids</p>	<ul style="list-style-type: none"> <li>• Identify core elements to effective MiTEAM supervision.</li> <li>• Explain how supervision is valuable to the strength-based model.</li> <li>• Recognize common obstacles and identify ways to overcome them.</li> </ul>
<p><b>Impact of Childhood Neglect on Early Development: An Interdisciplinary Approach</b></p> <p>Western Michigan University 04/21/17 8:45am - 12:00pm WMU College of Health and Human Services, Kalamazoo</p>	<ul style="list-style-type: none"> <li>• Understand the importance of attachment and how it can mitigate neglectful care: secure attachment, ambivalent attachment, and disorganized attachment.</li> <li>• Understand sensory processing disorder.</li> <li>• Better understand sensory modulation disorder and its subtypes: over responsive, under-responsive, and craving.</li> </ul>
<p><b>Perspectives on Youth Substance Abuse</b></p> <p>Wayne State University 04/28/17 9:00am - 12:00pm Macomb Advanced Technology Education Center, Warren</p>	<ul style="list-style-type: none"> <li>• Recognize emerging youth drug use trends.</li> <li>• Recall the signs and symptoms of drugs most commonly used by children and adolescents.</li> <li>• Employ the SBIRT (Screening, Brief Intervention and Referral to Treatment), an evidence-based approach for youth substance use screening.</li> </ul>

<p><b>Understanding Emotional and Mental Health Concerns of Youth</b></p> <p>Spring Arbor University 05/05/17 8:45am - 12:00pm Spring Arbor University, Lansing</p>	<ul style="list-style-type: none"> <li>• Understand typical adolescent development versus development of adolescents with emotional and mental health concerns.</li> <li>• Understand various emotional and mental health disorders related to youth.</li> <li>• Utilize strategies for working with emotional and mental health concerns in various settings.</li> </ul>
<p><b>Working with Children Who Have Attachment Issues</b></p> <p>Michigan State University 05/11/17 9:00am - 12:15pm Kellogg Hotel and Conference Center, East Lansing</p>	<ul style="list-style-type: none"> <li>• Describe the nature and necessity of a secure parent-child attachment.</li> <li>• Identify the connection between attachment relationships and emotional and behavioral regulation or dysregulation in children.</li> <li>• Identify tools and techniques used to foster attachment connection and reparation.</li> <li>• Identify tools and techniques for self-care and self-management for adoptive parents.</li> </ul>
<p><b>Taking a Pulse: Examining Compassion Fatigue in Child Welfare</b></p> <p>University of Michigan 05.11.17 9:00am - 12:00pm UoM School of Social Work, Ann Arbor</p>	<ul style="list-style-type: none"> <li>• Review key literature on compassion fatigue in the child welfare field.</li> <li>• Examine strategies to address compassion fatigue in the organization.</li> <li>• Explore one's own level of compassion fatigue and ways to build wellness.</li> </ul>
<p><b>Effective Placement Strategies for Children in Foster Care</b></p> <p>Ferris State University 05/19/17 9:00am - 12:15pm West Campus Community Center, Big Rapids</p>	<ul style="list-style-type: none"> <li>• Identify specific challenges that relative caregivers encounter.</li> <li>• Recognize the importance of preparing children for transition in placement.</li> <li>• Develop concrete skills to retain relative caregivers and mitigate difficult situations.</li> </ul>
<p><b>Did You Hear What I Said? Culture, Communication, and Conflict</b></p> <p>Grand Valley State University 05/26/17 8:45am - 12:00pm GVSU Pew Campus, Bicycle Factory, Grand Rapids</p>	<ul style="list-style-type: none"> <li>• Explain barriers to cross-cultural communication.</li> <li>• Identify linguistics that promotes inclusion.</li> <li>• Create your story as a bridge-building tool to cross-cultural relationships and working with others.</li> </ul>
<p><b>Addressing Suicide: A Culturally Responsive Approach to Prevention and Intervention</b></p> <p>University of Michigan 06/02/17 9:00am - 12:15pm UoM School of Social Work, Ann Arbor</p>	<ul style="list-style-type: none"> <li>• Describe the nature and necessity of a secure parent-child attachment.</li> <li>• Describe how to assess and confirm the risks of suicide and suicidal behaviors.</li> <li>• Describe the complexity of social work ethical and legal responsibility when suicide and suicidal behaviors are present.</li> </ul>
<p><b>Supporting African-American Youth in Schools</b></p> <p>Eastern Michigan University 06/09/17 9:00am - 12:15pm EMU-Livonia, Livonia</p>	<ul style="list-style-type: none"> <li>• Understand the research related to the school-to-prison pipeline and how policies and practices impact outcomes among vulnerable students.</li> <li>• Describe how African American students who are facing challenges may benefit from receiving intensive support services in schools and communities.</li> <li>• Understand how a mentoring program was developed to interrupt the school-to-prison pipeline by fostering supportive learning environments for students, teachers, and families and how schools of social work can partner with local school districts.</li> </ul>
<p><b>Help the Helper! Recognizing and Treating Compassion Fatigue</b></p> <p>Andrews University 06/16/17 9:00am - 12:15pm Chan Shun Hall, Berrien Springs</p>	<ul style="list-style-type: none"> <li>• Understand what compassion fatigue is and recognize the symptoms.</li> <li>• Recognize the wide range of difficulties that caregivers with compassion fatigue experience.</li> <li>• Identify strategies and resources for supporting caregivers experiencing compassion fatigue.</li> </ul>

<p><b>Early Education and Child Welfare Services: Working Together</b></p> <p>Michigan State University 06/22/17 9:00am – 12:15pm Country Inn and Suites East by Carlson, Grand Rapids</p>	<ul style="list-style-type: none"> <li>• Identify challenges for early education teachers/staff when working with the child welfare system.</li> <li>• Identify tangible solutions to work as a team with early education teachers/ staff.</li> <li>• Identify ways to engage the child welfare team in a child's early education goals.</li> </ul>
<p><b>Moving Toward Cultural Intelligence</b></p> <p>Michigan State University 06.23.17 8:45am – 12:00pm GVSU Pew Campus, Bicycle Factory, Grand Rapids</p>	<ul style="list-style-type: none"> <li>• Understand and learn our own biases.</li> <li>• See cultural and understand cultural competency/intelligence through a clearer lens.</li> <li>• Engage in culturally intelligent dialogue with greater knowledge and comfort.</li> </ul>
<p><b>Putting Your Own Mask on First: Understanding Secondary Traumatic Stress and Self-care in the Workplace</b></p> <p>Michigan State University 07/12/17 9:00am – 4:30pm Great Wolf Lodge, Traverse City</p>	<ul style="list-style-type: none"> <li>• Understand key trauma definitions and understand what is and is not secondary traumatic stress (STS)</li> <li>• Recognize and assess their own levels of trauma exposure in the workplace.</li> <li>• Identify supports to help manage any experienced secondary traumatic stress, including the introduction to mindfulness-based self-care for STS management.</li> <li>• Identify areas in their personal and professional lives that need self-care attention.</li> <li>• Identify resources for self-care when they are experiencing feelings of stress.</li> <li>• Utilize a self-care tool kit they created as a result of attending the workshop.</li> </ul>
<p><b>Operationalizing Retention-focused Management</b></p> <p>Michigan State University 07/14/17 9:00am – 12:15pm Great Wolf Lodge, Traverse City</p>	<ul style="list-style-type: none"> <li>• Identify two concepts that underpin the supervisor's role in building a culture of retention.</li> <li>• Name three strategies designed to develop and retain child welfare staff.</li> <li>• Implement two techniques to increase the intentional use of supervision for staff within the first year of employment</li> </ul>
<p><b>Transitioning to Higher Education: Improving Outcomes for Youth from Foster Care</b></p> <p>Michigan State University 08/04/17 9:00am – 12:15pm Greater Lansing Association of REALTORS®, Lansing</p>	<ul style="list-style-type: none"> <li>• Locate resources to assist youth preparing for higher education, including financial aid, career development and planning, and applying to higher education programs.</li> <li>• Understand alumni's perceptions of transitions from foster care to higher education.</li> <li>• Address mental health needs for youth in higher education and locate resources for mental health.</li> </ul>
<p><b>“¿Qué? Help Me Understand! Latino or Hispanic? Implications for Practice That Go Beyond the Spanish Language</b></p> <p>Andrew University 08/11/17 9:00am – 12:15pm Chan Shun Hall, Berrien Springs</p>	<ul style="list-style-type: none"> <li>• Increase cultural competency by better understanding the diversity within the Hispanic population and its implications for practice.</li> <li>• Identify the ramifications, stressors, reasons, and history that immigration status places on the family.</li> <li>• Utilize strengths-based and culturally aware interventions for working with Latino families.</li> </ul>
<p><b>Supporting Children Through Trauma and Grief</b></p> <p>Andrew University 09/08/17 9:00am – 12:15pm Lori's Place, St. Joseph</p>	<ul style="list-style-type: none"> <li>• Understand the research related to the school-to-prison pipeline and how policies and practices impact outcomes among vulnerable students.</li> <li>• Describe how African American students who are facing challenges may benefit from receiving intensive support services in schools and communities.</li> <li>• Understand how a mentoring program was developed to interrupt the school-to-prison pipeline by fostering supportive learning environments for students.</li> </ul>
<p><b>Trauma and Crisis Management for Children in Placement</b></p> <p>Ferris State University 09/15/17 9:00am – 12:15pm West Campus Community Center, Big Rapids</p>	<ul style="list-style-type: none"> <li>• Gain awareness of the effects of abuse and neglect as they relate to trauma</li> <li>• Obtain skills associated with minimizing trauma for children during the removal and replacement process.</li> <li>• Recognize the importance of safety planning for families in crisis.</li> </ul>

<p><b>Promoting Healing Health and Wellness in Youth Who Have Been Sexually Abused and Experienced Other Trauma</b></p> <p>Michigan State University 09/21/17 1:00pm - 4:15pm Houghton/Keweenaw Department of Health and Human Services, Houghton</p>	<ul style="list-style-type: none"> <li>• Develop an awareness of the health and wellness needs of children who have been sexually abused and experienced other trauma.</li> <li>• Identify protective factors that promote health and wellness for children who have been sexually abused and experienced other trauma.</li> <li>• Strategize to meet the health and wellness needs of children who have been sexually abused and experienced other trauma.</li> </ul>
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## Webinars

