State of Michigan
Department of Human Services

Review of Higher Risk Cases: 7/1/09-9/30/09
Maltreatment Cohorts A & B

Introduction

The state of Michigan Department of Human Services (DHS) is responsible for administering the state's child welfare program. The DHS mission includes a commitment to ensure that children and youth are safe; to promote, improve and sustain a higher quality of life while enhancing their well-being; and to have permanent and stable family lives. The DHS Children's Services Administration (CSA) is responsible for planning, directing and coordinating statewide child welfare programs, including social services provided directly by DHS via statewide local offices and services provided by private child-placing agencies.

In 2006 a class-action lawsuit was filed alleging systemic failures in the Michigan child welfare system. A settlement agreement was signed July 3, 2008 and a final consent decree was entered on October 28, 2008. Since then, DHS has made significant strides to improve the quality of service to children and families in the child welfare system by reducing caseloads for its workers, moving more children to permanency and reducing the number of children in out of home care, launching a continuous quality improvement (CQI) system, increasing oversight of contracted providers, and developing extensive data reporting capabilities.

The consent decree required DHS to develop and implement a statewide Quality Assurance (QA) program. The QA Unit has been established as a division of the Child Welfare Improvement Bureau to ensure the provision of service in accordance with DHS philosophy. The goal of the QA Unit is to ensure that children receive high quality services. Our aim is to achieve positive outcomes on behalf of the children, through improved service delivery, through regular monitoring of case records and data trends, and through improved implementation of policy.

The QA unit has developed an internal capacity to undertake data collection, verification, and analysis in addition to case record reviews for the higher risk cases identified in the consent decree. After the submission of the CQI plan in April 2009, the QA Unit began to conduct special reviews for the higher risk cases.

During the time frame of 7/1/09 through 9/30/09 the QA Unit conducted special reviews for higher risk cases in the following categories:

> Cohort A: 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. 345 cases were identified for this category in the data list compiled on 6/30/09.

Cohort B: 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. 23 cases were identified for this category in the data list compiled on 6/30/09.

Cohort C: Children who, at the time of review, have been in three or more placements, excluding return home, within the previous 12 months. 2,569 cases were identified for this category in the data list compiled on 6/30/09.

Cohort D: Children who, at the time of review, have been in residential care for one year or longer. 478 cases were identified for this category in the data list compiled on 6/30/09.

Cohort E: 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. 172 cases were identified for this category in the data list compiled on 6/30/09.

The primary focus of the QA Unit was to complete special reviews involving maltreatment of children (Cohorts A & B as defined above) for the quarter ending 9/30/09. This report is a summary of the findings for the special case reviews conducted for those maltreatment groups.

Review Process:

The case reads were completed by reviewing Services Worker Support System (SWSS) documentation, the physical case file record and if deemed necessary, communication with the services worker. The QA Unit developed a comprehensive tool to conduct the special reviews. This tool was developed in April 2009 and updated in July 2009. The current version of the tool is in Microsoft Excel and is designed to guide reviewers as well as capture specific information relevant to each high risk category. QA Unit analysts contributed to updating the tool currently used. To further ensure inter-rater reliability, analysts participated in team meetings, telephone discussions and email communications to come to consensus regarding specific questions, suggestions and protocols.

The process for conducting a special review includes reading corresponding Children's Protective Services (CPS) investigation reports, the case file, and the licensing file when appropriate. Prior to conducting a full review, analysts screened the case for eligibility through SWSS. Several cases were screened

out due to not fitting the specific requirements at the time of review. The reasons for screening out cases are detailed in the results sections of this report.

The case review process has evolved and will continue to change as we strive to improve the structure of the case read tool and refine the steps to obtain required information. Revisions to the case read tool will correspond with the quarterly release of the compiled case read data lists.

