



# State of Michigan Department of Human Services

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## Special Review of Higher Risk Cases Quarterly Report: 7/1/10 - 9/30/10

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## **Preface**

The Michigan Department of Human Services (DHS) is responsible for administering the state's child welfare programs. The DHS mission includes a commitment to ensure that children and youths served by our public and private providers are, first and foremost, safe, receive high quality services that enhance their well being, and have permanent and stable families and lives. This mission is executed with help from the Children's Services Administration (CSA), which is responsible for planning, directing, and coordinating statewide child welfare programs.

On July 3, 2008, Governor Granholm, on behalf of Michigan, reached an out-of-court agreement with Children's Rights, Inc. regarding the Dwayne B. v. Granholm, et al. lawsuit. The agreement provides Michigan with a valuable opportunity to reform our existing child welfare system. The agreement builds upon reform efforts already under way and improves safety for children while providing stronger support and oversight for those responsible for them. This agreement is generally referred to as the "consent decree" and is often cited in this report.

## **Introduction**

The Child Welfare QA Unit has been established as an element of the Federal Compliance Division to ensure the provision of service is in accordance with DHS philosophy and federal standards of safety, well-being, and permanency. Part of the Child Welfare QA Unit's aim is to foster a continuous quality improvement (CQI) culture throughout DHS by introducing CQI concepts at all levels of the child welfare system. A key role is the training of staff on improvement processes and integrating CQI philosophy into long-term and everyday decision making. The QA Unit is working to develop an internal capacity to undertake data collection, verification, and analysis in addition to completing case record reviews for the higher risk cases identified in the consent decree.

In April 2009, the QA Unit began to conduct special reviews as specified by the consent decree. The Data Management Unit (DMU) provides an initial list of identified cases for the high-risk categories. The QA Unit reviews each identified case in the Services Worker Support System (SWSS) to pre-screen for possible data errors, and ensure that the case meets the cohort definition.

The QA Unit completed special reviews of higher risk cases as defined by the consent decree for July 1, 2010 through September 30, 2010. This report is a summary of the findings for the special case reviews conducted during this time frame.

## Review Process

The case reads were completed by CQI analysts by reviewing SWSS documentation, actual case files and, if deemed necessary, direct communication with the services worker.

The QA Unit developed a comprehensive case reading tool to conduct the special reviews. The case review process has evolved and will continue to change as we strive to improve the structure of the tool and refine the steps to obtain required information. The current version is in Microsoft Excel and is designed to structure a review of the file and capture information relevant to each high risk category.

The Data Management Unit provides the QA Unit with an initial list of cases identified as meeting the requirements of each special review cohort. Prior to conducting a full review, CQI analysts screen each case on this initial list to determine if the case information on SWSS confirms that the case meets the requirements of the cohort. For all cohorts, except Cohort A and B, if a case was previously reviewed by the QA Unit, it will be screened out for future reviews. However, in Cohorts A and B, if a case had been reviewed and a new complaint of child abuse/neglect is received and the youth continues to reside in the home, the CQI analyst will review the case again. The focus of this second review is to determine the quality of the investigation and what, if any, actions or patterns are evident since the initial case review.

Once the CQI analyst screens each child on the list and determines eligibility, the analyst completes a full case review, which includes reading information contained in SWSS-FAJ (Social Work Contacts and Updated Services Plans/Permanent Ward Services Plans), the foster care case file (review and verification of necessary documentation corresponding to the time frame), Children's Protective Services Investigation Reports (DHS-154) as needed, and the licensing file, when appropriate. Case worker interviews are conducted for clarification as necessary.

Upon completion of a case review, the analyst provides feedback to each local field office through exit interviews and county summaries. The analyst discusses recommendations for improvement with the local management team and requests the development of a Quality Improvement Plan (QIP) based on the review findings. The QIP is a tool used to identify, track, and update progress on targeted areas for improvement in each county or district office. It is then the responsibility of the analyst and the local office to monitor and assess the county's progress on the QIP to track and verify the improvements.

**Results: Cohort A**

*Definition: Children who have been the subject of an allegation of abuse or neglect in a residential care setting or a foster home, whether licensed or unlicensed, between June 2007 and September 2008, and who remain in the facility or home in which the maltreatment is alleged to have occurred.*

One hundred-eighteen cases were identified as meeting the definition of this cohort from the 7/1/2010 data pull. After the CQI analyst screened each case and determined eligibility, two cases were reviewed for this cohort. The eligibility criteria for the original 118 cases are as follows:

- One hundred-seven cases had been reviewed through the QA process and there was either no change since the last review or QA determined the case did not meet the requirements of the cohort.
- Nine youths were adopted and received a separate abbreviated review that was targeted to assess for safety. The assessments of those cases are in the "Adoption Cases" section below.
- The remaining two cases were previously reviewed by the QA Unit but were reviewed again this quarter because a new complaint had been filed since the last review. Neither complaint included allegations of a child death.

**Quality Assurance Assessment: Cohort A**

For the two cases identified for this cohort, the analyst conducted a comprehensive assessment of all complaints received and not just the new complaints since the last review. The analyst looked for patterns or trends of abuse in both cases.

In this review, as in other reviews completed in this cohort, QA continues to note that communication among programs (CPS, foster care, licensing) and documentation of contacts are consistent areas of concern. The 2009 "QA Report of Fatality Reviews" also noted a lack of communication and coordination among CPS, DHS foster care and licensing, and private agencies. Failure to recognize this vital communication issue could indirectly affect the safety and well being of the children in care, as information that might seem insignificant at first glance could later be crucial to the ultimate safety, well-being, and permanency of the child.

This finding has been a noted pattern not only in this cohort, but also in Cohort B. QA made recommendations to the counties to review and address this concern locally. The counties' action steps are being implemented and the progress of those improvement plans will be reviewed during future case reviews. QA has

also made recommendations on a state level to evaluate policy and training regarding this issue. Changes in training and efforts to enhance policy and procedures are under way.

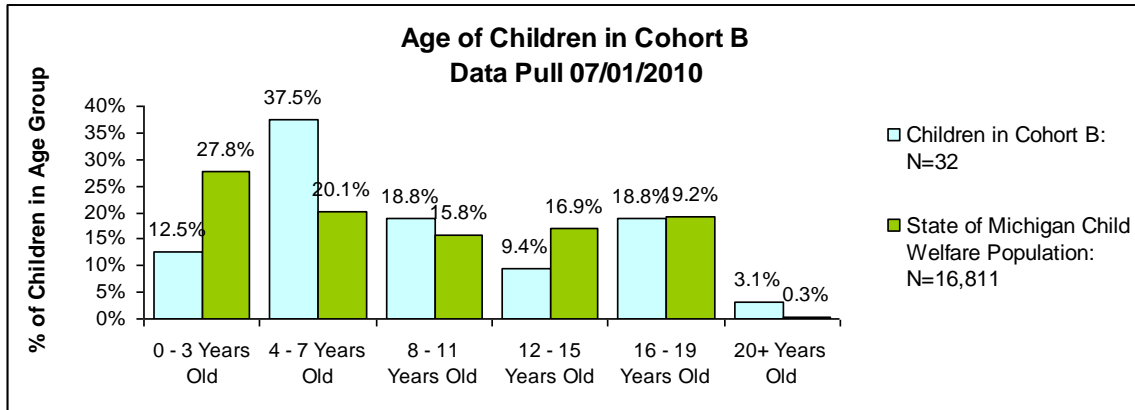
At this time QA has completed all cases that have met this cohort definition. Despite the pattern noted above, all the reviews completed have indicated that the safety of the children was not compromised. The investigations were completed thoroughly and case work decisions did not leave any children at imminent risk of harm. The QA Unit will complete an overall summary of the findings on all case reviews completed in this cohort and will submit a request to the monitors to terminate future case reads in this cohort.

**Results: Cohort B**

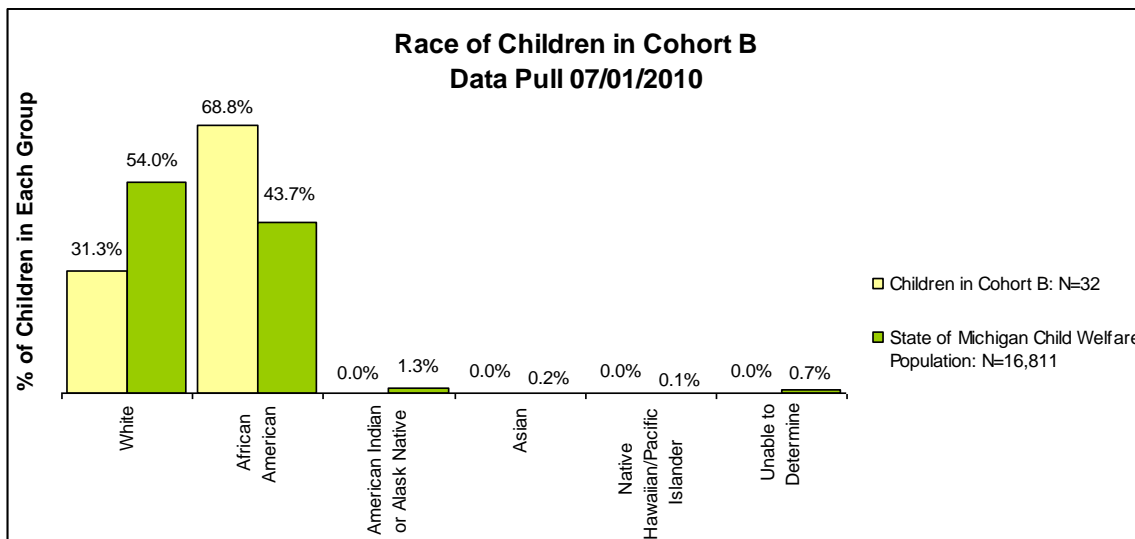
*Definition: Children, not in Cohort A, who have been the subject of three or more reports alleging abuse or neglect in a foster home, the most recent of which reports was filed during or after July 2007, and who remain in the foster home in which maltreatment is alleged to have occurred.*

Sixty-four cases were identified as meeting the definition of this cohort in the 7/1/2010 data pull. After the CQI analyst screened each case and determined eligibility, 32 cases were reviewed for this cohort.