<b>Training Title, Date and Provider</b>	<b>Training Objectives</b> <b>As a result of this workshop, participants will be prepared to:</b>
<p><b>Making the Case for Retention- focused Supervision</b></p> <p>Michigan State University 10/13/16 12:00pm - 1:15 PM</p>	<ul style="list-style-type: none"> <li>• Identify two concepts that form the basis for retention-focused supervision.</li> <li>• Describe two techniques to create a retention-focused work environment.</li> </ul>
<p><b>Child Welfare: Your Role in Making Medicaid Happen</b></p> <p>Michigan State University 10/20/16 9:00am - 10:15 AM</p>	<ul style="list-style-type: none"> <li>• Understand the basic construct of the federal, Medicaid program and state responsibilities and children’s benefits and rights under the program.</li> <li>• Understand and exercise their role in preempting delays and denials in Medicaid eligibility and services and be informed as to federal and state resources to access for assistance.</li> </ul>
<p><b>Mindfulness Tools to Combat Secondary Trauma and build Well-being Among Child Welfare Professionals</b></p> <p>Michigan State University 10/23/16 12:00pm - 1:15 PM</p>	<ul style="list-style-type: none"> <li>• Define key concepts including mindfulness, secondary trauma, well-being and self-care.</li> <li>• Understand the difference between cognitive and somatic tools of mindfulness.</li> <li>• Identify three different mindfulness practice tools that combat secondary trauma.</li> </ul>
<p><b>Child Abuse and Neglect: The Signs, Symptoms and Consequences</b></p> <p>Michigan State University 12/7/16 9:00am - 10:15 AM</p>	<ul style="list-style-type: none"> <li>• Identify the risk factors and signs of abuse and neglect.</li> <li>• Identify the consequences of abuse and neglect on children.</li> <li>• Understand and explain the impact abuse and neglect as a child can have on adult life.</li> </ul>
<p><b>Becoming Trauma Informed Parents</b></p> <p>Michigan State University 1/18/17 12:00pm - 1:15 PM</p>	<ul style="list-style-type: none"> <li>• Develop a basic understanding of what trauma is and how it affects the brain and body.</li> <li>• Describe two ways that trauma affects behaviors and emotions.</li> <li>• Recognize caregiving strategies for children who have experienced trauma that are more likely to be safe and effective.</li> </ul>
<p><b>Fetal Alcohol Syndrome Disorder: What You Should Know</b></p> <p>Michigan State University 01/24/17 3:30pm - 4:45pm</p>	<ul style="list-style-type: none"> <li>• Describe the neurobehavioral profile of FASD: primary and secondary characteristics.</li> <li>• List best practices for helping manage behaviors connected to FASDs.</li> </ul>
<p><b>Involving Fathers to Create Functional Families</b></p> <p>Michigan State University 02/10/17 9:00am - 1:15pm</p>	<ul style="list-style-type: none"> <li>• Discuss the Dynamic Maturation Model (DMM) of Attachment and the role of Family Functional Formulations.</li> <li>• Review how family members may come to hold convergent ways of viewing a problem.</li> <li>• Discuss the unique role fathers play in families and the lack of clinical attention given to fathers.</li> <li>• Review array of DMM assessments that can be useful in including fathers in clinical work through an example case.</li> </ul>
<p><b>Promoting Health and Wellness for Foster Youth</b></p> <p>Michigan State University 02/23/17 12:00pm - 1:15pm</p>	<ul style="list-style-type: none"> <li>• Develop an awareness of the health and wellness needs of foster youth.</li> <li>• Identify protective factors that promote health and wellness of foster youth.</li> <li>• Strategize to meet the health and wellness needs of foster youth.</li> </ul>

<p><b>Making the Case for Retention-focused Management</b></p> <p>Michigan State University 03/16/17 11:00am - 12:15pm</p>	<ul style="list-style-type: none"> <li>• Identify two concepts that form the basis for retention-focused supervision.</li> <li>• Describe two techniques to create a retention-focused work environment.</li> </ul>
<p><b>Teen Parent in Foster Care</b></p> <p>Michigan State University 03/21/17 12:00pm - 1:15pm</p>	<ul style="list-style-type: none"> <li>• Identify the factors that contribute to a high rate of early parenthood among youth in foster care.</li> <li>• Describe some of the challenges faced by young parents in foster care.</li> <li>• Summarize some of the approaches being used to improve their outcomes.</li> </ul>
<p><b>Intergenerational Trauma and Our Work with Birth Parents: Understanding the Bridge to Success</b></p> <p>Michigan State University 04/06/17 9:00am - 10:15am</p>	<ul style="list-style-type: none"> <li>• Identify three factors contributing to patterns of intergenerational trauma.</li> <li>• Conduct an adult trauma screen to identify a birth parent's history of trauma and trauma responses.</li> <li>• Analyze at least three common adult behaviors in the context of their own childhood/emerging adulthood exposure to trauma.</li> </ul>
<p><b>Engagement Readiness for Change, and Transitioning Planning</b></p> <p>Michigan State University 05/02/17 12:00pm - 1:15pm</p>	<ul style="list-style-type: none"> <li>• Define engagement and why it's important.</li> <li>• Identify strategies to effectively facilitate engagement.</li> <li>• Identify evidence that engagement is present or not present in a client/worker relationship.</li> <li>• Summarize the importance of integrating transition planning as a part of the course of service provided.</li> <li>• Identify strategies and techniques to promote successful transition planning.</li> <li>• Identify the stages of change and the impact that client engagement and transition planning has on this.</li> </ul>
<p><b>Transitioning Youth Out of Foster Care</b></p> <p>Michigan State University 05/12/17 12:00pm - 1:15pm</p>	<ul style="list-style-type: none"> <li>• Identify the challenges faced by youth transitioning out of foster care.</li> <li>• Describe the major federal policies that affect this population.</li> <li>• Summarize what we know about programs to improve the outcomes of transition age foster youth.</li> </ul>
<p><b>Post Adoption Services: Assisting Adoptive Families to Avoid Disruption/Dissolution</b></p> <p>Michigan State University 05/16/17 12:00pm - 1:15pm</p>	<ul style="list-style-type: none"> <li>• Define types of current post adoption services available in Michigan.</li> <li>• Describe the challenges that families have in accessing post adoption services.</li> <li>• Identify strategies to help families plan for adjustment to adoption and plan for crisis.</li> </ul>
<p><b>The Welfare of Children with Autism Spectrum Disorders and Their Families</b></p> <p>Michigan State University 05/19/17 12:00pm - 1:15pm</p>	<ul style="list-style-type: none"> <li>• Demonstrate knowledge of the characteristics of autism spectrum disorders.</li> <li>• Describe the challenges families face when parenting children with ASD.</li> <li>• Demonstrate knowledge of evidenced based practices and therapies for children with ASD.</li> </ul>
<p><b>Understanding and Supporting Adoptive Families</b></p> <p>Michigan State University 06/06/17 12:00pm - 1:15pm</p>	<ul style="list-style-type: none"> <li>• Describe the potential complex dynamics of adoptive families.</li> <li>• Identify ways to engage and support adoptive families and youth.</li> <li>• List resources available for adoptive families.</li> </ul>
<p><b>Accessing Special Education Supports for Children in Foster Care</b></p> <p>Michigan State University 06/08/17 12:00pm - 1:15pm</p>	<ul style="list-style-type: none"> <li>• Identify the prevalence of children in foster care and special education.</li> <li>• Identify the process of seeking special education supports.</li> <li>• Identify alternative supports available to struggling children in the education system.</li> </ul>
<p><b>Psychological and Emotional Trauma in Children and Its Impact on Adoption/Foster Care and Family Development</b></p> <p>Michigan State University 06/15/17 9:00am - 12:15pm</p>	<ul style="list-style-type: none"> <li>• Identify psycho-emotional trauma and its impact on individual and family development.</li> <li>• List symptoms of psycho-emotional trauma in clients.</li> <li>• Identify strategies to assist your client population in achieving positive steps toward psycho-emotional healing.</li> </ul>

<b>Child Welfare Workers: The Ethical Obligation</b>  Michigan State University 06/15/17 9:00am - 10:15am	<ul style="list-style-type: none"> <li>• Identify a conceptual framework of advocacy for social justice.</li> <li>• Identify how ethical child welfare practice is consistent with the pursuit for social justice.</li> <li>• Identify new opportunities to advocate for social justice within child welfare practice.</li> </ul>
<b>Honoring and Empowering Adolescents</b>  Michigan State University 06/15/17 9:00am - 12:15pm	<ul style="list-style-type: none"> <li>• Discuss normal adolescent development.</li> <li>• Identify issues facing adolescents.</li> <li>• Implement strategies to honor and empower the teens you serve.</li> </ul>
<b>Having the Tough Conversations About Race with Your Clients</b>  Michigan State University 08/01/17 9:00am - 12:15pm	<ul style="list-style-type: none"> <li>• Establish a safe environment to have a challenging discussion about race and current events with child welfare clients.</li> <li>• Summarize the difficulty surrounding conversations about race and race relations.</li> <li>• Discuss self-awareness of implicit biases.</li> <li>• Identify tangible ways to have the discussions about race and current events with child welfare clients.</li> </ul>

## Leadership Training Events

Training Type	Training Title	Training Location	Training Objectives As a result of this workshop, participants will be prepared to:
In-person	<b>Operationalizing Retention-focused Management (11.10.16)</b>	MSU Federal Credit Union 4825 E. Mt. Hope Road, East Lansing, MI 48824	<ul style="list-style-type: none"> <li>• Identify two concepts that underpin the supervisor's role in building a culture of retention.</li> <li>• Name three strategies designed to develop and retain child welfare staff.</li> <li>• Implement two techniques to increase the intentional use of supervision for staff within the first year of employment.</li> </ul>
In-person	<b>Operationalizing Retention-focused Management (04.28.17)</b>	Troy Community Center 3179 Livernois, Troy, MI 48083	<ul style="list-style-type: none"> <li>• Identify two concepts that underpin the supervisor's role in building a culture of retention.</li> <li>• Name three strategies designed to develop and retain child welfare staff.</li> <li>• Implement two techniques to increase the intentional use of supervision for staff within the first year of employment.</li> </ul>
In-person	<b>Operationalizing Retention-focused Management (07.14.17)</b>	Great Wolf Lodge 3575 US-31 South, Traverse City, MI 49684	<ul style="list-style-type: none"> <li>• Identify two concepts that underpin the supervisor's role in building a culture of retention.</li> <li>• Name three strategies designed to develop and retain child welfare staff.</li> <li>• Implement two techniques to increase the intentional use of supervision for staff within the first year of employment.</li> </ul>
Webinar	<b>Making the Case for Retention-Focused Supervision (10.14.16)</b>	Online	<ul style="list-style-type: none"> <li>• Identify two concepts that form the basis for retention-focused supervision.</li> <li>• Describe two techniques to create a retention-focused work environment.</li> </ul>
Webinar	<b>Making the Case for Retention-Focused Supervision (03.16.17)</b>	Online	<ul style="list-style-type: none"> <li>• Identify two concepts that form the basis for retention-focused supervision.</li> <li>• Describe two techniques to create a retention-focused work environment.</li> </ul>

## Caregiver Training Events

Training Type	Training Title	Training Location	Training Objectives As a result of this workshop, participants will be prepared to:
In-person	<b>Claiming Shame Resilience and Self Compassion for Foster, Adoptive, Kin, and Birth Parents (10.22.16)</b>	Mt. Pleasant Comfort Inn and Suites Hotel and Conference Center 224 South Mission, Mt. Pleasant, MI 48858	<ul style="list-style-type: none"> <li>Identify that shame is a universal experience and has a negative impact on raising healthy children.</li> <li>Recognize that the way our brain and nervous system function underpins self -compassion and shame resilience and that it relates to healing and a sense of well-being.</li> <li>Define and practice two strategies that support self-compassion and shame resilience.</li> </ul>
In-person	<b>Raising Traumatized Children (11.12.16)</b>	2125 University Park Drive, Okemos, MI 48864	<ul style="list-style-type: none"> <li>Identify three concepts relating to how traumatic experiences can impact a child's behavior and development.</li> <li>Implement three trauma Informed parenting strategies to use with your children.</li> <li>Describe the importance of self-care in raising traumatized children.</li> </ul>
In Person	<b>True Grit of Self Care: Thriving in Foster, Adoptive and Kinship Families (05.05.17)</b>	Jackson College Maher Campus, 3000 Blake Road, Jackson, MI 49201	<ul style="list-style-type: none"> <li>Describe the universal experience of shame and its adverse impact on healthy functioning.</li> <li>Discuss the neurobiological underpinnings of self-compassion and shame resilience as it relates to healing and a sense of well-being.</li> <li>Discuss/practice various strategies that support self-compassion, self-care, and shame resilience.</li> </ul>
In Person	<b>Parenting Youth Who Have Been Sexually Abused and Have Experienced Other Trauma (09.21.17)</b>	47420 State Highway M26, Suite 62, Houghton, MI 49931	<ul style="list-style-type: none"> <li>Develop an awareness of the health and wellness needs of children who have been sexually abused and experienced other trauma.</li> <li>Identify protective factors that promote health and wellness for children who have been sexually abused and experienced other trauma.</li> <li>Strategize to meet the health and wellness needs of children who have been sexually abused and experienced other trauma.</li> </ul>
Webinar	<b>Becoming Trauma Informed Parents (01.19.2017)</b>	Online	<ul style="list-style-type: none"> <li>Develop a basic understanding of what trauma is and how it affects the brain and body.</li> <li>Describe two ways that trauma affects behaviors and emotions.</li> <li>Recognize caregiving strategies for children who have experienced trauma that are more likely to be safe and effective.</li> </ul>
Webinar	<b>Is That Your REAL Mom? (03.07.17)</b>	Online	<ul style="list-style-type: none"> <li>Identify how "race" and culture impact a child's identity formation and self-esteem.</li> <li>List two ways that "race" and culture impact children and families involved in cross-cultural parenting relationships.</li> <li>Identify the tools and tasks necessary to successfully raise a child of another "race" or culture.</li> </ul>

## Appendix B • Pre-training Evaluation Child Welfare In-service Training

This in-service training for DHHS and private agency child welfare workers in protective services, foster care and adoption workers is provided through support made possible by a grant from the Michigan Department of Health and Human Services. Please assist us in evaluating this in-service training initiative by answering the questions below. Your feedback will be useful in our efforts to meet your future in-service training needs. You indicate your voluntary agreement to participate in this evaluation by completing and returning this survey.