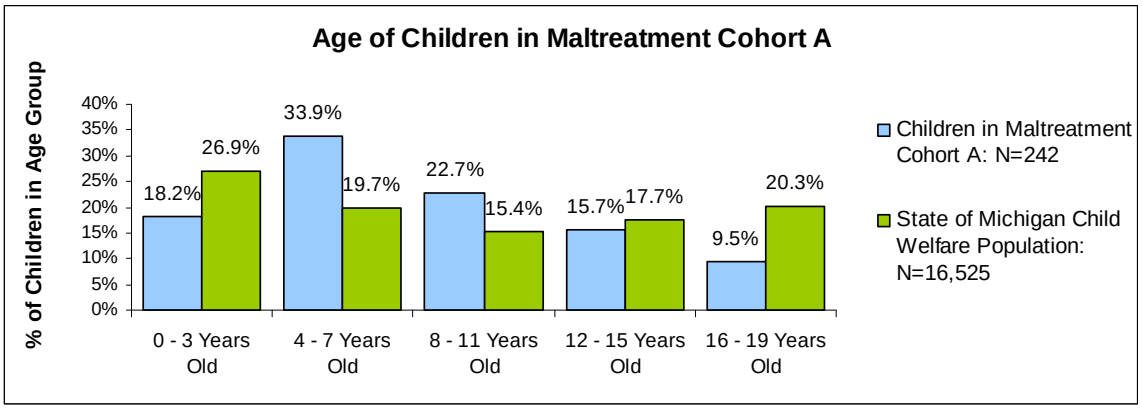
Results: Cohort A

345 cases were identified on 6/30/09 as meeting the criteria for the special review Cohort A. 327 of these cases, 94.8%, were reviewed as of 9/30/09. None of the cases reviewed involved a child death. The remaining 18 cases are scheduled to be reviewed at the beginning of reporting period 3. 54.5 percent of the cases were under the direct responsibility of DHS and 45.5 percent were under the direct responsibility of private child placing agencies.

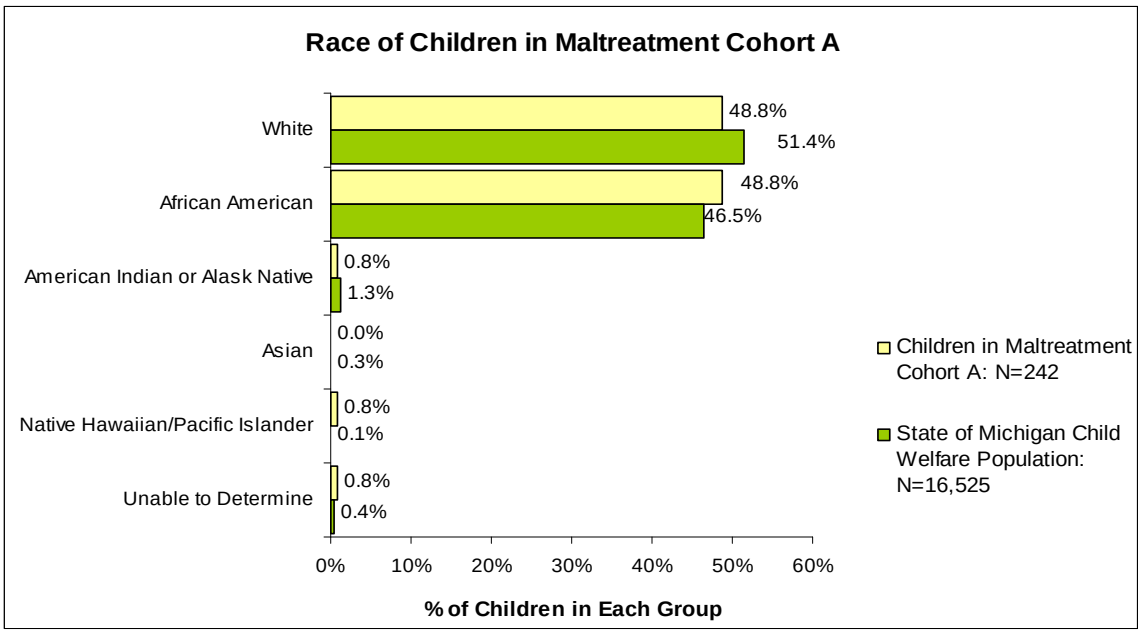
85 of the 327 cases read were screened out at the beginning of the review because they did not meet the requirements of the high-risk category at the time of the review. Cases were screened out for the following reasons:

- 56.5 percent were no longer in the placement where the allegation of maltreatment was alleged to have occurred.
- 20.0 percent of the cases had allegations that were not against the current placement.
- 7.1 percent of the cases were closed.
- 15.3 percent were screened out at intake by CPS.
- 1.2 percent or one case involved a child that was absent without legal permission.