- Twenty-seven of the original 64 cases had either been reviewed by the QA Unit and there was no change since the last review or it was determined that the case did not meet the requirements of the cohort at the time of review.
- QA erroneously screened out four cases, and those cases will be reviewed during the subsequent quarter.
- One case involved a youth that was adopted and received a targeted review for safety. The assessment of that case is in the “Adoption Cases” section below.
- Overall, 32 cases received a comprehensive review of SWSS and the case record. Four of these cases were reviewed previously but received further review as there were new allegations of child abuse or neglect.
- Seven of the 32 cases were under the direct responsibility of DHS and 25 were under the direct responsibility of private child placing agencies.
- Twenty-three children were living in a licensed, unrelated foster home, seven were living with a licensed/unlicensed relative, one was placed with a guardian, and one was in an independent living situation.
- Fourteen children in this special review category were female and 18 were male.
- Twenty-three of the children were Michigan Children's Institute wards and seven were temporary court wards, while one child was a voluntary ward and one child was a permanent court ward.

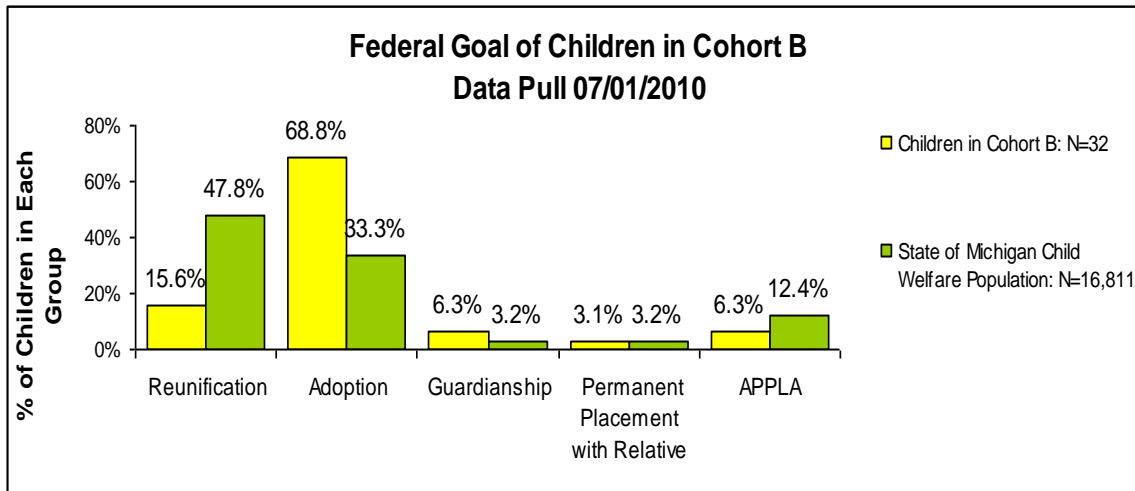


The median age of the children in this group was 7.5 years. The median age of the children in the child welfare population is 8.5 years.

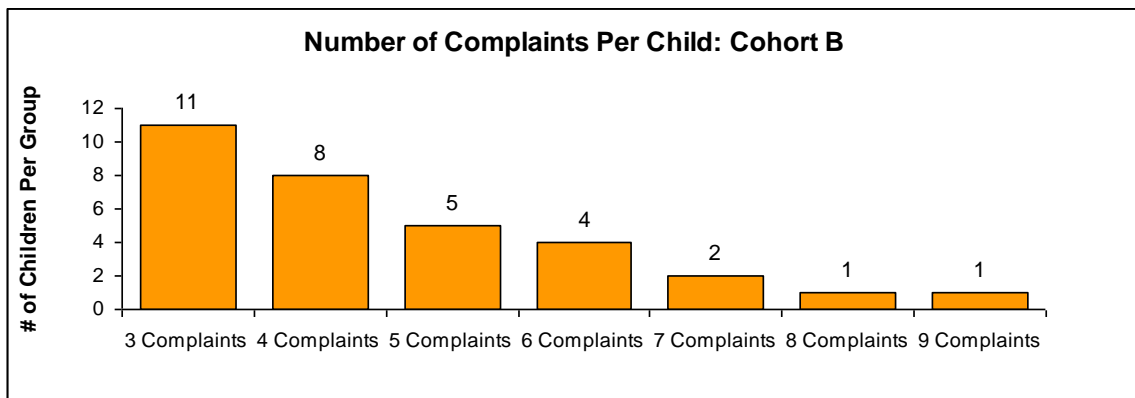


Twenty-two of the children were African American and 10 were white. Proportionally, there is an imbalance in the number of African American children represented for this cohort.

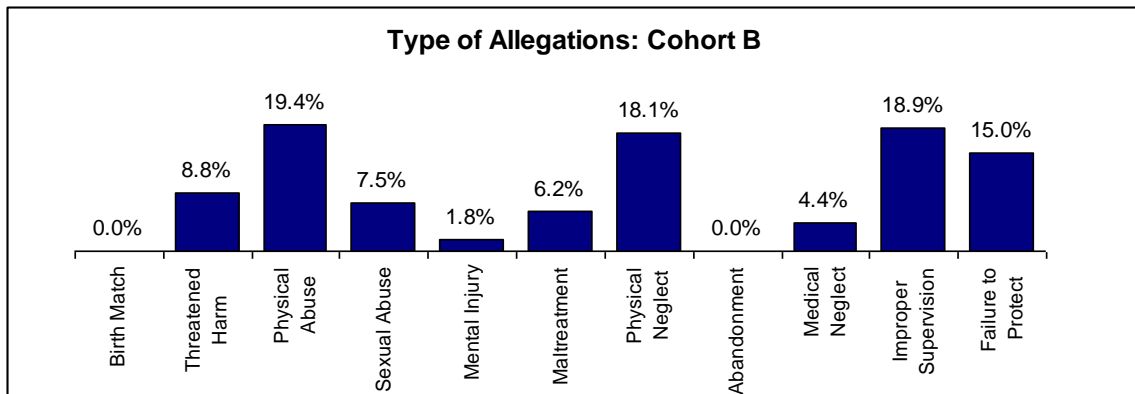




Twenty-two of the children had a federal permanency planning goal of adoption, five had a goal of reunification, two had a goal of Another Planned Permanent Living Arrangement (APPLA), two had a goal of guardianship, and one child had a goal of placement with a fit and willing relative.



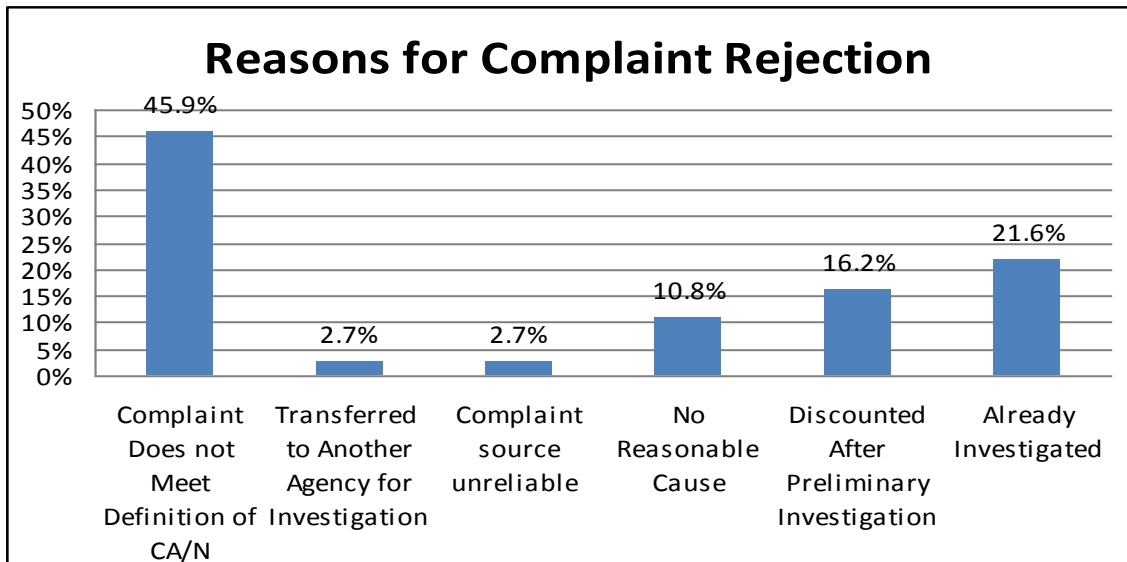
One hundred forty-five CPS complaints were reviewed for the 32 children in this cohort. The number of complaints ranged from three to nine per child.