Please complete the next 4 questions to be used as your unique identifier. This identifier allows us to link your responses to this survey to your post-training and follow-up survey responses while also keeping your responses anonymous.

- A. What are the first two letters in your middle name? \_\_\_\_ \_\_\_\_
- B. What are the last two digits of the year of your high school graduation? \_\_\_\_ \_\_\_\_
- C. How many siblings do you have? (Note: Enter '02' for 2 siblings) \_\_\_\_ \_\_\_\_
- D. What are the first two letters of the city in which you were born? \_\_\_\_ \_\_\_\_

**Training title: Promoting Healing, Health and Wellness in Youth • Date of training: September 21, 2017**

1. **Where are you employed?**
  - Michigan Department of Human Services
  - Private child welfare agency or organization
  - Community Mental Health or Affiliate Agency
  - Clinician/Therapist in Private Practice
  - School/ISD
  - Other (please describe): \_\_\_\_\_
2. **What is your primary position?**
  - Child protective services worker
  - Foster care worker
  - Adoption worker
  - Supervisor
  - Child Welfare Licensing
  - Mental Health Clinician/Counselor/Therapist
  - Teacher/Educator/School Personnel
  - Other (please describe): \_\_\_\_\_
3. **County/counties where you are employed:**  
\_\_\_\_\_
4. **Number of years worked in child welfare:**
  - Less than 1 year     1 - 2 years
  - 3 - 4 years         5 - 10 years
  - 11 - 15 years       16 - 20 years
  - 21 - 25 years       more than 25 years
5. **Years worked at current employer:**
  - Less than 1 year     1 - 2 years
  - 3 - 4 years         5 - 10 years
  - 11 - 15 years       16 - 20 years
  - 21 - 25 years       more than 25 years
6. **How did you hear/learn about this training workshop?**
  - DHS in-service catalog
  - University newsletter/website
  - Continuing Education website
  - Email
  - Word of mouth
  - Other (please describe): \_\_\_\_\_
7. **What influenced you to attend this particular training workshop? (Please check all that apply.)**
  - Topic
  - Location
  - Date/Time
  - Affordable Price
  - Instructor
  - Networking Opportunities
  - Something else (please describe): \_\_\_\_\_
8. **What are the most convenient days and times for you to attend professional development trainings? Please select up to three convenient days/times you could attend by filling in the circle of the corresponding day/time below.**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<b>Morning</b> (8am - 12pm)	<input type="radio"/>						
<b>Afternoon</b> (12pm - 5pm)	<input type="radio"/>						
<b>Evening</b> (5pm - 9pm)	<input type="radio"/>						

- 9. With what race do you identify?**
- White or Caucasian
  - Black or African American
  - American Indian or Alaskan Native
  - Asian, Pacific Islander or Native Hawaiian
  - Two or more races/Multi-Racial
  - Other (please specify): \_\_\_\_\_
  - I prefer not to answer this question

- 10. With what ethnicity do you identify?**
- Spanish/Hispanic/Latino
  - Not Spanish/Hispanic/Latino
  - I prefer not to answer this question

- 11. With what gender do you identify?**
- Female
  - Male
  - Other
  - I prefer not to answer this question

- 12. What is your age?**
- |                                    |                                    |
|------------------------------------|------------------------------------|
| <input type="radio"/> Less than 25 | <input type="radio"/> 45 to 49     |
| <input type="radio"/> 25 to 29     | <input type="radio"/> 50 to 54     |
| <input type="radio"/> 30 to 34     | <input type="radio"/> 55 to 59     |
| <input type="radio"/> 35 to 39     | <input type="radio"/> 60 to 64     |
| <input type="radio"/> 40 to 44     | <input type="radio"/> 65 and older |

- 13. What is highest level of education you have completed?**
- BSW
  - BA/BS
  - MSW
  - MA/MS
  - Other (please explain): \_\_\_\_\_
  - I prefer not to answer this question

<b>Learning Objectives for This Training Event</b>	<b>Not at all Competent</b>	<b>Minimally Competent</b>	<b>Somewhat Competent</b>	<b>Moderately Competent</b>	<b>Competent</b>
<b>Rate your current level of competence to....</b>					
<b>14A.</b> Develop an awareness of the health and wellness needs of children who have been sexually abused and experienced other trauma.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>14B.</b> Identify protective factors that promote health and wellness for children who have been sexually abused and experienced other trauma.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>14C.</b> Strategize to meet the health and wellness needs of children who have been sexually abused and experienced other trauma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**15. Please provide at least two possible training topics, besides today's topic, regarding which you would be interested in receiving professional development training.**

Training Topic #1: \_\_\_\_\_

Training Topic #2: \_\_\_\_\_

**16. Additional comments:**

*Thank you for your participation!*

## Appendix C • Post-training Evaluation Child Welfare In-service Training

This in-service training for DHHS and private agency child welfare workers in protective services, foster care and adoption workers is provided through support made possible by a grant from the Michigan Department of Health and Human Services. Please assist us in evaluating this in-service training initiative by answering the questions below. Your feedback will be useful in our efforts to meet your future in-service training needs. You indicate your voluntary agreement to participate in this evaluation by completing and returning this survey.

Please complete the next 4 questions to be used as your unique identifier. This identifier allows us to link your responses to this survey to your pre-training and follow-up survey responses while also keeping your responses anonymous.

- A. What are the first two letters in your middle name? \_\_\_\_ \_\_\_\_
- B. What are the last two digits of the year of your high school graduation? \_\_\_\_ \_\_\_\_
- C. How many siblings do you have? (Note: Enter '02' for 2 siblings) \_\_\_\_ \_\_\_\_
- D. What are the first two letters of the city in which you were born? \_\_\_\_ \_\_\_\_

**Training title: Promoting Healing Health and Wellness in Youth • Date of training: September 21, 2017**

### 1. How well did the facilitator deliver the program material?

Poor		Fair		Good		Very Good		Excellent	
1	2	3	4	5	6	7	8	9	10
0	0	0	0	0	0	0	0	0	0

Please rate the following:                      Strongly Disagree      Disagree      Neutral      Agree      Strongly Agree

- 2. This training has increased my understanding of the topic.                      0                      0                      0                      0                      0
- 3. This topic is relevant to the work I do currently.                      0                      0                      0                      0                      0
- 4. I will use the information from this training in my current employment.                      0                      0                      0                      0                      0
- 5. I would recommend this training to co-workers.                      0                      0                      0                      0                      0

**Learning Objectives for This Training Event**      Not at all Competent      Minimally Competent      Somewhat Competent      Moderately Competent      Competent

Rate your current level of competence to....

- 6A. Develop an awareness of the health and wellness needs of children who have been sexually abused and experienced other trauma.                      0                      0                      0                      0                      0
- 6B. Identify protective factors that promote health and wellness for children who have been sexually abused and experienced other trauma.                      0                      0                      0                      0                      0
- 6C. Strategize to meet the health and wellness needs of children who have been sexually abused and experienced other trauma.                      0                      0                      0                      0                      0

7. What specific knowledge or skills from this training do you plan to implement in your professional work with children and families in the child welfare system? (Please be specific.)

8. This training provided me with the knowledge and/or skills that were identified in the course objectives.

Strongly Disagree		Disagree		Unclear		Agree		Strongly Agree	
1	2	3	4	5	6	7	8	9	10
0	0	0	0	0	0	0	0	0	0

Please rate the following:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
9a. It is easy to get <u>paid</u> time off work from my employer to attend outside training events.	<input type="radio"/>				
9b. It is easy to get <u>unpaid</u> time off work from my employer to attend outside training events.	<input type="radio"/>				
9c. My agency/organization encourages its employees to attend outside training events.	<input type="radio"/>				
9d. My agency/organization provides enough in-service trainings during working hours to meet my professional development needs.	<input type="radio"/>				
9e. The majority of trainings offered at work are helpful in my job.	<input type="radio"/>				

10. Please describe any barriers or obstacles that you have encountered to attending outside training events.

11. Additional comments?

*Thank you for your participation!*

# Appendix D • Follow-up Training Evaluation Child Welfare In-service Training

Dear Trainee,

Thank you for registering for the training entitled: “Promoting Health and Wellness in Youth Who Have Been Abused and Experienced Other Trauma” on September 21, 2017. As part of materials for this training event, you are receiving an electronic pretest (see link below). You will also receive an electronic post test shortly after the training event.

Please click on the link below to complete the pretest BEFORE the training event. Thank you for your help!

Survey link for Training #608-17 - Promoting Health and Wellness in Youth

<https://www.surveymonkey.com/r/BPZG5WQ>

\*\*\*\*\*

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## DHHS Training Follow-Up Survey - Promoting Health and Wellness for Foster Youth 09.21.17

\* 1. What are the first two letters in your middle name? 

\* 2. What are the last two digits of the year of your high school graduation? 

\* 3. How many siblings do you have? (Note: Enter "02" for 2 siblings) 

\* 4. What are the first two letters of the city in which you were born? 

Next

5. Please rate your ability to.... 

	Not at All Competent	Minimally Competent	Somewhat Competent	Moderately Competent	Competent
Develop an awareness of the health and wellness needs of foster youth.	<input type="checkbox"/>				
Identify protective factors that promote health and wellness of foster youth.	<input type="checkbox"/>				
Strategize to meet the health and wellness needs of foster youth.	<input type="checkbox"/>				

Prev Next

6. What specific knowledge or skills from this training have you implemented in your professional work with children and families in the child welfare system? Please provide examples if possible. 

7. Do you have additional comments to share? 

Prev Done



**MICHIGAN STATE**  
UNIVERSITY

School of Social Work

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## FOSTER AND ADOPTIVE PARENT DILIGENT RECRUITMENT PLAN

The MDHHS Office of Child Welfare Policy and Programs provided materials and data to counties to assist them in completing their Adoptive and Foster Parent Recruitment and Retention plans for 2018. Each county received data regarding:

- Demographics of children in care by county.
- Children entering and exiting care by county.
- Total number of foster homes licensed by county.
- Foster home closures by relative and non-related foster homes.
- Data to complete the foster home calculator, a foster home needs assessment tool.

Counties and agencies reviewed the data and Foster Home Estimator results to identify targeted populations. The counties and agencies collaborated to identify non-relative licensing goals and strategies to recruit homes for the targeted populations. Collaboration and planning between the MDHHS county office, private agencies, federally recognized tribes, faith communities and key foster/adoptive/kinship parents is necessary to determine the county's overall recruitment needs and goals and the actions steps required to achieve those goals.