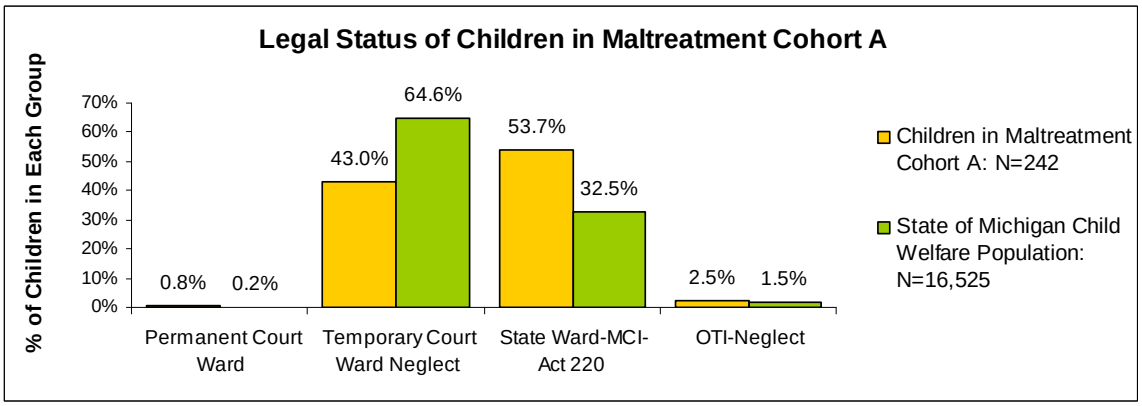
The average age of the children in this group was 8.1 years. The average age of the children in the child welfare population is 8.8 years. The graph below illustrates the age of the children and how they compare to the ages of children in the general child welfare population in the state of Michigan as of 6/30/09.



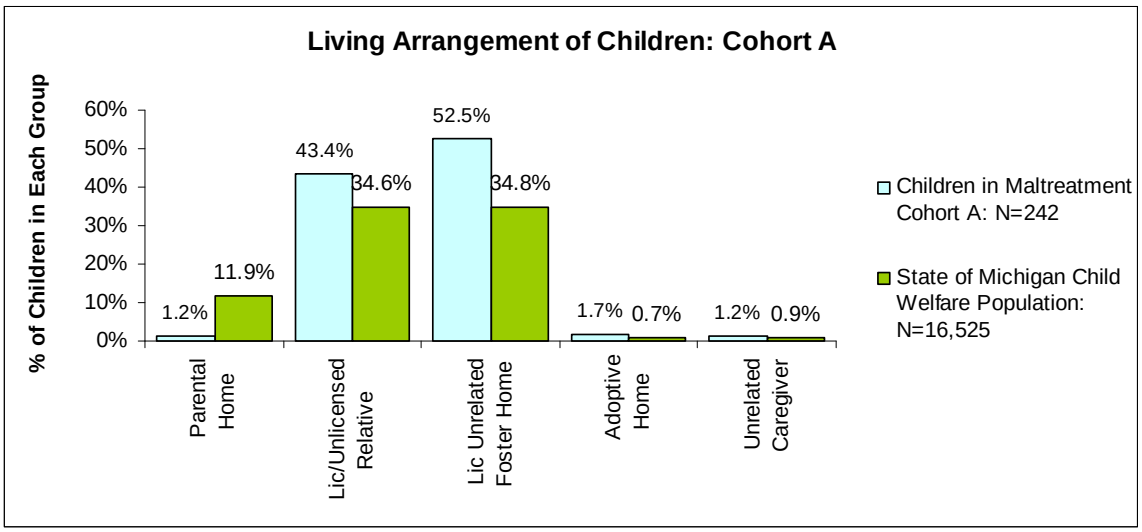
The race demographics of the cases reviewed are similar to the demographics for the child welfare population in the state of Michigan. 118 were African American, 118 were white, two were American Indian or Alaska Native, two were Native Hawaiian/Pacific Islander, and two were unable to determine. None of the cases reviewed included Asian ethnicity. The graph below shows how the cases reviewed compare to the state of Michigan child welfare population.



The legal status of the children reviewed compared to the general child welfare population shows two distinct differences. There were 21.2 percent more Michigan Children's Institute (MCI) wards and 21.6 percent less temporary court wards reviewed than the overall percentages for the state. Of the cases reviewed, 130 were MCI wards, 104 were temporary court wards, six were out of town inquiries (OTI-Neglect), and two were permanent court wards. The graph below illustrates the percentage breakouts and how they compare to the state of Michigan child welfare population.