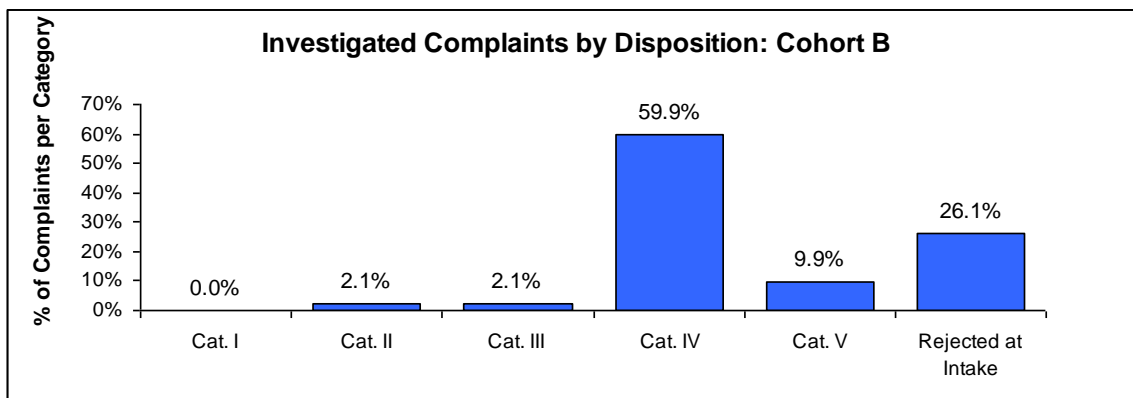
Within each complaint there was at least one, but sometimes several, different types of allegations of child abuse. Seventy-eight percent of the complainants were mandated reporters.

The alleged perpetrators identified in the complaints are as follows:

- Six percent were relative caregivers.
- Eighty-five percent were foster parents.
- Eight percent were other relatives.
- One percent was a non-relative who was not a caregiver.



Of the 145 complaints, 37 were rejected at intake. QA analysts found that all rejections met policy standards and were appropriately rejected.



One hundred-eight complaints received full investigations.

As noted in the above table, 2.1 percent of the investigations, or two CPS cases, were substantiated as Category II, and another 2.1 percent of the investigations were opened as a Category III. The two Category II cases involved one relative

caregiver and one unrelated, licensed foster parent and both Category III cases involved licensed foster parents.

The first Category II case involved a relative caregiver, who is a half-brother to the children. The complaint was called in by a non-mandated reporter who alleged that the caregiver sexually assaulted one of the youth in the home. During the course of the investigation it was discovered that the caregiver had been charged in 1995 with lewd and lascivious behaviors when he was approximately 14 years old. This incident occurred in Florida and because the caregiver was a juvenile the records were sealed. CPS was unable to obtain any information to verify if the caregiver received and/or completed services to rectify the prior issues and the caregiver openly admits that he does not recall if he completed the program as his father moved him to Michigan.

The children in the home deny all the allegations and the children were interviewed by Kids Talk (a child advocacy center) and the University of Michigan Child Protection Team, who all found insufficient evidence. The police also closed the criminal investigation due to insufficient evidence. Current criminal checks revealed that there were no other charges found for this caretaker as an adult. The DHS-154 indicates that the case was substantiated based on threatened harm.

Policy does indicate that a finding of threatened harm is appropriate if there is a prior conviction and services were not completed to rectify the issues. The foster care worker, courts and the MCI superintendent have all reviewed and evaluated the appropriateness of this placement and a determination was made that the children would remain in the care of the relative. The adoption has not been authorized due to the allegations involving the caregiver. Foster care is providing the caregiver with services to address his history. The courts have also assigned the youths a guardian *ad litem* (GAL) in order to ensure that all decisions made are in the children's best interest.

Policy requires that a Permanency Planning Conference (PPC) should be conducted prior to a placement change or immediately following an emergency placement. QA noted that there have been numerous meetings regarding these children and the possibility of a replacement, but there has never been a scheduled PPC. It was recommended to the county that a PPC is conducted on this case, and that it include all significant parties.

The second Category II case involves a child who is placed with an unrelated, licensed foster parent. Several complaints have been made against the foster mother alleging threatened harm, physical abuse, sexual abuse, maltreatment, improper supervision, failure to protect and medical neglect. This family has received nine complaints in total and all were denied except the complaint made on 2/1/2010, which was substantiated as a Category II. The disposition concluded that the child was a victim of threatened harm of failure to protect due

to intra-familial violence between the adoptive/foster mother and the adoptive/foster sibling. This child is currently an MCI ward and remains in the care of the foster mother. The CQI analyst made contact with the local office management (for both CPS and foster care), the child placing agency (Spectrum Human Services) licensing supervisor, and the QA manager. At this time, it is reported that the MCI superintendent approves of the placement with the foster mother, as she plans to adopt this child. Through the reviews on this case it has been noted that there is a conflict between the foster parent and another party who wishes to adopt and as a result, complaints to CPS continue to be made.

The two CPS investigations that were substantiated a Category III involved a total of three foster care cases. Because CPS cases are conducted on the entire household, and not by youth, one CPS case involved two children who are siblings and reside in the same placement.

The substantiated Category III sibling case was investigated in Wayne County. The disposition resulted in a preponderance of the evidence due to allegations that the victim had sexually molested another foster child in the home and had a physical altercation with the foster mother and other foster children. During the case review, the analyst had questions regarding the Category III disposition as it did not appear that there was sufficient evidence to support the substantiation. The documentation in the report indicated that the investigation was only substantiated due to the actions of abuse by a minor child and not a person responsible. The CQI analyst brought the information to the attention of the section manager who agreed that further assessment was needed and appropriate corrections would be made.

The complaint in Genesee County alleged medical neglect. The investigation was completed appropriately and the case was opened as a Category III. The foster parent was placed on Central Registry (appropriate per policy) and her license was to be revoked; however, the child remained in the home at the time of review. The analyst made contact with the county director's administrative assistant to address the concerns. It was reported that the concern was already brought to the attention of the MCI superintendent, prior to the QA review and a change of placement PPC was scheduled for 10/1/2010. The foster care worker, who had recently visited the child, stated that the youth was "fine" and that the foster mother was giving the medication as prescribed. The child has since moved to a relative home.

### **Quality Assurance Assessment: Cohort B**

As in Cohort A, communication and documentation of communication among programs (CPS, foster care, licensing) and other collateral contacts were consistent areas of concern. The 2009 "QA Report of Fatality Reviews" also noted a lack of communication and coordination among DHS and private foster care and licensing agencies, and CPS.

The DHS-154 is an important tool for communication. Of the cases reviewed in Cohort B, 60 percent of the CPS case files contained documentation that contact was made with the assigned foster care worker. The foster care service plan for the relevant time period documented that a CPS complaint had been made and investigated for only 34 percent of the complaints. Only 23 percent of the investigated complaints had a copy of the CPS Safety Assessment and the DHS-154 in the foster care case record.

In the cases involving licensed foster homes, 73 percent of the applicable complaints contained documentation that contact was made with the licensing/certification worker, while only 23 percent of the investigated complaints contained a copy of the DHS-154 and the CPS Safety Assessment in the licensing case file.

Through case worker interviews, QA established that communication is occurring, but the staff members are not documenting these discussions consistently across programs. CPS case files indicated a contact with the foster care worker, but the foster care case file would not have the same contact documented. Failure to recognize this communication issue could indirectly affect the safety and well-being of the children in care. As stated in Cohort A, this finding has been noted in prior case reviews and QA has made quality improvement recommendations through exit interviews, county summaries and state reports; these recommendations have resulted in local office changes, and state-level evaluations of policy and training regarding this issue.

Reviewers noticed an improvement in the general quality of the investigations, including improved communication, since the establishment of Maltreatment in Care (MIC) units in urban counties, specifically in Genesee and Wayne counties. Plans for QA case reviews and process evaluations of MIC investigations are under way. QA will make recommendations as needed based on the findings of the case reviews.

The safety of the child was the primary focus of the QA reviews for this cohort. Of the cases reviewed this quarter, only the above-mentioned cases were noted as having possible safety concerns. As noted above, QA has been conducting re-reviews on any child where a new complaint is again alleged. QA has noted that the investigations continue to be completed appropriately and there were no concerns for the safety of the children.

Well-being and permanency were also addressed in Cohort B reviews. In Genesee and Macomb counties, reviewers noted instances where the caregivers considered giving notice for a youth's replacement because of the CPS investigations. In both counties, specialists were able to sustain the placements by appropriately addressing the situation by way of PPCs and other communications.

## Adoption Cases

Twenty cases were reviewed this quarter in which there was an allegation or allegations of abuse or neglect in a foster home and the child has since been adopted by the identified care provider. These cases are either closed in SWSS or open for adoption subsidy only. CQI analysts completed an abbreviated review of these cases to assess safety. Analysts conducted a review of the CPS DHS-154 and information in SWSS-CPS only.

- Ten of the twenty cases were identified in the 7/1/2010 data pull.
  - Nine cases would have qualified for Cohort A.
  - One case would have qualified for Cohort B.
- The other ten adoption cases were identified in previous data pulls but were erroneously screened-out by QA.
- Of the 20 children reviewed, 70 percent of the caregivers were licensed/unlicensed relatives, while 30 percent were unrelated licensed caregivers (prior to the adoption). This 3:1 relative-to-licensed foster home proportion is the opposite of the proportion of placements identified for Cohort B.