In 2017, each county's licensing goal was analyzed and monthly targets were established to assist counties in monitoring their progress toward meeting their unrelated licensing goal.

In 2017, MDHHS collected and analyzed trends on new licenses, closed homes and the number of relative homes compared to non-relative homes, achieving the following:

- The Division of Child Welfare Licensing issued 1,831 new foster home licenses, an increase of 106 from 2016.
- Of new licenses, 1,299 accept unrelated placements, an increase of 228 from 2016.
- On Oct. 1, 2016, there were 6,242 licensed foster homes. One year later, 4,382 of those licensed foster parents remained licensed, which is a 70 percent retention rate and a 2 percent increase from 2016.
- The number of homes that closed was 1,896, a decrease of 280 from 2016.
- Each month approximately 100 to 200 surveys are sent to foster parents whose foster home closed during the previous month.

The results of the closed home surveys show the majority of homes close voluntarily, with adoption as one of the top reasons for not continuing as foster parents. The top reasons foster parents closed their license were:

- Adopted the child(ren) placed with them.
- Demands/stress of being a foster parent.

The chart below details the trend of licensure and closed homes in urban counties:

County	Original Licenses			Closed Homes		
	Fiscal Year 2015	Fiscal Year 2016	Fiscal Year 2017	Fiscal Year 2015	Fiscal Year 2016	Fiscal Year 2017
Genesee	72	70	77	106	120	78
Kent	134	115	118	176	178	117
Macomb	101	71	105	129	135	97
Oakland	122	160	149	161	141	124
Wayne	185	216	219	257	246	220
<b>Total</b>	<b>614</b>	<b>632</b>	<b>668</b>	<b>829</b>	<b>820</b>	<b>636</b>

The chart below describes the type of homes (relative and non-relative) opened in urban counties in 2017:

County	Relative	Non-relative	Total
Genesee	26	51	77
Kent	40	78	118
Macomb	30	75	105
Oakland	38	111	149
Wayne	92	127	219
<b>Total</b>	<b>226</b>	<b>442</b>	<b>668</b>

## Statewide and Regional Recruitment Progress in 2017

- MDHHS worked with several media venues to execute effective marketing strategies and advertising for recruitment of foster and adoptive parents statewide.
- The 2017 Heart Gallery Opening was held on April 29, 2017. The opening featured 136 young people who were photographed by 54 photographers from around the state.
- MDHHS held its fourth annual Foster, Adoptive and Kinship Parent Conference in collaboration with the Foster, Adoptive and Kinship Parent Collaborative Council. The conference was held on May 5 and 6, 2017, and was attended by foster, adoptive and kinship parents from throughout the state.
- MDHHS hosted the annual Community and Faith Leader Summit on April 18, 2017 in Kalamazoo and on April 27, 2018 in Dearborn. Over 160 faith and community leaders and partners attended the events.
- The Community and Faith-Based Initiative on Foster Care and Adoption collaborated with faith communities throughout the state. This initiative worked with Faith Communities Coalitions on Foster Care located in 11 different regions across the state.
- The MDHHS Community and Faith-Based Initiative on Foster Care and Adoption Advisory Council continued to promote foster care and adoption and identified ways in

which communities can assist in enhancing services to children and families served by MDHHS. The council is comprised of faith and community members and meets at least quarterly.

- The Michigan Adoption Resource Exchange (MARE) held “meet and greet” recruitment events that provided an environment for families to meet children available for adoption without an identified forever family.
- MARE hosted Heart Gallery events statewide.
- The template for the Adoptive and Foster Parent Recruitment and Retention Plans was revised for 2018 based on feedback from the field.

## **Using Foster and Adoptive Parents for Recruitment Progress in 2017 and 2018**

- The Foster Care Navigator Program assisted families who inquired about becoming a licensed foster parent. The Foster Care Navigators helped families navigate the licensing process, locate resources and understand the licensing rules and needs of children in foster care. From Oct. 1, 2014, when the program was awarded to a new contractor, to March 31, 2018, the Foster Navigator Program has assisted 597 families in completing the licensure process.
- Since October 2014, 10,014 new family inquiries have been received through the Foster Care Navigator Program, of which over 150 families are actively engaged in Foster Care Navigator services and working toward foster parent licensure.
- Navigators through the Foster Care Navigator Program are a resource for mentoring and supporting relatives seeking to undergo the licensing process. Each month a navigator reaches out to all relatives with a new child placement to offer mentoring and guidance through the licensing process.
- MDHHS collaborated with the Foster Care Navigator Program to celebrate exceptional foster parents by fulfilling wishes of 31 Michigan foster families in May 2017.
- MDHHS continued to co-lead the Foster, Adoptive and Kinship Parent Collaborative Council. This council is a collaboration of MDHHS, tribes and parent-led organizations whose focus is to connect foster, adoptive and kinship parents to resources, education and training.

## **Addressing Barriers to Adoption – Progress in 2017 and 2018**

- MDHHS collaborated with the Adoption Resource Consultants and the Michigan MARE to look at 49 youth who were photo listed with MARE without an identified family for over four years.
  - The group reviewed information regarding the 49 young people including length of time since termination, placement history, type of placement, MARE hold history, assigned adoption agency and worker to identify trends.
  - The group met bi-monthly to review barriers to achieving permanency.
  - To achieve permanency for young people involved in Project 49, the group enlisted the help of Permanency Resource Monitors and community mental health liaisons.

- MDHHS continued to provide post-adoption services statewide through eight regional contracts. Post-adoption services include case management, family support and support groups, coordination of community services, information and referral. Beginning in 2016, post-adoption services host annual conferences in their regions to support and educate adoptive parents.
- The MARE contract was amended to include the Match Support Program. The Match Support Program is a statewide service for families who have been matched with a child from the MARE website and are moving forward with an adoption. The Match Support Program has specialists who provide up to 90 days of services to families including referral to support groups, training opportunities and other community resources.
- Adoption Navigators are experienced adoptive parents who offer guidance and personal knowledge to potential adoptive families. Adoption Navigator services continued to be provided through MARE.

### **Recruitment of Foster and Adoptive Parents for Diverse Youth**

At any given time, Michigan has approximately 13,000 children in foster care and relies on private child placing agencies to help find temporary and permanent homes for these children. Michigan has over 90 contracts with child placing agencies for foster care case management and over 60 contracts for adoption services.

### **Progress in 2017 and 2018**

- MDHHS Office of Child Welfare Policy and Programs held a two-day summit for licensing and foster care staff from agencies throughout the state. The summit included training on engaging relative and non-relative caregivers, developing thorough assessments, common licensing rule issues, marketing for social workers, customer service, licensing, recruitment and retention planning, life books, MiTEAM, vicarious trauma, permanency, Autism, making trauma informed placements and forensic interviewing.
- The Office of Child Welfare Policy and Programs held a two-day conference for adoption workers, supervisors, Adoption Resource Consultants, Post Adoption Resource Center staff and others involved in the adoption process. The conference included training on trauma, mental health, Michigan's adoption assistance programs, cross racial adoptions, Central Adoption Registry, successful transitions, family development and preparation, cross-sector support for LGBTQ children, making adoptions last and recruitment strategies.

## HEALTH CARE OVERSIGHT AND COORDINATION PLAN

Providing well-coordinated, comprehensive, trauma-informed health care to children in foster care requires ongoing commitment to collaboration between state departments, non-governmental advocacy organizations and the medical and mental health community. This collaboration must extend throughout each level from the child and family served to organizational leadership. To achieve positive outcomes, it is critical to develop policy based on the best available evidence about effective care delivery, infrastructure to support all parties involved and oversight mechanisms.

The Health Care Oversight and Coordination Plan was assessed in 2018 and the following substantive changes were made to the plan:

- A section was added, “Family First Prevention Services Act” which describes the actions MDHHS takes to ensure the reasons for children being placed in residential treatment programs are based on diagnoses by qualified medical personnel and documented safety needs and include a treatment rationale that includes the necessity for treatment in an institution.
- A description of a qualified residential treatment program was added.
- A section was added titled “Ensuring Accurate Documentation and Sharing of Child Health Information” that describes the MDHHS strategy for ensuring accurate up-to-date medical and behavioral health information for children in foster care is shared with caregivers and medical care providers.
- Under Comprehensive (routine) Medical Examination Guidelines: The “Lean Process Improvement Project” facilitated by the Office of Good Government continued in the implementation phase and completed most of the project action steps.
- Under Comprehensive (routine) Medical Examination Guidelines: A protocol was established to address vacancies when a health liaison officer is on a medical leave or working out of class.
- Under Mental Health Care Needs: Trauma Screening Checklist Training 101 is scheduled statewide for all CPS workers, public and private foster care workers, Juvenile Justice Specialists and their supervisors and managers. Training will help participants utilize the checklist to effectively case plan.
- Under Mental Health Care Needs: A trauma screening protocol and best practices guide was developed and disseminated to staff.
- Under Psychotropic Oversight Policy and Procedures: A review of professional standards of care and child welfare practices in several other states continues to inform revision to MDHHS policies and procedures.
- Under Psychotropic Oversight Policy and Procedures: The Fostering Mental Health website will be renamed and expanded to include general health information for children in foster care, Health Liaison Officer resources, policy alerts and data.

MDHHS is committed to ensuring every child in foster care receives the preventive and primary health care necessary to meet his or her physical, emotional and developmental needs. The

Health Care Oversight and Coordination Plan provides structure and guidance to support the activities of MDHHS and its partners.

### **Family First Prevention Services Act**

Michigan is developing processes to ensure compliance with the Family First Prevention Services Act. Key strategies described below include developing clinical pathways to:

- 1) Ensure that placement of a child in any setting that is not family foster care is based on the needs of the child as identified in a child's diagnosis by a qualified medical practitioner and documented safety needs.
- 2) Ensure accurate documentation and sharing of child health information with health providers and caregivers.

### **Ensuring Appropriateness of Placement in Qualified Residential Treatment**

Child welfare teams consider several factors when pursuing residential treatment for a child, including the capacity to maintain safety and benefit from treatment in the community. When a child's diagnosis includes medical/mental or behavioral health needs that cannot be safely met in the community or in a foster family home, a child may be placed in a qualified residential treatment program. Qualified residential treatment programs must:

- Include a trauma-informed treatment model designed to treat children with emotional or behavioral disorders.
- Have licensed nursing and clinical staff onsite as required by the program's treatment model.
- Facilitate outreach to family members of the child.
- Document how family members are integrated into the treatment process.
- Provide discharge planning and family-based care support for six months after discharge.

Prior to placement of a child in a qualified residential treatment facility, caseworkers must prepare a Placement Exception Request that documents supervisor and county director review and approval.

- The referring worker must provide the residential provider with all recent medical, behavioral and mental health diagnoses and reports.
- MDHHS contracts with residential providers require that a licensed clinician with a minimum of a master's level degree conduct a bio-psycho-social assessment of a child using evidence-based tools within 30 calendar days following placement.
- The bio-psycho-social assessment ensures placement is based on documented need for the treatment provided in the program and used to develop a treatment plan based on a review of past information with current assessments specific to the child's needs.

To ensure that practitioners with the appropriate knowledge, training and skills have the tools to arrive at an accurate diagnosis, all members in the child welfare systems of care must follow clinical pathways or procedures to guide decisions about treatment in residential settings. These clinical pathways are informed by the best available evidence, re-evaluated and

improved regularly based on statewide outcome data and emerging scientific evidence. The process of developing clinical pathways include the following elements:

- A means to support and hold providers accountable for providing and documenting accurate and comprehensive diagnostic assessments that include diagnosis, functional capacity and recommendations based on the best available evidence.
- Specific guidelines defining the child and family characteristics that would require intervention within a residential setting.
- Capacity and accountability within the MiTEAM case management process to follow the clinical pathways for each child.
- Education of all members of the systems of care on the clinical pathways, including parents and caregivers, courts, child welfare personnel and health/mental health care providers.
- Evaluation methods to track fidelity in following the clinical pathways and outcomes for the children and families served.

MDHHS has initiatives in process to address some of these elements:

- Systems transformation project, described in the Permanency section of the APSR.
- Enhanced MiTEAM practice model training and support.
- Trauma screening, assessment and treatment protocols.

### **Ensuring Accurate Documentation and Sharing of Child Health Information**

Children in foster care are categorically eligible for Medicaid, and the health providers that serve them must meet educational and licensing requirements to bill Medicaid for their services. Health providers must have a comprehensive health history of a child (the medical passport) to provide care and make an appropriate diagnosis. The medical passport must be provided to a new health provider at or before the first appointment with the child. The medical passport prints from MiSACWIS and includes the following information:

- Current primary care physician, dentist and insurance information.
- Allergies.
- Diagnosis.
- Medications.
- Health history.
- Health appointments, including behavioral health appointments in the last 18 months.
- Developmental/behavioral concerns.

During summer 2018, mandatory foster care worker training is being offered in eight sites on accessing and navigating CareConnect360, which has information on Medicaid claims from MiSACWIS. The training includes how to develop a medical passport with up-to-date and accurate information and how to enter information into MiSACWIS correctly. Beginning in June 2018, six webinars are available in the learning management system. Viewing of the webinars by caseworkers is mandatory by Dec. 31, 2018.

## **Assessment and Treatment for Children with Behavioral Needs**

Foster care workers are provided information on how to access assessment and treatment for children with behavioral needs. Foster care policy and Michigan's Health Care Oversight and Coordination Plan requirements include:

- Every child entering foster care must receive a comprehensive medical examination, meeting Early and Periodic Screening, Diagnosis and Treatment guidelines within 30 calendar days of the child's entry into foster care, regardless of the date of the last physical examination.
- Annual medical exams are required for children and youth ages 3 through 20 years.
- Children under the age of 3 require more frequent medical exams outlined in the current American Academy of Pediatrics Periodicity Schedule.
- Children re-entering foster care after their case closed must receive a full medical examination within 30 days of the placement episode.
- All children must have a medical home.
- The foster care worker is responsible for any recommended follow-up health care.
- Caseworkers are required to maintain a medical passport for each child and distribute the medical passport to health providers, foster caregivers, parents and older youth.
- Caseworkers must continue oversight when children are returned to their parents as long as MDHHS has jurisdiction.

## **Coordination and Collaboration**

MDHHS takes a team approach to addressing the needs of children in foster care by working with and soliciting input from a variety of experts that includes:

- Michigan Department of Health and Human Services:
  - Office of Child Welfare Policy and Programs.
  - Division of Continuous Quality Improvement.
  - Child Welfare Services and Supports.
  - Office of Workforce Development and Training.
  - Medical Services Administration.
  - Medicaid Program Operations and Quality Assurance.
  - Pharmacy Management Division.
  - Office of Medicaid Health Information Technology.
  - Mental Health Services to Children and Families.
  - Behavioral Health and Developmental Disabilities Administration.
  - Business Integration Center Administration.
  - MiSACWIS Division.
  - CPS Centralized Intake.
  - External Affairs and Communication.
  - Bureau of Community Based Services.
  - Population Health Administration.
- Private Foster Care Agencies:
  - Michigan Federation for Children and Families.
  - Association of Accredited Child and Family Agencies.

- Community-Based Professional and Advocacy Organizations:
  - American Academy of Pediatrics, Michigan chapter.
  - Michigan Association of Family Physicians.
  - Michigan Primary Care Association.
  - Michigan Council of Child and Adolescent Psychiatry.
  - Association for Children’s Mental Health, Michigan branch.
- Office of Good Government.

## Medical Data Management

MDHHS policy requires documentation of all medical, dental and mental health services and maintenance of a medical passport for each child that is updated as services are provided. The medical passport is available to foster caregivers, parents, older youth and health providers throughout the child’s foster care placement. Michigan’s Statewide Automated Child Welfare Information System (MiSACWIS) includes enhancements that improve the capacity to obtain reports from the data entered in the course of case management. MDHHS continues to collaborate with the Michigan Department of Technology, Management and Budget to develop system enhancements to provide access to health information within MiSACWIS that will further improve case practice. In the past year, these enhancements included expanding access of the Medicaid claims management software, CareConnect360, to health liaison officers, foster care workers and supervisors. Future enhancements include the transfer of information from the medical services data warehouse directly into MiSACWIS health screens, which will populate the medical passport and the case services plans.

## Health Care Needs of Children in Foster Care

MDHHS recognizes the importance of providing caregivers, health providers and the court with information necessary to meet the needs of foster children. The shared information includes:

- **Insurance Coverage** - Michigan ensures that all children are enrolled in a Medicaid Health Plan upon entry into foster care to ensure the continuity of health care services. MDHHS tracks the enrollment of children in Medicaid Health Plans and the MDHHS Child Welfare Medical Unit provides assistance to the field when barriers to enrollment occur. Once successfully enrolled in a Medicaid Health Plan, this information is given to foster parents so they can facilitate routine medical care for the children in their care.
- **Comprehensive (routine) Medical Examination Timelines** - MDHHS ensures that all foster children receive routine comprehensive medical examinations according to nationally accepted Early and Periodic Screening, Diagnosis and Treatment guidelines as outlined by the American Academy of Pediatrics. Foster care policy outlines expectations for completion of medical and dental examinations and immunization status. MDHHS actions to meet this goal include:
  - Monitoring the assignment of a child to a Medicaid Health Plan at placement.
  - Local health liaison officers establishing working relationships with the primary care community to support cooperation and access to medical services.
  - Providing data to local offices to help gauge their adherence to policy and assist with local planning efforts.
  - Amending CPS policy to require notification of a removal to the health liaison

officer within one business day of the removal.

- Implementing recommendations from the lean process improvement project facilitated by the Office of Good Government, monitoring impact on compliance with timelines and engaging in ongoing quality improvement.
- **Care Continuity** - MDHHS policy requires foster parents to maintain care with the child's previous primary care provider (i.e. "medical home") unless doing so is impracticable. When there must be a shift in the primary care provider, foster care workers must ensure medical information is transferred. The department also values continuity into early adult years. To facilitate these goals, the department continued the following initiatives:
  - Access to CareConnect360, a software system that allows authorized users to view health-related information from Medicaid Claims, by Health Liaison Officers, county-based foster care workers and supervisors and private agency foster care workers and supervisors.
  - Extended Foster Care Transitional Medicaid to former foster youth from age 21 to age 26, effective Jan. 1, 2014.
  - Revised information systems to continue Medicaid coverage for current beneficiaries until the age of 26.
  - Distributed Affordable Care Act Medicaid extension information to post-secondary education programs with independent living skills coaches and campus coach programs.
  - Included information on the Affordable Care Act in Fostering Success Michigan's informational webinar and forwarded it to their Google distribution group.
  - Through collaboration with the State Court Administrative Office, the initial removal order includes a specific order for parents to sign releases for medical records transfer within seven days from the court hearing.
- **Durable Power of Attorney for Health Care** - MDHHS provides foster children with the option to execute Durable Power of Attorney and distributes a brochure that explains the purpose of a Durable Power of Attorney and how to attain one. Other efforts include development of a page on the Foster Youth in Transition website that includes:
  - How to choose a patient advocate.
  - A brochure explaining Durable Power of Attorney.
  - The purpose of a Durable Power of Attorney.
  - Frequently asked questions.
  - A link to the Michigan State Bar website for additional information.

## **Mental Health Care Needs**

Circumstances leading to foster care significantly raise the likelihood of mental health needs of children in foster care. These circumstances highlight the need for early and periodic mental health screening, and when indicated, assessment and referral for appropriate mental health treatment. Screening for mental health problems during yearly and periodic well-child examinations may be the first indication of need for children in foster care.

Effective Dec. 1, 2014, Medicaid provider policy changed to allow surveillance or the use of a

validated and standardized screening tool to accomplish the psychosocial/behavioral assessment required at each well-child visit. MDHHS policy was updated to allow surveillance as documentation that a mental health screening was completed during a child's routine exam.

MDHHS continues to work with partners to ensure that case planning and interventions are trauma informed. In 2015 and 2016, as part of the Defending Childhood project (a technical assistance process sponsored by the Office of Juvenile Justice and Delinquency Prevention), MDHHS reviewed and recommended screening and assessment tools for trauma exposure and its impact. MDHHS developed protocols for trauma screening to expand access to trauma-informed clinical assessments and comprehensive team and trans-disciplinary assessments. MDHHS developed policy, protocols and training to ensure that trauma screening results in appropriate follow up, including completing assessments and ensuring that information gathered is integrated into the child and family service plans and with medical and mental health treatment. MDHHS awarded contracts with seven providers for statewide comprehensive trauma assessment services effective June 2017.

### **Oversight of Psychotropic Medications**

MDHHS continues to refine an infrastructure to conduct psychotropic medication oversight.

The goals of this oversight are to ensure:

1. Foster children receive a comprehensive mental health assessment.
2. Interdisciplinary treatment for foster children that includes psychotropic medications when indicated.
3. Informed consent by the legal consenting authority when psychotropic medications are recommended for foster children.
4. Psychotropic medication recommendations that are consistent with current clinical standards based on evidence and/or best practice guidelines.

In response to this need, MDHHS established the Foster Care Psychotropic Medication Oversight Unit. This unit:

1. Develops, maintains and updates databases necessary to track the use of psychotropic medications in the foster care population. This includes tracking individual and aggregate use and reporting on trends based on child characteristics, e.g., age and placement status and clinical diagnosis.
2. Tracks informed consent documentation from the field to ensure consent engagement and consent per MDHHS policy.
3. Enters psychotropic medication, diagnosis, physician review information and uploads informed consent documentation into MiSACWIS.
4. Facilitates case reviews by physicians.
5. Provides technical assistance to the field.

### **Psychotropic Medication Data Management**

The MDHHS Foster Care Psychotropic Medication Oversight Unit loads Medicaid claims weekly into a foster care database. Pre-review queries are run at least monthly to identify cases where the recommended medication regimen meets established review criteria for a secondary

physician review. When triggering criteria are met for physician review, the unit arranges and tracks the reviews.

The MDHHS Foster Care Psychotropic Medication Oversight Unit receives informed consent documents from the field, enters the medication data in MiSACWIS and uploads the consent document into MiSACWIS. The unit also cross-references consent documentation to Medicaid prescription claims and conducts outreach to the field when there are medication claims without accompanying consent documentation. The unit works with the Child Welfare Medical Unit to track and analyze psychotropic medication prescribing trends for children in foster care.

### **Psychotropic Oversight Policy and Procedures**

MDHHS continues to develop policy and practice under general principles derived from a review of professional standards of care and child welfare practices in several other states:

- A psychiatric diagnosis based on the current Diagnostic and Statistical Manual should be made before prescribing psychotropic medications.
- Clearly defined symptoms and treatment goals should be identified and documented in the medical record when beginning treatment with a psychotropic medication.
- When recommending psychotropic medication, clinicians should consider potential side effects, including those that are uncommon but potentially severe and evaluate the benefit-to-risk ratio of pharmacotherapy.
- Except in the case of emergency, informed consent must be obtained from the appropriate party(s) before beginning psychotropic medication. Informed consent includes discussion of diagnosis, expected benefits and risks of treatment, common side effects, need for laboratory monitoring, the risk for adverse events and treatment alternatives.
- Appropriate monitoring of indices such as height, weight, blood pressure or other laboratory findings should be documented in the medical record.
- Monotherapy regimens for a given disorder or specific target symptoms should be tried before polypharmacy regimens.
- Doses should usually be started low and titrated carefully as needed.
- Only one medication should be changed at a time, unless a clinically appropriate reason to do otherwise is documented in the medical record.
- The frequency of clinician follow-up with the patient should be appropriate for the severity of the child's condition and adequate to monitor response to treatment, including symptoms, behavior, functioning and potential side effects.
- The potential for emergent suicidality should be carefully evaluated and monitored in the context of the child's mental health condition.
- If the prescribing clinician is not a child psychiatrist, referral to or consultation with a child psychiatrist should occur if the child's clinical status has not improved within a period appropriate for the child's clinical status and the medication regimen.
- Before adding additional psychotropic medications, the child should be assessed for medication adherence, accuracy of the diagnosis, the occurrence of comorbid disorders (including substance abuse and general medical disorders) and the influence of

psychosocial stressors.