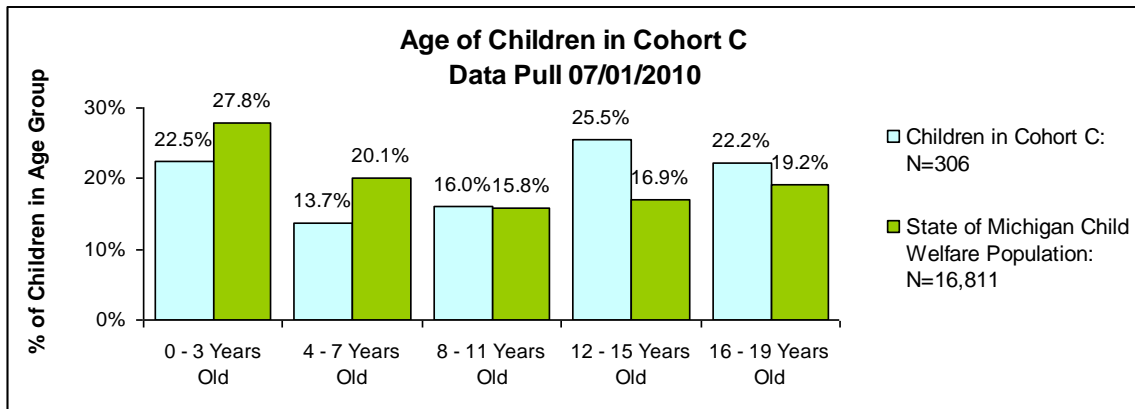
Child safety was the primary focus of the reviews in this cohort. Analysts assessed child safety by ensuring that the investigator verified the well-being of the alleged victim and all other children in the home, along with confirming that the alleged perpetrator was identified and interviewed, and assessed that all possible collateral contacts were made in order to determine the safety of the child. While areas of policy non-compliance were found during the case reviews, there were no noted imminent safety concerns, nor was there an indication that the non-compliances led to an incorrect disposition of the investigation. All the adoption placements were deemed appropriate to meet the youths' needs.

**Results: Cohort C**

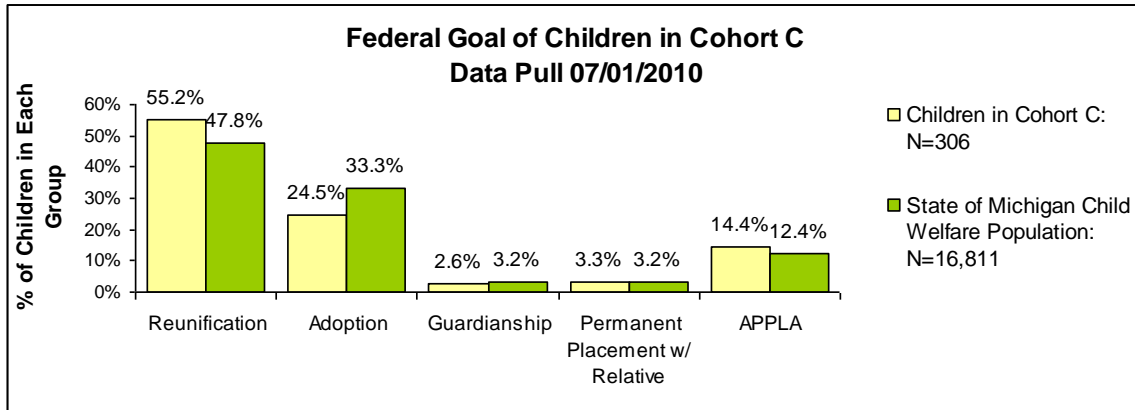
*Definition: Children who, at the time of review, have been in three or more placements, excluding return home, within the previous 12 months.*

The Data Management Unit identified 2,392 cases that met the definition for this cohort in the 7/1/2010 data pull. After the CQI analyst screened each case and determined eligibility, 306 cases were reviewed for this cohort.

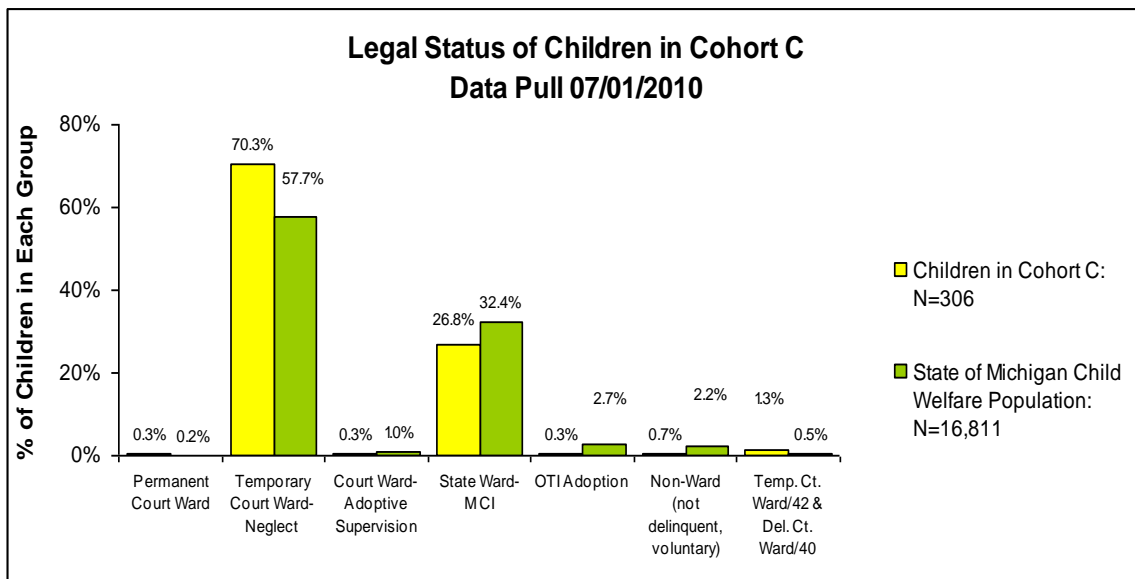
- Of the original 2,392 cases, 892 cases were previously reviewed by the QA Unit or it was determined that the case did not meet the requirements of the cohort at the time of review.
- After excluding the previously reviewed cases and cases that did not meet eligibility, 1,500 cases remained for review. QA utilized a web-based sample size calculator, called Raosoft, to determine a statistically significant sample size of 306 cases for this cohort.
- One hundred sixty-seven of the 306 cases were under the direct responsibility of DHS and 139 cases were under the direct responsibility of private child placing agencies.
- One hundred and forty-five of the children were female and 161 were male.



The median age of the children in this group was 11 years. The median age of the children in the child welfare population is 8.5 years.

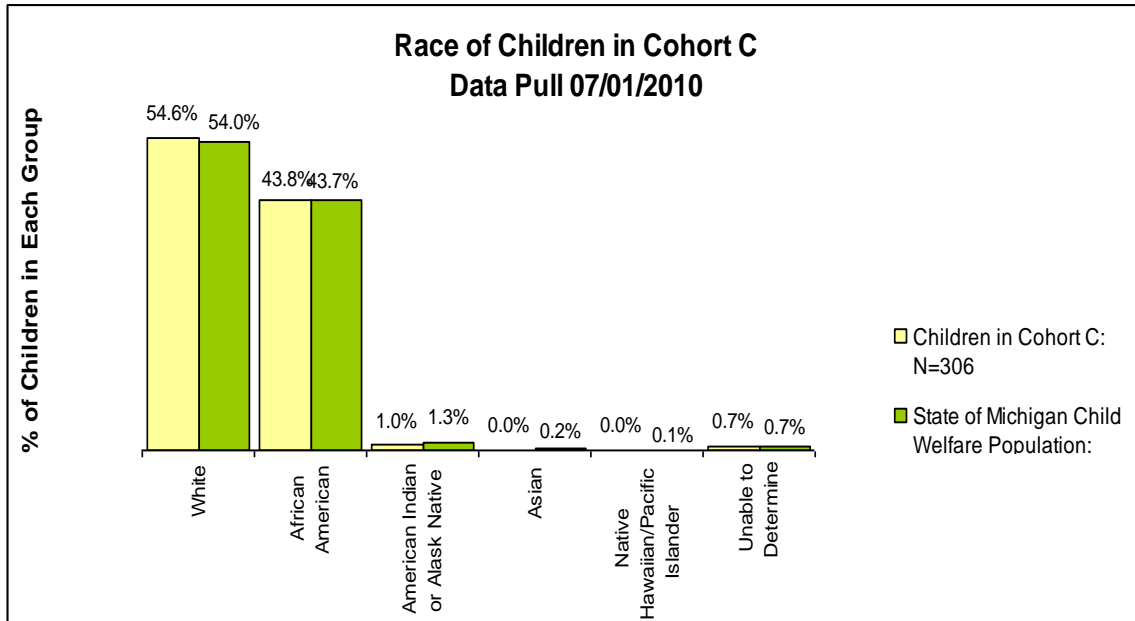


One hundred sixty-nine children had a federal permanency planning goal of reunification. Forty-four had a goal of APPLA, 75 a goal of adoption, 10 a goal of permanent placement with fit and willing relative, and eight had a goal of guardianship. There is no specific trend in permanency goals in the cases reviewed for this cohort.



Two hundred-fifteen were temporary court wards, 82 were Michigan Children's Institute wards, two were non-wards (not delinquent), one was a permanent court ward, one was an OTI-adoption ward, four were dual wards, and one was court ward-adoption supervision. There is no specific trend in the legal statuses of the children in this cohort as compared to the children in the Michigan child welfare population.