- If a medication is used for a primary target symptom of aggression and the behavior disturbance has been in remission for six months, serious consideration should be given to tapering and discontinuation of the medication. If the medication is continued, the necessity for continued treatment should be evaluated a minimum of every six months.
- The medical provider should clearly document care in the child's medical record, including history, mental status assessment, physical findings, impressions, laboratory monitoring specific to the prescribed drug and potential known risks, medication response, presence or absence of side effects, treatment plan and intended use.

MDHHS will continue to review and amend policy in the context of changing general practice standards, new medical knowledge and foster care practice needs across the state.

### **Psychotropic Medication Oversight/Review Process**

The MDHHS Foster Care Psychotropic Medication Oversight Unit staff use Medicaid prescription claims to determine whether triggering criteria are met, arrange and track the review process. The unit staff uploads the physician review documentation into MiSACWIS. Physician reviews occur based on the presence of specific medication regimens. Physician reviewer actions depend on the presence or absence of medical concern based on the medication regimen and/or specific health characteristics and may include:

1. No further action when no significant medical concerns are noted.
2. Written outreach to the prescribing physician outlining the concerns raised during the review when concerns are present but not serious.
3. Verbal outreach to the prescribing clinician when concerns are potentially serious.

The Foster Care Psychotropic Medication Oversight Unit completed staffing expansion in 2017 to allow for more rapid tracking of prescription claims and informed consent documentation and direct outreach to foster care workers when consent documentation is due. The unit also provides witnessed verbal consent for psychotropic medication when consenting parties cannot attend medication evaluation and management appointments in person.

### **Progress in 2017**

- The child well-being website launched in 2016 was updated.
- Contracts for comprehensive trans-disciplinary and comprehensive team trauma assessment services are in place.
- Fair market rate counseling contractors working with child welfare clients completed mandated training.
- Witnessed verbal consent for psychotropic medication became available to legal consenters.
- The Psychotropic Medication Oversight Unit refined protocols developed in 2016 to review claims regularly and expedite the documentation process.
- The physician leadership team identified target areas for quality improvement.

## Progress in 2018

- Statewide training on using the Trauma Screening Checklist was initiated for CPS, foster care and juvenile justice workers, supervisors and managers.
- A CSA trauma protocol was developed and implemented.
- MDHHS awarded funds to hold Learning Collaborative events statewide to engage local/regional child welfare, medical, dental and mental health providers and other stakeholders in identifying and addressing barriers to achieving the health well-being needs of children in foster care. This project (Fostering Health Partnerships) will continue through calendar year 2019.
- All foster care staff, public and private, have access to CareConnect360. This application provides workers with Medicaid claims information for children under MDHHS supervision.
- Mandatory supervisor training on psychotropic medication and informed consent was provided in 17 sites.
- Webinars for MISACWIS health screen completion was developed and made available to CPS and foster care staff.
- The joint application design team process for the integration of Medicaid claims information in the medical passport.
- Tasks from the timely medical exams project were completed.

The Foster Care Psychotropic Medication Oversight Unit developed and launched a website, Fostering Mental Health, which provides information to youth, families, child welfare staff and health professionals on mental health resources and psychotropic medication. The website can be viewed here: [http://www.michigan.gov/mdhhs/0,5885,7-339-73971\\_7117\\_77104---,00.html](http://www.michigan.gov/mdhhs/0,5885,7-339-73971_7117_77104---,00.html).

## CHILD WELFARE DISASTER PLAN

Michigan participated in disaster planning, response and recovery activities required by the Child and Family Services Improvement Act of 2006 and Section 422 (b)(16) of the Social Security Act. The Child Welfare Disaster Plan addresses the federal requirements below:

- To identify, locate and continue services for children under state care or supervision who are displaced or adversely affected by a disaster.
- To respond, as appropriate, to new child welfare cases in areas adversely affected by a disaster, and provide services in those cases.
- To remain in communication with caseworkers and other essential child welfare personnel who are displaced because of a disaster.
- To preserve essential program records.
- To coordinate services and share information with other states.

The Michigan Department of Health and Human Services (MDHHS) holds the primary responsibility to perform human service functions in the event of a disaster. The MDHHS emergency management coordinator is responsible for conducting emergency planning and management, and interfaces with MDHHS local directors and central office staff to ensure adequate planning. Michigan's Child Welfare Disaster Plan remained in place in 2017.

The MDHHS local county offices, Business Service Centers and Child Welfare Field Operations Administration reviewed Michigan's Child Welfare Disaster Plan in 2017. As a result, MDHHS now has all county MDHHS plans comprehensively address children under jurisdiction of that county instead of creating separate public and private agency plans. The Child Welfare Disaster Plan was reviewed in 2018 and no changes were needed.

### **Emergency Response Planning for State-Level Child Welfare Functions**

MDHHS incorporated the following elements into an integrated emergency response:

- **Coordination with the Michigan Emergency Coordination Center.** The state-level Emergency Coordination Center is activated by the MDHHS emergency management coordinator during a state-declared emergency or at the request of a local MDHHS local director or designee. The coordination center is a central location for coordination of services and resources to victims of a disaster.
- **Local shelter and provision of emergency supplies.** MDHHS requires all MDHHS local offices to have a plan for disasters that provides temporary lodging and distributes emergency supplies and food, as well as an emergency communication plan. The state plan must address widespread emergencies and the local plan must address local emergencies.
- **Dual and tri-county emergency plans.** In large counties with more than one local office site or in local offices located in dual or tri-counties, each local office site is required to have an emergency or disaster plan designed to address unique local needs.

- **Local and district MDHHS offices.** MDHHS local and district offices submit their emergency office procedures to their associated Business Service Center for approval and to the MDHHS emergency management coordinator. MDHHS local offices review their disaster plans annually and re-submit updated plans.
- **Foster parent emergency plans.** According to licensing rules for foster family homes and foster group homes for children, licensed foster parents must develop and maintain an emergency plan. This must include plans for relocation, if necessary, communication with MDHHS and private agency caseworkers and birth parents as well as a plan to continue the administration of any necessary medications to foster children and a central repository for essential child records. The plan must also include a provision for practicing drills with all family members every four months.
- **Institutional emergency plans.** According to licensing rules for child caring institutions, an institution shall establish and follow written procedures for potential emergencies and disasters including fire, severe weather, medical emergencies and missing persons.

### **Local Office Emergency Procedures**

Each MDHHS local office is required to create their own emergency plan that addresses local needs and resources. The required elements of local office emergency plans include:

- Resource list including local facilities suitable for temporary lodging and local resources for emergency supplies, clothing and food. The licensing certification worker updates and distributes this list annually and as needed in an emergency.
- An emergency communication plan that includes the person to contact in case of emergency. When there is an emergency or natural disaster, a communications center in a different region from the disaster area shall be established as a backup for the regional/local office. The selected site should be far enough away geographically that it is unlikely to be affected directly by the same event.
- A central list of all foster care placements for children under the supervision of the local office or private agency that includes telephone numbers, addresses and alternate contact persons.

Local emergency plans are submitted to their Business Service Center, and are reviewed and revised as necessary to ensure all required elements are included.

### **Emergency Communication**

- **Staff communication protocol.** During an emergency, the local office mobilizes a protocol to communicate with staff to ascertain their safety and ability to come to the work site (or an alternative site) and perform emergency and routine duties. The local office director or designee will initiate this protocol. The local office director or designee will maintain contact with the MDHHS emergency management coordinator to synchronize services and provide updates.
- **Caregiver communication protocol.** During an emergency that involves evacuation, either voluntary or mandatory, all caregivers shall inform MDHHS of

their foster children's whereabouts and status using telephone service, cell phone, email or another means of communication when normal methods of communication are compromised. CPS centralized intake will provide a toll-free number that caregivers may use for this purpose when other means of communication are inoperable.

- **Disaster coordination protocol.** Each local office will designate an individual(s) to coordinate information from the area affected by a disaster and communicate to their Business Service Center or Child Welfare Field Operations. The protocol will include instructions that all staff in the affected area should call in to a locally designated communication center. If communication channels are compromised, the centralized intake telephone lines may be used to share instructions. The foster caregiver guidelines for responding to emergencies shall include the MDHHS Children's Protective Services (CPS) Central Intake toll-free number (855) 444-3911, to be used as a clearinghouse to share instructions or ascertain the location and well-being of foster children and youth in the affected area.

**The local emergency/disaster plan shall include:**

1. The person whom staff and clients may contact for information locally during an emergency during normal work hours as well as after hours.
2. The expectation that all staff not directly affected by an emergency shall report for work unless excused.
3. The person whom clients may contact during an emergency when all normal communication channels are down.
4. The person designated to contact the legal parent to inform them of their child's status, condition and whereabouts if appropriate.
5. The minimum frequency that all caregivers shall communicate with the designated communication site during emergencies or natural disasters.
6. The necessary information to be communicated in emergencies.
7. How and where in the case record the information is to be documented.
8. The method of monitoring the situation and the local person responsible.
9. Procedures to follow in case of voluntary or involuntary closure of facilities.
10. Any additional requirement as specified by the local or regional office.

**Foster Parents' Responsibilities Developing an Emergency Plan**

- **Family emergency plan.** Licensed foster parents shall develop and display a family emergency plan that will be approved by their local office and become part of their licensing home study. Foster parents must update and review their plans annually. The plan should include:
  1. An evacuation plan for various disasters, including fire, tornado and serious accident.
  2. A meeting place in a safe area for all family members if a disaster occurs.
  3. Contact numbers that include:
    - a. Local law enforcement.

- b. Regional communication plan with contact personnel.
  - c. Emergency contacts and telephone numbers of at least one individual likely to be in contact with the foster parent in an emergency. It is preferable to list one local contact and one out-of-county contact.
  - d. MDHHS Central Intake toll-free number or another emergency number to be used when no other local/regional communication channels are available.
4. A disaster supply kit that includes special needs items for each household member (as necessary and appropriate), first aid supplies including prescription medications, a change of clothing for each person, a sleeping bag or bedroll for each foster child, battery-powered radio or television, batteries, food, bottled water and tools.
  5. Each local office designates a contact person as the disaster relief coordinator. In the event of a mandatory evacuation order, foster parents must comply with the order insofar as they must ensure they evacuate foster children in their care according to the plan and procedures set forth by the state emergency management agency (MDHHS).
- **Communication with MDHHS caseworkers during emergencies.** Foster parents and MDHHS caseworkers have a mutual responsibility to contact each other during an emergency that requires evacuation or displacement to ascertain the whereabouts, safety and service needs of the child and family, as described above. If other methods of communication are not operating, the centralized intake telephone line will be mobilized to serve as a communications clearinghouse.
  - **School response.** As part of the disaster plan, each foster parent will identify what will happen to the child if he/she is in school when an emergency occurs, such as an arrangement for moving the child from the school to a safe, supervised location.
  - **Review plan with each foster child.** Foster parents will review this plan with each of their foster children regularly and the worker will update this information in the provider's file.