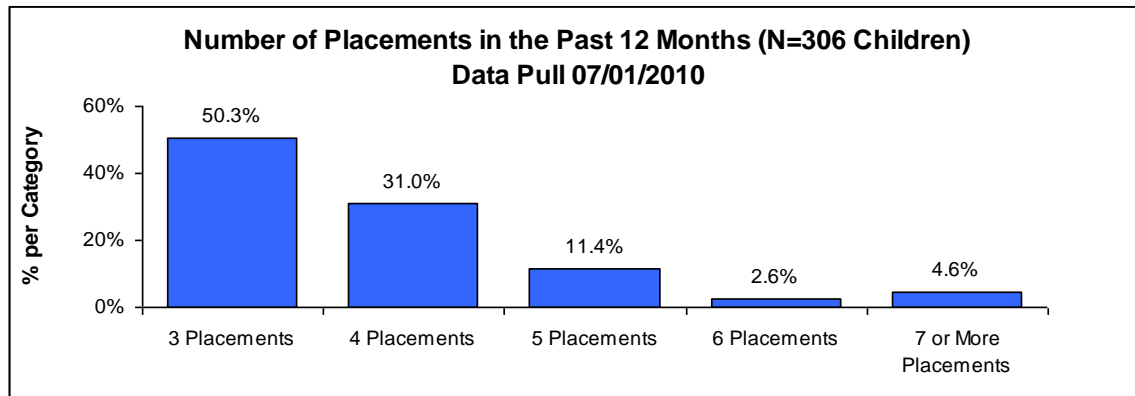




One hundred thirty-four children were African American, 167 were white, three were American Indian/Alaskan Native, and two were listed as unable to determine. There is no identified trend in the race of the children in this cohort when compared to the children in the Michigan child welfare population.

| Current Living Arrangement                                      | Children in Cohort C: N=306 | Child Welfare Population: N=16,811 |
|---|-----------------------------|------------------------------------|
| Parental Home   | 6.9%                        | 11.1%                              |
| Licensed/Unlicensed Relative                                    | 20.3%                       | 34.5%                              |
| Legal Guardian  | 0.0%                        | 2.1%                               |
| Licensed Unrelated Foster Home                                  | 39.9%                       | 34.8%                              |
| Independent Living  | 7.5%                        | 6.2%                               |
| Unrelated Caregiver   | 2.6%                        | 0.8%                               |
| Detention   | 1.6%                        | 0.3%                               |
| Jail  | 0.0%                        | 0.1%                               |
| Private Child Care Institution                                  | 15.0%                       | 5.8%                               |
| Mental Health Facility  | 0.0%                        | 0.1%                               |
| Boarding School, Runaway, Services Facility, Hospital, Adult FC | 0.3%                        | 0.1%                               |
| AWOL  | 2.0%                        | 1.1%                               |
| Out of State Relative   | 1.3%                        | 0.6%                               |
| Out of State Child Care Institution                             | 0.7%                        | 0.1%                               |
| Out of State Licensed Relative                                  | 0.7%                        | 0.3%                               |

The previous table outlines the living arrangement of the children in this cohort at the time of review. The percentage of placements in private child care institutions is significantly higher than the state child welfare population. This could correlate to the high number of replacements that were reportedly due to the child's behavior. Excluding moves to meet the child's case goals, the most commonly noted reason for replacement was the caregiver's request due to the child's behavior. Furthermore, the third most commonly noted reason for replacement was to move the child to a more restrictive setting as a result of his or her behavior.



There is a noted reduction this quarter in the percentage of the cases with four or more placements in the past 12 months. For the cases reviewed for the 7/1/2010 data pull, 49.7 percent of the children have been in four or more placements and for the 4/1/2010 data there was 55 percent. The average length of stay for placements was four months.

### Quality Assurance Assessment: Cohort C

Three hundred-six cases were reviewed for this cohort. Those children have a combined total of 1,175 placements in the past year. There was clear documentation of efforts by the worker to prevent replacement for 414 (35%) of those replacements. Prior Quality Assurance summaries noted that foster care policy on placement/replacements, FOM 722-3, describes in detail the need for stability and permanency when placing and replacing children in foster homes; however, foster care policy on updated service plans, FOM 722-9, does not currently require the worker to list reasonable efforts to *prevent* replacement. The lack of policy to direct the need for this information does result in a lack of documentation of the services that were utilized to prevent a replacement. Therefore, the 65 percent of the replacements that were lacking documentation of efforts to prevent replacements could have been due to a lack of policy to direct the workers to include this documentation. Without proper documentation, QA is unable to ascertain if a lack of provided services is the reason for the multiple replacements. With worker turnover and changes from DHS to private child placing agency supervision, new workers may not be able to determine

what efforts have been made to prevent multiple placements. Lack of policy hinders supervisory oversight to ensure that appropriate services are in place. This may result in duplicated services that are not effective or services that do not address needs. The lack of quality documentation continues to be a focus of concern for the reviews completed this quarter, and led to numerous CQI analysts making recommendations to the foster care program office for changes to policy as well as to the DHS-69, Action Summary, which is the required form used whenever there is "action" on a case, including but not limited to a child replacement.

Of the 1,175 placement changes, a copy of the DHS-69 was filed 62 percent of the time. It was noted that many of the placement settings did not require an Action Summary per policy as the placement was the child's first placement in care. In an effort to track this information in future reviews, QA made adjustments to the case read tool to track first placements in care. In many cases, the DHS-69 was found in the case file, but the form was incomplete or included invalid information. Sections of the form were left blank, the information was clearly referring to a prior replacement and not the current replacement, or the information provided is vague and does not clearly detail the reasons and events that resulted in the placement move. Many replacements occurred while CPS still maintained case management responsibilities. Current policy does not detail what documentation must be completed by which program when a replacement is executed by CPS. Subsequently, there is no mandate that the CPS worker must document the replacement in the DHS-154 or CPS updated service plan, nor is there a mandate that the assigned foster care worker must complete a DHS-69 for the previous replacement. A recommendation will be made in this report to address both gaps in policy.

Another finding for this cohort was a lack of documentation of efforts to locate relatives, and a lack of completion of the DHS-987, Relative Notification form, which is used as a comprehensive and continuous documentation of all possible relatives in order to comply with the relative notification requirements of the Fostering Connections to Success and Increasing Adoptions Act of 2008. Proper and complete documentation of efforts to notify relatives is especially important for children in this cohort. Worker turnover and constant changes from DHS to private child placing agency responsibilities can create difficulties for the new worker when trying to determine what relatives are known and if they have been contacted for possible placement or other support. In 251 (82%) of the 306 cases in this cohort, the case file included documentation of efforts to contact relatives. However, based on the assessments of that documentation, there is an inconsistency in the quality of documentation of efforts to locate relatives for support and/or placement of these youths. For example, some service plans included comprehensive and detailed documentation of efforts to contact and involve relatives in the child's case planning, while other service plans included only one-sentence, vague references to relative notification, such as "There are no known relatives at this time," and those vague references are repeated from

service plan to service plan and there is no supporting documentation in the case file to support that statement. To summarize, analysts are finding some documentation, but it is not of good quality. Only 41 (13.4%) of the case files included a DHS-987.

There was clear documentation that the placement change was planned in an effort to achieve the child's case goals or to meet the needs of the child for 50.2 percent of the replacements. While this indicates that the majority of replacements were appropriate due to meeting needs of the child, the data does suggest that there is a need for more supportive services in the home in order to assist the caregivers with the children's special needs and possibly help prevent further placement changes. QA recommends the development of additional resources to preserve foster care placements; e.g., built-in respite services, mental health education/ training, 24-hour access to on-call crisis worker/ Families First services (not including CPS on call/after-hours units). Such preventative behavioral and family services could help maintain placement stability.

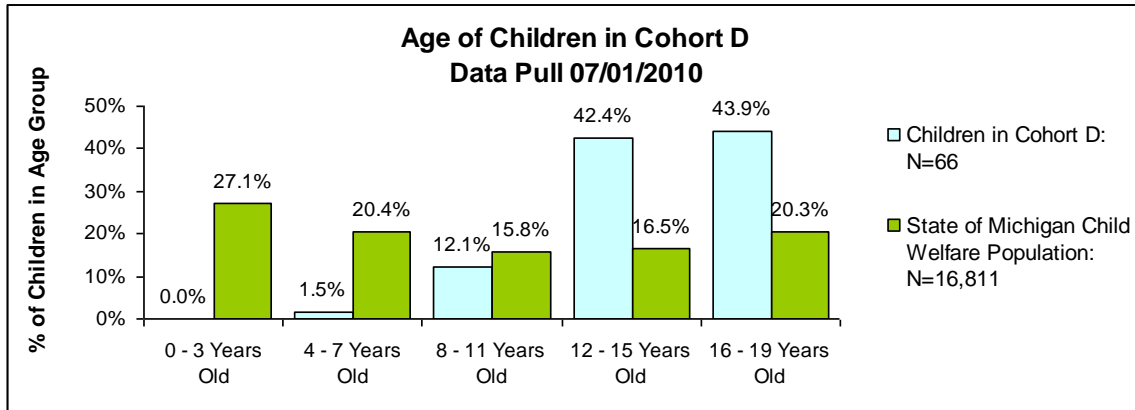
There were no imminent safety concerns noted for this cohort.

## Results: Cohort D

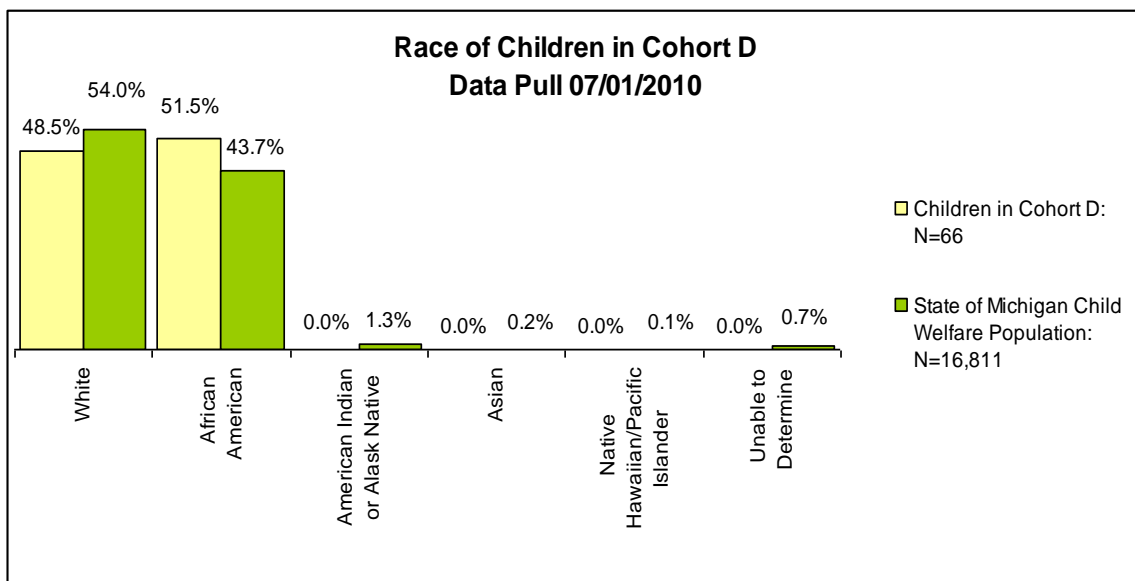
*Definition: Children who, at the time of review, have been in residential care for one year or longer.*

Three hundred seventy-two cases were identified as meeting the definition for this cohort in the 7/1/2010 data pull. After the CQI analyst screened each case and determined eligibility, ultimately 66 cases were reviewed for this cohort.

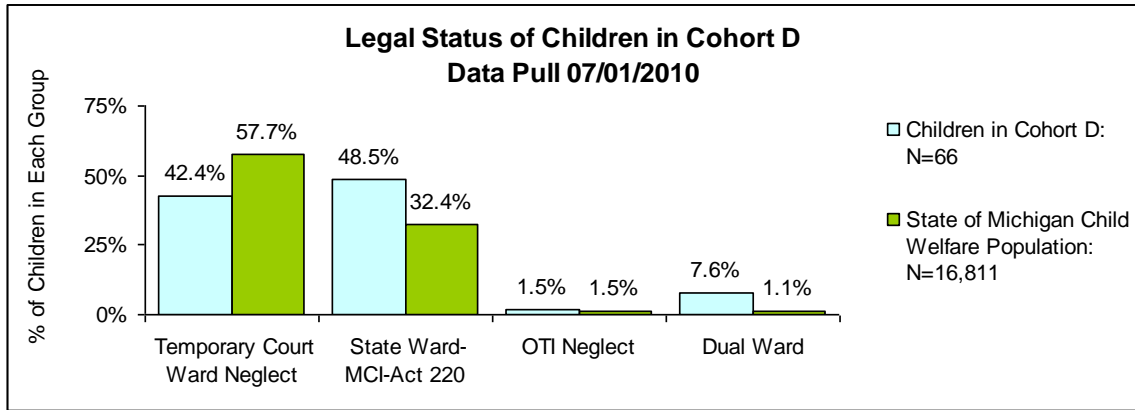
- Three hundred-four of the 372 cases were either previously reviewed by the QA unit or it was determined that the case did not meet the requirements of the cohort at the time of review.
- One case was screened out in error and will be reviewed in the subsequent quarter.
- One case was unavailable due to a title IV-E review and will also be reviewed during the next quarter.
- Sixty-three cases were under the direct responsibility of DHS and three were under the direct responsibility of private child placing agencies.
- Forty-one youths were male and 25 were female.
- The average length of time in the current residential placement for the cases reviewed was 11 months. The longest amount of time was 27 months and the median was 13 months.
- The average length of total time in residential settings for these children was 25 months.
- Forty-seven youths had previous residential placements.



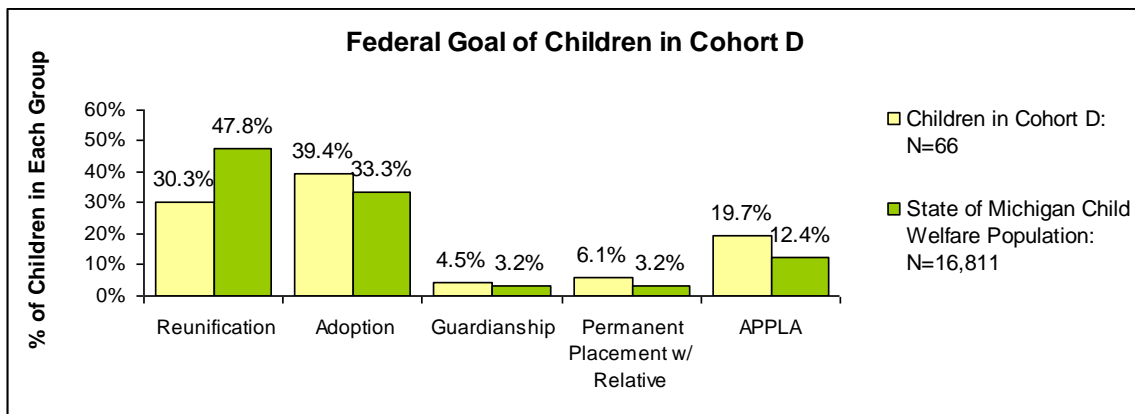
The QA Unit has noted that the median age of the children in this group was 15 years, which is older than all of the other special review cohorts and is over six years older than the median age of the children in the child welfare population, which is 8.5 years. Future assessments will be needed to determine the reason for the large gap in average age for this cohort.



This graph details the race of the children in this cohort as compared to the children in the entire child welfare population. There is no significant difference in the ethnicities of the children identified for this cohort when compared to the children in the state child welfare system.



Thirty-two of the children and youths were MCI wards, 28 were temporary court wards, five were dual wards, and one was an OTI-neglect ward. There is no significant difference in the legal statuses of the children in this cohort compared to the legal statuses of the children in the Michigan child welfare population.



Twenty youths had a federal permanency goal of reunification, 26 had a goal of adoption, 13 had a goal of APPLA, four had a goal of permanent placement with a fit and willing relative, and three had a goal of guardianship.

**Quality Assurance Assessment: Cohort D**

During the reviews, QA noted that a large number of youths have serious behavior problems that warrant the placement in a residential facility. The ages of the youths in this cohort are much higher than the other cohorts and there appears to be a pattern of older youths aging out of foster care directly from the residential setting. Of the youths that are 14 years old or older, 75 percent have permanency goals other than reunification, and 28 percent of the youths have permanency goals of APPLA or APPLA-E (emancipation). As these older youths are getting ready to leave the child welfare system, it is imperative that they have at least one identified significant support person.

When completing these reviews, the QA unit found that a number of counties have allowed their DHS-direct foster care staff to use a residential Updated Service Plan (USP) in lieu of the required DHS USP. Forty-nine (74.2%) of the 66 residential cases reviewed contained a current residential USP and only 45 (68.2%) of the cases contained an updated DHS service plan. The DHS service plan is required for documentation of certain elements of the case that are not required in the residential service plan, such as monthly contact by the DHS worker, family contact documentation, recommendations to the court, and reasonable efforts to achieve permanency. Documentation of reasonable efforts is mandated by federal law and outlined in foster care policy FOM 722-6, Reasonable Efforts. Without documentation of reasonable efforts in the DHS service plan, it is difficult to determine if these youths and their families are being provided services to help move the child to permanency.

An example of a reasonable effort is the search for absent parents or other relatives. Sixty-one (92.4%) out of 66 cases included documentation of the child's contact with significant people in the last 90 days (pre-adoptive family, birth family, siblings), and 57 (86.4%) of the 66 cases included attempts to locate relatives. As in Cohort C, based on the assessments of documentation found in the relevant sections of the service plans, there is an inconsistency in the quality of documentation of efforts to locate relatives for support and/or placement of these youths. Analysts are finding some documentation, but that documentation is found to be repetitive from other reports or the information is not supported in other sections of the report. A thorough, all-inclusive relative search could not only help prevent multiple moves, as noted in the Cohort C assessment, but it also provides multiple other benefits for the youths: family relationships, improved support systems, and incentives to achieve service goals that could result in discharge from the residential placement. Foster care policy FOM 722-6, Relative Notification, states that throughout the case, the foster care worker must continue to seek, identify, and notify relatives *until legal permanency for the child is achieved*.

Similarly, only four of the 66 cases included a DHS-987, Relative Notification, in the case file. The DHS-987 was created as a tool to assist in the relative search, and is mandatory for compliance with federal guidelines. While it is important that the case worker document any attempts that were made to contact and place with relatives in every service plan, it is equally important to keep a detailed list of all identified and contacted relatives since the child entered care in order to maintain a complete account of all possible relatives in one place. Again, such documentation is important due to worker turnover and changes in case management responsibilities. It does not appear that the current format of the DHS-987 is driving the staff to document relative contacts. Through continued recommendations and Quality Improvement Plans, the QA unit is working to make sure that all counties recognize the importance of family involvement and appropriate documentation of all relative information.