### **Federal Disaster Response Procedures**

Following is a listing of the required procedures for disaster planning and Michigan's procedures that address those requirements:

#### **1. To identify, locate and continue availability of services for children under state care or supervision.**

- During an emergency that involves evacuation, either voluntary or mandatory, all caregivers shall inform MDHHS of their foster children's whereabouts, status and service needs, utilizing telephone service, cell phone, email or the centralized intake number when normal methods of communication are compromised.
  - Following declaration of a public emergency that requires involuntary evacuation or shelter, the assigned caseworker or another designated worker will contact

the legal parent to ascertain the whereabouts, condition and needs of the child and family.

- The local office must provide information on where to seek shelter, food and other resources and coordinate services with the MDHHS emergency management coordinator. The voluntary or involuntary closure of facilities in emergencies is addressed in the licensing rules for child-placing agencies (R 400.12412 Emergency Policy).

**2. Respond as appropriate to new child welfare cases in areas adversely affected by a disaster and provide services in those cases.**

- If current staff is displaced or unable to provide services, alternate counties designated in local MDHHS disaster plans shall be prepared to help provide services to new child welfare cases and to children under state care or supervision displaced or adversely affected by a disaster. The toll-free Central Intake number will be the primary means of accessing services for new child welfare cases.

**3. Remain in communication with caseworkers and other essential child welfare personnel who are displaced because of a disaster.**

- In an emergency, caseworkers and caregivers must attempt to call their local office to report their status and receive information or instructions. If local office phone lines are unavailable, caseworkers and caregivers will contact the alternate local office. In offices covering multiple counties, they will call the designated county.
- Caseworkers may use cell phones to remain in contact. Michigan State Police radios are located in offices without cell phone towers to maintain cell phone service.
- If the local Emergency Coordination Center is activated by the MDHHS emergency management coordinator, the toll-free centralized intake number will be available as a backup communication method for current and new child welfare cases.

**4. Preservation of essential program records.**

- MDHHS maintains essential records in the MiSACWIS database and can access records statewide. MDHHS caregivers enrolled in electronic funds transfer will not have a disruption in foster care payments, since payments are made to their account electronically.
- To safeguard the database itself, the servers are located in Michigan's secure data center. Schedules are configured to perform a full system backup for both onsite and offsite storage. The databases are also configured for live replication in case of a disaster that involves loss of the primary server. The Department of Technology, Management and Budget retains one quarterly update per year and maintains an annual backup indefinitely. That code base is backed up as well, so in case of a catastrophic event that affects the computer system, the application can be rebuilt with minimal loss of time.

**5. Coordinate services and share information with other states.**

- In the event of an emergency, the MDHHS emergency management coordinator is responsible, under the direction of the Michigan governor and in coordination with the state MDHHS director, to mobilize and coordinate the statewide emergency response including sharing information with other states.
- The MDHHS Office of Communication will coordinate communication on the MDHHS emergency response to the news media, MDHHS executive staff and human resources, persons served and the public.

**City of Flint Water Emergency 2016**

Michigan Governor Rick Snyder declared a state of emergency for the city of Flint on Jan. 5, 2016 due to evidence of high lead levels in the water system. The state of emergency was approved by President Barack Obama on Jan. 16, 2016. The federal declaration of emergency ended on Aug. 14, 2016.

- Through the Emergency Management and Homeland Security Division of the Department of State Police, the State of Michigan Emergency Operations Center was activated on Jan. 5, 2016 to coordinate state response and recovery efforts.
- The Department of Homeland Security, Federal Emergency Management Agency was authorized to coordinate all disaster relief efforts following the declaration by the President.

**1. Identify, locate and continue availability of services for children under state care and supervision who are displaced or adversely affected by a disaster.**

Statewide planning regarding the children potentially adversely affected by the Flint water crisis included the following:

- Ensuring all children under the supervision of the MDHHS who reside in placements that utilize Flint water have access to a clean water source.
- Through collaborative efforts, bottled water, water filters, water filter replacement cartridges and water test kits were either distributed directly or made available to foster care placements within the Flint water catchment area. Verification by the caseworker of a clean water source was required for all placements.
- Water testing was required and completed on all placements where a child currently under the supervision of MDHHS was identified to be residing.

During 2016 and into April 2018, MDHHS continued to address the needs of residents of the city of Flint who were exposed to contaminated drinking water:

- The state Medicaid expansion was broadened to include the screening and healthcare of children and adults exposed to lead and other contaminants.
- Caregivers were provided with resources and information on the need to have the children in their care screened for lead and receive care to alleviate the effects if a high blood level was identified.

- Michigan used federal and state funds to alleviate the effects of exposure to contaminants on residents and providing safe drinking water and filters.
- Testing of drinking water in Genesee County over the past two years has shown the county's levels of lead are now below federal standards. The state is ending the provision of bottled water to Flint residents in 2018.

**2. Respond as appropriate to new child welfare cases in areas adversely affected by a disaster and provide services in those cases.**

A statewide Communication Issuance was released by the Children's Services Agency regarding expectations to observe a clean water source prior to all future placements involving children under the care and supervision of the MDHHS.

**3. Remain in communication with caseworkers and other essential child welfare personnel who are displaced because of a disaster.**

Communication channels were not interrupted by this disaster.

**4. Preservation of essential program records.**

Children's Services program records were not affected by this disaster.

**5. Coordinate services and share information with other states.**

Coordination of services and sharing of information with other states as necessary was completed by the State of Michigan Emergency Operations Center and/or the Federal Emergency Management Agency.

**Washtenaw County Extended Power Outage, March 2017**

The power outage was one week in duration. The MDHHS response is described below:

**1. Identify, locate and continue availability of services for children under state care and supervision who are displaced or adversely affected by a disaster.**

- Washtenaw County Children's Services staff were mobile while financial assistance staff were temporarily housed at the adjacent Washtenaw County Building where the generator allowed use of computer equipment. Washtenaw MDHHS did not re-deploy to either of the MDHHS offices as outlined in their plan because power restoration was expected sooner than it actually occurred. It worked well for MDHHS staff to be next door because they were in close proximity to state cars and case files if needed.
- Children's Services staff were able to access state cars daily for visiting clients and conducting state business.
- Children's Services staff utilized their Local Resource Guide to continue to provide services to families.

**2. Respond as appropriate to new child welfare cases in areas adversely affected by a disaster and provide services in those cases.**

- Washtenaw County Children's Services staff were mobile while financial assistance staff were

temporarily housed at the adjacent Washtenaw County Building where the generator allowed use of computer equipment.

- MDHHS staff ensured signage was on the front door to direct clients to go to the Washtenaw County Building where families were served from the lobby by Washtenaw Emergency Services staff and supervisors.
- Children's Services staff were able to access state cars daily for visiting clients and conducting state business.
- Children's Services staff utilized their Local Resource Guide to continue to provide services to families.

### **3. Remain in communication with caseworkers and other essential child welfare personnel who are displaced because of a disaster.**

- The foster care and licensing staff communicated with caregivers, legal and foster parents of youth on their caseloads to ensure they were not affected by the outage and that their needs were met.
- A list of youth in care, which is reviewed monthly, allowed managers and staff to know at a glance approximately how many youth were in care at the time.
- Supervisors were able to communicate with their staff via phone or email. The county Director and Program Managers, along with several supervisors, were on site to assist during the outage.
- Each day of the outage, Children's Services staff utilized a calling tree as defined in their plan.

### **4. Preservation of essential program records.**

- Electronic case records were accessible to caseworkers via generator power at the Washtenaw County Building and mobile MiSACWIS through cell phones.
- No essential client records were damaged or destroyed.

### **5. Coordinate services and share information with other states.**

- The Washtenaw County Director maintained communication with the BSC and MDHHS CSA with updates of the outage.

**Lesson Learned:** Ensure there are enough large flashlights with a supply of batteries and print cartridges for the mobile printer.

### **Isabella County Flood June 2017**

Several regions in the county were affected by flooding beginning June 23, 2017 and extending for an unspecified length of time thereafter. However, other than changes in routes used to complete investigations, home visits and parenting time due to road closures, there was no impact on child welfare services.

## STAFF AND PROVIDER TRAINING PLAN

The MDHHS Staff and Provider Training Plan was reviewed in 2018, and it was determined that updates were necessary. Changes in the updated Staff and Provider Training Plan include:

- Tracking and monitoring institutional and residential training processes utilizing the new learning management system (LMS) are described.
- Training evaluation: Results of levels one and two evaluation are provided, as well as a plan for developing level three evaluation methods.
- In the Foster and Adoptive Parent Training section, more information is provided about how the Office of Workforce Development and Training is improving the monitoring of training requirements and training quality for foster and adoptive caregivers.
- A description of the new initial child welfare supervisor training.
- Ongoing training requirements changed from per fiscal year to per calendar year.

### **Child Welfare Training Overview**

Training is tracked using the Office of Workforce Development and Training's Cornerstone OnDemand LMS. The LMS is updated from MiSACWIS, assuring that the training available to child welfare staff is aligned with their roles and responsibilities. In addition to registering for training and directly accessing online training, child welfare staff document completion of external training on this LMS, resulting in a complete individual transcript reflecting all child welfare specific training completed.

The primary training audience is public and private child welfare caseworkers, supervisors and those in specialized and supportive positions. Some of these positions include:

- Protect MiFamily staff.
- Pathways to Potential Success Coaches.
- Education Planners.
- Health Liaison Officers.
- Child Welfare Funding Specialists.
- Foster Home Licensing Specialists.
- Maltreatment in Care Investigators.
- Permanency Resource Monitors.

Training requirements are listed in MDHHS policy manual SRM 103, and summarized below in each section.

### **Initial Training for Caseworkers**

Public and private child welfare caseworkers must complete the nine-week Pre-Service Institute within 16 weeks of hire or promotion. The training consists of four weeks of classroom training and five weeks of on-the-job training.

The five field weeks consist of activities such as reading policy, working in MiSACWIS, learning local procedures, becoming familiar with community service providers and completing online

training. All of these activities are guided by the local supervisor and the supervisor confirms that the activities are completed.

During classroom weeks, trainees receive instruction, feedback and coaching on the application of MiTEAM case practice skills. Strong emphasis is placed on personal and child safety, family preservation and the continuum of care. New workers are assisted in developing a trauma-informed lens that stresses the importance of the parent/child visitation process and helps to create networks of support.

During the training, two scored exams are administered to the trainees to evaluate knowledge gained. Trainees are required to pass both exams at least at the 70 percent level. In addition, a competency-based evaluation of the new worker is completed in partnership by the supervisor and trainer. These evaluations are kept on file locally. Evaluations measure:

- Safety awareness.
- Cultural and self-awareness.
- MiTEAM case practice skills.
- Interviewing skills.
- Documentation skills.

While in training, a progressive caseload may be assigned.

- Caseload progression for CPS:
  - No cases will be assigned until after completion of four weeks of training and passing the first exam.
  - After successful completion of week four, up to five cases may be assigned using case assignment guidelines. The first five cases will not include an investigation involving children under eight years of age or children who are unable to communicate.
  - A full caseload may be assigned after nine weeks of training, passing exam two and receiving an overall meets or exceeds expectations rating on the competency based evaluation.
- Caseload progression for foster care and adoption:
  - Three training cases may be assigned on or after day one of training at the supervisor's discretion using case assignment guidelines.
  - After successful completion of week three of pre-service training and passing exam one, up to five cases may be assigned.
  - A full caseload may be assigned after nine weeks of training, passing exam two and receiving an overall meets or exceeds expectations rating on the competency based evaluation.

Training caseloads are assigned strategically to help support the new caseworkers in applying new skills under the guidance the supervisor and with the support of peers.