Only 37 (56%) of the 66 cases reviewed in this cohort have a current approved, or copy of a pending approval, residential placement exception request in the case file. The consent decree states that no child shall be placed in a residential treatment center without express written approval by the county Administrator of Children's Services in a designated county, or by the Children's Services Field Manager in any other county (Section X.B.7, Limitations on Residential Care Placements). In many instances, it was found that the most pertinent and detailed information about the child's history and reason for the need for residential was actually found in the residential placement waiver and not in the DHS service plan. This is a concern as the waiver is a supplemental form and should not replace the mandated information in the service plan.

Fifty-seven (86.4%) of the 66 cases included documentation that the caseworker discussed permanency issues with the child. In 58 (87.9%) of the 66 cases reviewed there was documentation of activities in the past 90 days to achieve permanency or place the child in a less restrictive setting. These higher percentages of compliance compared against the low percentage of updated or completed service plans (68.2%) supports the conclusion that this information was obtained from supplemental reports, such as the residential placement exception request. The service plan is meant to be a summary of all information obtained and therefore it is imperative that these service plans are always up to date.

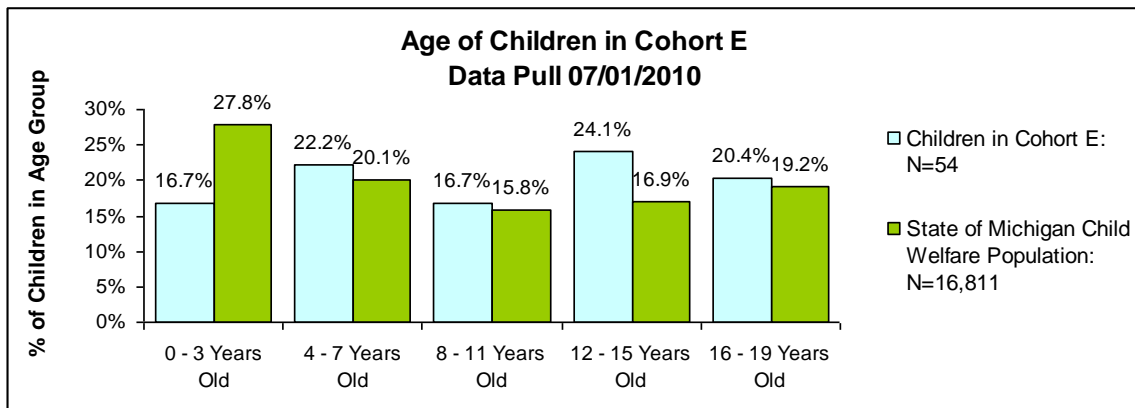
Forty-nine cases included documentation that the youth is receiving medications while in residential. Of those 49 cases, 96.1 percent included documentation within the current residential USP of a medication review by a qualified professional.

**Results: Cohort E**

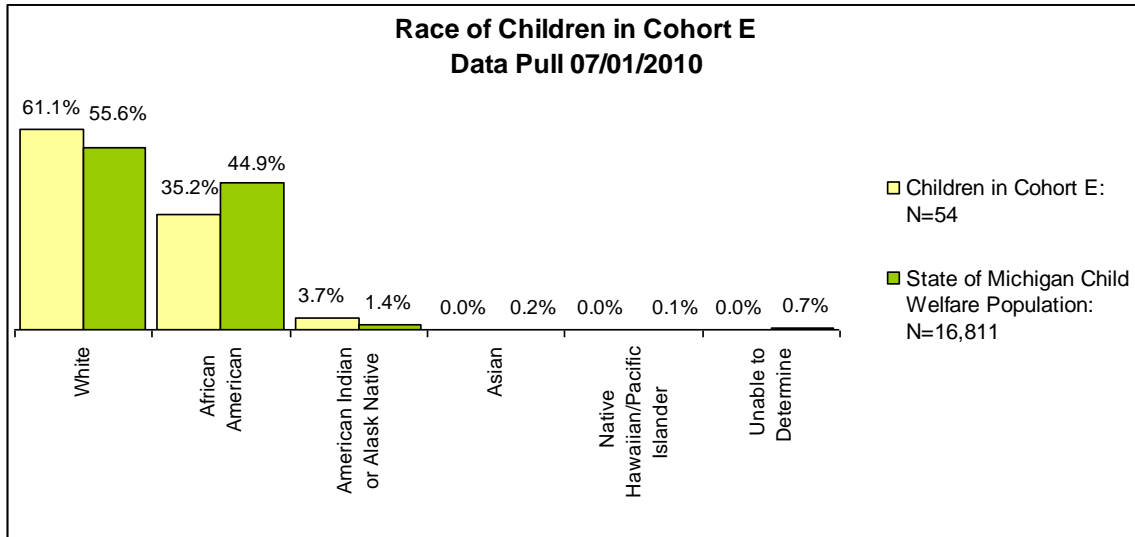
*Definition: Children who, at the time of review, are in an unrelated caregiver placement, defined as an unlicensed home in which the caregiver is not a relative of the child but has been approved as a placement resource because of prior ties to the child and/or the child’s family.*

One hundred forty-five cases were identified as meeting the definition of this cohort on the 7/1/2010 data pull. After the CQI analyst screened each case and determined eligibility, 54 cases were reviewed for this cohort.

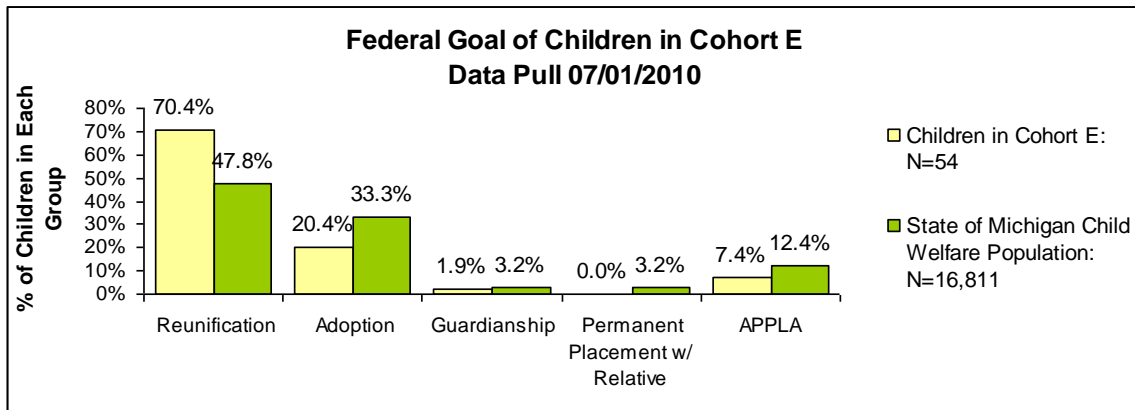
- Ninety-one cases were either previously reviewed by the QA Unit or it was determined that the case did not meet the requirements of cohort at the time of review.
- Forty-seven of these cases were under the direct responsibility of DHS and seven were under the direct responsibility of private child placing agencies.
- Thirty-one children in this special review category were male and 23 were female.
- Forty-two of the children were temporary court wards, 11 were Michigan Children's Institute wards and one was a dual ward.



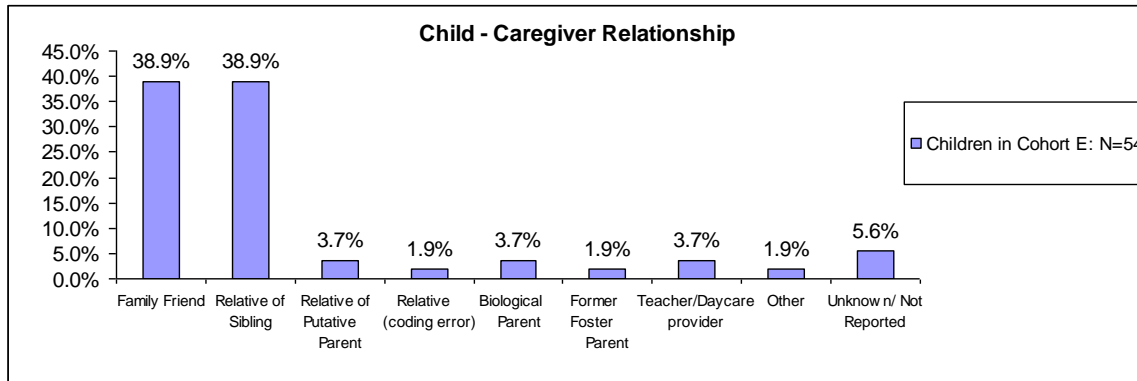
The median age of the children in this group was 10 years. The median age of the children in the child welfare population is 8.5 years. There is no significant difference in the median age of the children in this cohort when compared to the median age of the children in the state child welfare population.



Thirty-three children were white, 19 were African American, and two were American Indian/Alaskan Native. There is no significant difference in ethnicities when comparing the children in this cohort to the children in the state child welfare population.



Thirty-eight children had a federal permanency planning goal of reunification, 11 had a goal of adoption, four had a goal of placement in another planned permanent living arrangement, and one had a goal of guardianship. As noted in the above graph, the percentage of reunification goals for the children in this cohort is higher than the percentage of reunification goals for the children in the state child welfare population; however, this difference has not been consistent through prior reviews and therefore cannot be determined significant.



In most cases, there was documentation that the child was placed with people where a significant relationship existed, indicating that these placements are in the children’s best interest. The most frequent relationships are family friends and family of siblings. In only three cases the relationship was not known or not clearly documented. The graph details the child-caregiver relationships for the cases in this cohort.

**Quality Assurance Assessment: Cohort E**

Child safety and permanence were the primary focuses of the QA reviews for this cohort.

During the reviews, two cases did rise to the level of requiring further review by the QA manager to ensure the youths’ safety.

In one case, QA found that the youth was absent without legal permission (AWOLP). This youth left the approved placement and independently chose to live with an unrelated, unlicensed acquaintance. The assigned foster care worker did not take the appropriate steps for such placement per policy and did not view the home. The CQI analyst noted the concern and brought it to the attention of the county administrator. The analyst ascertained that the child was no longer in the placement and was in jail. This youth was an adult and was in jail due to his criminal behavior. QA and the local office determined that the proper classification for this living arrangement was AWOLP. The living arrangement was corrected in SWSS.

In another situation, QA had a concern for an unrelated, unlicensed placement, since the caregivers were former foster parents whose licensed had been revoked. The children were removed from that home, but returned at a later date. Further review by the QA manager revealed that an administrative hearing was conducted, which reversed DHS decision to remove the child from that home. The foster care review board disagreed with DHS decision to move the children from that home, as did the Michigan Children’s Institute superintendent, so the court ordered placement with the unlicensed care providers. Even though DHS

did not agree with the placement decision, other authorities have deemed this placement in the best interest of these children.

Policy is very clear that no child may be placed with an unrelated caregiver unless that caregiver is licensed. If the court orders placement, specific conditions must be met prior to the placement. Home studies are completed only half the time. Twenty-seven (50%) of the 54 children placed with unlicensed, unrelated caregivers included a completed home study (DHS-197). Though there are inconsistencies regarding how workers obtain county director approval for these placements, 41 (75.9%) of the cases included some form of documented approval, which is a slight increase over last quarter's rate of 61.7 percent. The placement was court ordered in 42 (77.8%) of the 54 cases. Of those court orders, 23 (54.8%) included the specific language as identified in foster care policy FOM 722-3, Unrelated Caregiver Placement, "Conditions of custody at the placement and with the individual with whom the child is placed are adequate to safeguard the child from the risk of harm to the child's life, physical health, or mental well-being."

In 45 of the 54 cases (83.3%), the latest USP included documentation that the placement is in child's best interest (most family-like setting, maintains familial relationships, children able to remain in community/ school) and 46 cases (85.2%) included documentation of continued efforts to locate relatives.

As in prior reviews, it was noted that there is a significant conflict between foster care and CPS policies regarding unrelated caregiver placements. Currently, CPS policy dictates that placement of a youth in an unlicensed/unrelated home is not allowed. However, foster care policy gives specific procedures to be followed in order to make this type of placement permissible if the placement is ordered by the court. It is apparent throughout reviews in this cohort that CPS workers are placing youths in unlicensed/unrelated homes and due to a lack of procedural guidance, youths are being placed without proper court documentation/authorization. QA recommends that the CPS and foster care program offices collaborate to create consistent policy.

At this time, the QA Unit has not found any unlicensed, unrelated placements that have not been supportive of the youth's permanency goals. These placements are found to be safe and in the children's best interest.

## Conclusion

The Quality Assurance Unit is responsible for systematically monitoring service quality. The QA system is driven by the department's commitment to delivering high quality services that provide functional, positive outcomes for the children and families we serve. Analysis of the information gathered from these reviews continues to indicate an on-going need for improved case management, training, and supervisory oversight. The results of the special reviews of higher risk cases allow the department to make informed decisions about policy, process, and program effectiveness with a focus on the safety, well being, and permanency of those in care. In our last state report, recommendations were made to the Child Welfare Training Institute (CWTI) to address possible lapses in staff and supervisor training. CWTI completed a QIP, in which they have identified steps to take to improve the worker and supervisor training. Furthermore, foster care program office is looking at policy to specifically identify where certain case events should be documented. Through individual county reviews and feedback, local offices are also making efforts to develop plans for improved case management.

Our reviews indicate a need for more supportive services in foster homes, whether licensed, relative, or unrelated. It is noted that stability and permanency are disrupted due to a lack of support in the home, often due to a child's behavior. Providing a more structured support system for the foster parents may result in a reduction of placement changes and, more importantly, may encourage some foster families to have youths with special needs placed into their homes. These services could also provide more placement opportunities for older youths to help prevent them from aging-out while in residential settings. While supportive services are necessary, service workers must be diligent about contacting relatives and keeping *thorough* and *quality* records of those relatives and the results of the contacts. Finally, open communication between service programs and among child placing agencies is another area in need of improvement. Deficient communication and *documentation of that communication* has an indirect effect on safety, permanency, and well-being.

## Recommendations

The following recommendations result from all cohort reviews. The QA manager communicated with the various DHS child welfare offices and units in December 2010 to inform them of the pending recommendations.

### Foster Care Program Office:

Research and develop additional resources to preserve foster care placements. If it is found these types of resources are already available, then a process should be developed to share the information with the first line staff. For example, built-in respite services, mental health education/ training, 24-hour

access to on-call crisis worker/ Families First services (not including CPS on call/after-hours units).

Consider modifying the DHS-69, Action Summary, to better guide the case worker in documenting the reasons for child replacement, efforts made to prevent or support the placement change, and the action plan to maintain the new placement or transition youths to a less restrictive setting.

Consider modifying service plan policy to include mandates for documenting efforts to prevent replacements, or documenting the reason why reasonable efforts were not necessary, if applicable.

Clarify FOM 722-7, Permanency Goal Review Process, to identify when the DHS-643 (Permanency Goal Review) is updated and clarify when the first DHS-643 is to be completed. Even though the form indicates it is an annual review, staff are completing these inconsistently throughout the state.

Coordinate efforts with CPS program office to develop one consistent policy on unrelated, unlicensed caregivers.

Clarify policy concerning the documentation of a CPS complaint and investigation of a foster home in the foster care service plan. The current service plan only requests information on CPS complaints on the biological parent, resulting in workers failing to document findings on complaints against the foster home/residential placement.

CPS Program Office:

Modify policy to include documentation requirements for replacements conducted before a case is transferred to foster care, such as in the CPS Investigative Report or CPS Updated Service Plan, if applicable.

Coordinate efforts with FC program office to develop one consistent policy on unrelated, unlicensed caregivers.

Health Unit:

During reviews, QA found inconsistencies among the various L-Letters (written notification to the field to give direction while policy is pending) on documentation of annual medical and dental appointments. These concerns did not pertain to any one specific cohort and therefore were not addressed in the body of this report. QA recommends that the health unit provide clarification to the field regarding the multiple L-Letters on documentation requirements for annual medical and dental evaluations. This clarification should specify that the health unit has directed the use of L-10-047-CW, which states that the DHS 1662/1664

is standard documentation accepted by the Bureau of Child and Adult Licensing (BCAL) for medical or dental examinations, although comparable documentation is accepted if it contains the required information and a physician's or dentist's signature.

Data Management:

Native American cases are currently included in DHS statistics that are not representative of DHS recommendations due to the different standards for removal, termination of parental rights, and tribal decision making. County offices have requested that the Data Management Unit create an additional sort category for Native American children in care in order to provide additional explanations for the variations in those cases due to tribal requirements and differences.

SWSS/SACWIS:

*Given that efforts are afoot to develop the new SACWIS system, it is requested that recommendations be taken under advisement while the system is in development.*

Integrate the consent decree requirements of a valid and reliable tool for screening of potential mental health issues into the Child Assessment of Needs and Strengths (CANS), within 30 days of the child's entry into foster care.

Collaborate with the Contract Compliance Unit and Contracts and Rate Setting to determine the various levels of restriction within each residential program to help determine when a child is in a secure or non-secure residential program, and then address the living arrangement codes in SWSS-FAJ that will properly categorize these various settings. Such changes in SWSS/SACWIS would help identify goal achievement and assess child well being.

Connect the PPC database to the SWSS/SACWIS system to reduce redundancy and have all PPC recommendations populate the USP IV-A, Child Status. Develop a system to provide the worker and supervisor a tickler reminder for specific time-driven PPCs.

Expand SWSS/SACWIS capabilities to include a tickler reminder for the requirements of the completion of the DHS-396 (Placement Exception Requests).



## **Follow Up**

DHS continues to implement policies and develop training aimed at improving the quality of service to children and families in the child welfare system. As a result of prior recommendations made by the Quality Assurance Unit, the following steps have been taken by DHS, since last quarters case reviews, to address some of these recommendations:

**Medical Passports:** The QA Unit has consistently found that the medical passports are not being completed appropriately per policy. The case files are either missing the form, the form is present but void of any information or the information is outdated. The QA Unit has contacted other entities within DHS to collaboratively address this problem. The Health Unit is aware of this concern and has started to make efforts to address and assist the field. Currently there are plans to initiate a foster care public health nurse pilot program in three counties in order to simplify the medical assessment process and aid in keeping medical documentation up to date.

**Dual Wards:** As there is no unique policy for this population, CPS, foster care, and juvenile justice program writers are working to address the lack in policy and clarify questions from the field until policy is available.

**Medical/Dental Documentation:** Through inquiries from the field during special reviews, the QA Unit was able to clarify policy regarding documentation of medical/dental information. There are three L-Letters regarding medical/dental requirements/forms: L-10-034-CW, L-10-047-CW and L-10-091-CW and the information in these L-letters is contradictory and difficult to ascertain exactly what medical forms are required to meet policy. QA obtained clarification from the health unit that the DHS forms are not mandatory and other documentation is acceptable. QA is also making a recommendation in this state summary report to the health unit requesting an update in policy; in the meantime, QA is sharing this information with the local offices.