### **University Partnerships and Child Welfare Certificate Program**

MDHHS has collaborative relationships with 13 Michigan undergraduate and two graduate schools of social work on a certificate program to educate a pool of qualified applicants to fill child welfare positions statewide. This program is intended to help social work students be exposed to Michigan child welfare policies and practices through coursework and field experiences. The Child Welfare Certificate from an endorsed university shows that the participant has received a valuable foundation of knowledge and experiences. Program outcomes include:

- Certificate holders are a population of potential caseworkers having knowledge and experience in the child welfare system, resulting in improved quality of services to Michigan children and families.
- Certificate holders attend a condensed version of the Pre-Service Institute, allowing them to provide services to families sooner.
- Retention of qualified staff will increase because certificate holders have realistic job expectations.
- Promotion of consistent curricula and child welfare internship experiences for students attending schools of social work with endorsed Child Welfare Certificate Programs.

To receive a Child Welfare Certificate from an endorsed university, the student:

- Completes a core course in child welfare and courses in child development.
- Completes an elective course that supports the theory, knowledge, skills and values required to work with families and children.
- Completes a supervised, structured 400-hour field placement at MDHHS, a private agency or tribal child welfare program.
- Achieves a 3.0 grade point average for the last 60 credits of their studies.

Those who have a Child Welfare Certificate complete a condensed Pre-Service Institute training.

### **Program-Specific Transfer Training for Caseworkers**

For caseworkers who completed a Pre-Service Institute in one program and reassigned to another program, they must complete a two-week program-specific training. This training must be completed within six months of the transfer. Between three and six days are spent in a classroom depending on the program they are transferring to and on-the-job learning activities are also completed.

### **Initial Training for Supervisors – New curriculum starting Jan. 1, 2018**

All new child welfare supervisors must complete the four-week New Supervisor Training Institute within 112 days of hire. The training is comprised of classroom instruction and on the job training. The training encompasses both management competencies and program-specific skill development. MDHHS supervisors complete a classroom week learning state of Michigan human resources, performance management, labor relations, etc. Private agency staffs learn those things applicable to their agency while on the job.

During on-the-job training, supervisors must complete structured field activities, webinars and computer-based trainings.

### **Program Specific Transfer-Training for Supervisors**

For supervisors who completed initial training in one program and reassigned to another program, they must complete a one-week program-specific training. This training must be completed within six months of the transfer.

### **Initial Training Evaluation**

#### **Level One Evaluation**

A level one evaluation is issued to each trainee after the conclusion of training. Level one evaluations are issued on a weekly basis for Pre-Service Institute, and at the end of the training for all training delivered by the training office. With the information gained from level one evaluations, changes to the curriculum, trainers and facilities may take place to improve the trainee experience. These level one evaluations are posted on an internal shared drive for training staff and managers to review.

#### **Level Two Evaluation**

New caseworkers and supervisors complete multiple-choice exams, which are administered in the LMS. Scores from the exams are provided to the local supervisors. Areas needing extra support are discussed with the supervisor.

#### **Level Three Evaluation**

Level three evaluation data is collected to evaluate how new staff are doing on the job after completing training. In order to receive this level three data, several methods are employed.

- Meetings take place on a regular basis between the Office of Workforce Development and Training and Business Service Centers.
- Local offices are visited by trainers to observe new caseworkers.
- Child welfare workforce trends are identified through the Quality Improvement Council training sub-team.
- Level three evaluation surveys are sent to new caseworkers and their supervisors at three and twelve months after training completion.

### **Monitoring Initial Training Requirements**

Initial training is monitored locally, as well as through a collaborative effort between the training office, MDHHS central office and the Business Service Centers. Data is collected and analyzed from learning management and human resource systems, MiSACWIS caseload counts and a variety of other methods as needed.

### **Ongoing Training for Caseworkers and Supervisors**

Child welfare caseworkers and those in supportive positions are required to complete a minimum of 32 training hours each calendar year. Child welfare supervisors are required to complete a minimum of 16 ongoing training hours each year. To meet the ongoing training and development needs of the diverse child welfare population, staff can complete computer-based

training in the LMS, register for instructor-led training and add external training to their transcript. In Michigan, ongoing training is referred to as in-service training, differentiated from pre-service training.

In addition to searching the LMS for child welfare training, the Governor’s Task Force on Child Abuse and Neglect created a [child welfare training clearinghouse](#) to provide easy access for child welfare staff and their supervisors to see schedules of external training opportunities.

### **Monitoring Ongoing Training Requirements**

LMS reports are accessed locally and centrally to monitor individual, local office and Business Service Center progress in completing ongoing training throughout the year.

### **University-Based Ongoing Training**

MDHHS collaborates with Michigan universities to deliver ongoing training free of charge to public and private caseworkers, supervisors and foster/adoptive parents. The university training program was developed to promote competence and skill development of child welfare professionals to better serve children and families. Michigan State University leads the child welfare in-service training program, through a contractual partnership with the eight schools in Michigan with master of social work programs.

Catalogs are regularly distributed to communicate the child welfare training opportunities available statewide. Schools of social work provide both classroom and online training. All trainings are approved for continuing education units for licensed social workers in Michigan. This program utilizes a robust evaluation methodology.

### **Identifying Ongoing Training Needs**

The primary way to ascertain individual ongoing training needs is for the supervisor to use the competency based evaluation from initial training to identify areas for training and development. A computer-based training for supervisors “Creating an Employee Training Plan” teaches a systematic process to train supervisors to identify training and development needs of their staff, provide professional development opportunities and document them on the LMS.

There are multiple ways to identify ongoing training needs for the child welfare workforce:

- The Quality Improvement Council training sub-team provides information to the Office of Workforce Development and Training.
- The Business Service Center directors receive input from their counties and meet regularly with training to discuss how to best support the field. The training office has a standard process to receive and respond to training requests directly from the field.
- Collaboration with Child Welfare Supportive Services, Division of Child Welfare Licensing and the Division of Continuous Quality Improvement takes place to identify trends and monitor licensing, qualifications and training requirements.
- Level one evaluation surveys include a question about what other training the person needs.

- The Children’s Services Agency may identify statewide child welfare trends and collaborate with training staff to develop and deliver training.
- Collaboration with the Quality Improvement Council to create a list identifying training topics appropriate for development in the coming year of the university-based ongoing training contract.

### **Continuing Education Units**

In addition to the continuing education units offered through the university contract, in 2017, the Office of Workforce Development and Training offered continuing education units for the following child welfare classes:

- Adult Interviewing and Investigation.
- Children at Risk.
- Critical Thinking.
- Crucial Accountability for Workers.
- Domestic Violence.
- Forensic Interviewing.
- Indian Child Welfare Act.
- Indian Child Welfare Act Refresher.
- Independent Living Services Program Training.
- Medical Mental Health Issues in Child Welfare.
- Safety by Design.
- Self-Awareness.
- Substance Affected Families.

### **Title IV-E Partial Tuition Reimbursement**

MDHHS has not reestablished a Partial Tuition Reimbursement program.

### **Supporting and Affirming Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth**

MDHHS offers multiple training options to child welfare staff on providing appropriate and culturally sensitive services for LGBTQ youth and their families. See the Staff and Provider Training section of the APSR for details.

### **Anti-Racist, Multi-Cultural Training and Development**

The Office of Workforce Development and Training has a race equity team who meets regularly. In 2017, the “Understanding and Analyzing Systemic Racism” workshop was made mandatory for all training staff.

- Twenty-six staff took the workshop in 2017, bringing the total to 61 training staff.

The training office hosted a “Race Equity Child Welfare Executive” session for MDHHS child welfare leaders on April 12, 2017. The session was an opportunity to discuss the disproportionality of children of color in care in Michigan’s child welfare system, learn about the antiracism training and organizing model, and hear from leadership in the State of Illinois about their experience implementing strategies to address race-based disparities experienced

by children and families of color in their state. The training office forged a partnership with Children's Services Agency around a commitment to address the disproportionality of children of color in care in Michigan. This included sponsoring "Understanding and Analyzing Systemic Racism" workshop seats for children's services leaders and staff, and gaining commitment to collaborate and invest in a long-term statewide strategy to achieve equity in our child welfare system. In 2017, in collaboration with the MDHHS Health Disparities Reduction and Minority Health section, the training office began the development of an "Implicit Bias" training as well as revising the "Cultural Competence" training, scheduled for implementation in 2018.

### **Family Preservation Services Training**

Private agency service providers in the following family preservation programs complete core and special topic training:

- Families First of Michigan.
- Family Reunification Program.
- Families Together Building Solutions.

Family preservation training and technical assistance focuses on research-based service delivery using strength-based, solution-focused techniques. Family preservation core training attendance is limited to staff working in the specific programs, but all child welfare staff are able to attend special topic trainings. This provides another avenue for workers to meet their ongoing training requirement and helps develop shared skills across the continuum of care.

### **Leadership Development**

Leadership training and support services are available to MDHHS and private agency leaders and future leaders. During 2017, the following opportunities were offered:

- New supervisor institute introduced leadership skills, such as team-building, trust and conflict resolution. This training is offered monthly.
- Employee engagement workshop was designed to address the results of the MDHHS employee engagement survey. First and second line supervisors and senior leaders learned to effectively communicate and build trust with their team and manage change. Participants create their own engagement plans to apply on the job. This training was delivered by training staff in partnership with the MDHHS Workforce Transformation team.
- "Women in Leadership" is offered to women seeking to gain knowledge and skills on how to balance work and home and be successful in the workplace. This training is provided once per month at various locations throughout the state.
- "Building Successful Teams" utilizing the Positive Emotion Engagement Relationships Meaning Accomplishments (PERMA) model training was offered to first line supervisors and upper management. This training helps supervisors to build morale and assist in increasing work performance.
- "Emerging Leader Program" is for first line staff. It includes 5 computer-based courses, two classroom courses and a mentorship component. This training helps first line staff develop leadership skills to improve working relationships and strive for promotion.

### **Foster and Adoptive Caregiver Training**

A four-day train-the-trainer course led by training staff and experienced caregivers is provided to MDHHS and private agency staff who provide training to local prospective or licensed foster and adoptive parents in compliance with Michigan's licensing rules. The PRIDE (Foster and Adoptive Parent Resources for Information, Development and Education) model of practice is used.

The PRIDE model allows for a standardized, consistent, structured framework for the competency-based recruitment, preparation, assessment and selection of foster and adoptive (resource) parents. The aim of the competency-based team approach is to assure that resource families are willing, able, and have the resources to meet the needs of traumatized children and their families fully.

In 2019, the department will continue to support the newly created regional recruitment and retention centers with additional training options and standardized trainer certification. A more robust observation tool is currently in development, which will aid in providing a consistent, standardized and structured framework for certifying potential PRIDE trainers. The certification process would include one-on-one observation, evaluation, assessment and technical assistance by the PRIDE master trainer. Foster parent training coalitions, support groups, universities and a variety of other stakeholders will continue to provide ongoing training for foster and adoptive parents.

### **Collaboration**

Collaboration is critical to providing effective child welfare services. Office of Workforce Development and Training staff participate in various committees to assure consistency in addressing the training and development needs of child welfare professionals and foster and adoptive families. Following are some highlights from 2017 collaborative efforts:

- Several MDHHS local offices and Business Service Centers submitted training requests for training specifically for their office or region.
- The MiSACWIS project collaborates with the Office of Workforce Development and Training to deliver training to support successful MiSACWIS navigation.
- The State Court Administrative Office, the Michigan Attorney General's Office and the Prosecuting Attorneys Association of Michigan provide training on the model child abuse investigation protocol, forensic interviewing and facilitate consistent messaging to court personnel and child welfare professionals on legal matters.
- University of Michigan collaborated with the MDHHS in presenting the "36th Annual Child Abuse and Neglect Conference." MDHHS training staff assists with training preparation and classroom support during the conference.
- Staff collaborates with the MDHHS Health Disparities Reduction and Minority Health section to coordinate equity work across the department and collaborate on reducing disparities and improving health and wellbeing outcomes for marginalized groups.
- Workforce Transformation collaborated to design, develop and deliver Employee Engagement Training.

- Training staff collaborated with the Office of Family Advocate and assisted with reading child death review cases.