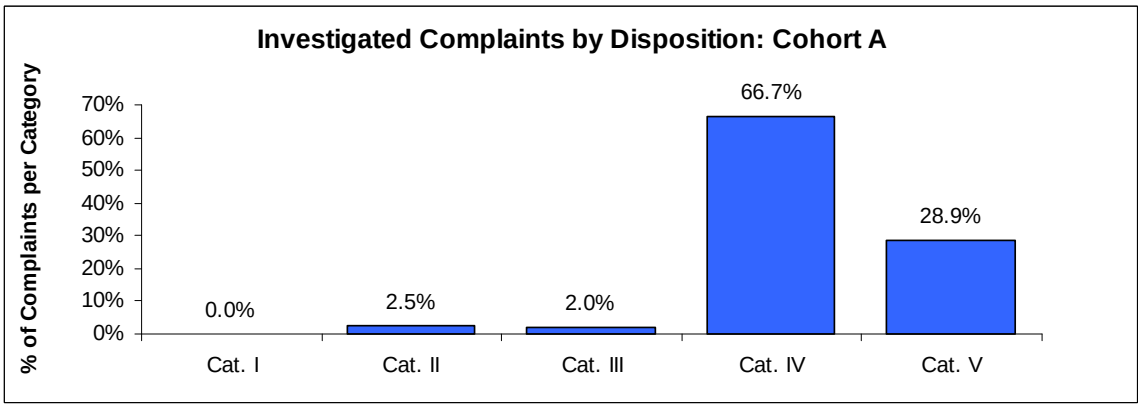


127 children were living in a licensed unrelated foster home, 105 were living with a licensed/unlicensed relative, four were in an adoptive home, three were in a parental home, and three were placed with an unrelated caregiver. The chart below shows the living arrangement of the children reviewed and how they compare to the state of Michigan child welfare population.



57.4 percent of the children in this special review category were male and 42.6 percent were female. 24 percent of the 242 children had a federal permanency planning goal of reunification. 59.9 percent had a goal of adoption, 8.7 percent had a goal of placement in another planned living arrangement, five percent had a goal of permanent placement with fit and willing relative, and 2.5 percent had a goal of guardianship.

The disposition of complaints for the cases reviewed show a high number of unsubstantiated (Cat. IV), 66.7 percent and denied-no basis (Cat. V), 28.9 percent. The chart below demonstrates the disposition pattern of all complaints reviewed regarding the identified Cohort A cases.



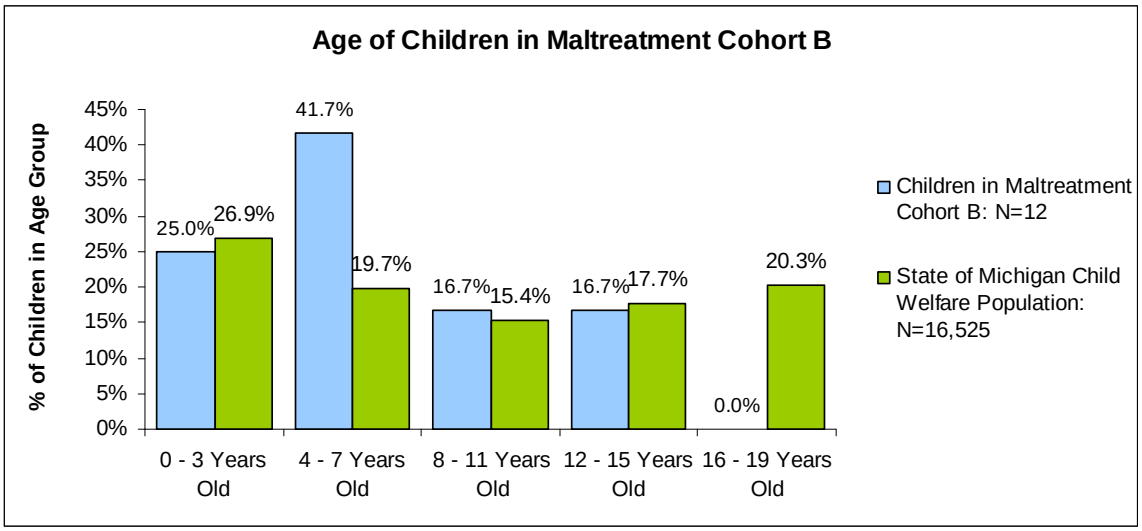
Results: Cohort B

23 cases were identified on 6/30/09 as meeting the criteria for the special review Cohort B. 100 percent of these have been read as of 9/30/09. None of the cases involved a child death. 83.3 percent of the cases were under the direct responsibility of DHS and 17.7 percent were under the direct responsibility of private child placing agencies.

11 of the 23 cases read were screened out at the beginning of the review because they did not meet the requirements of the high-risk category at the time of the review. Cases were screened out for the following reasons:

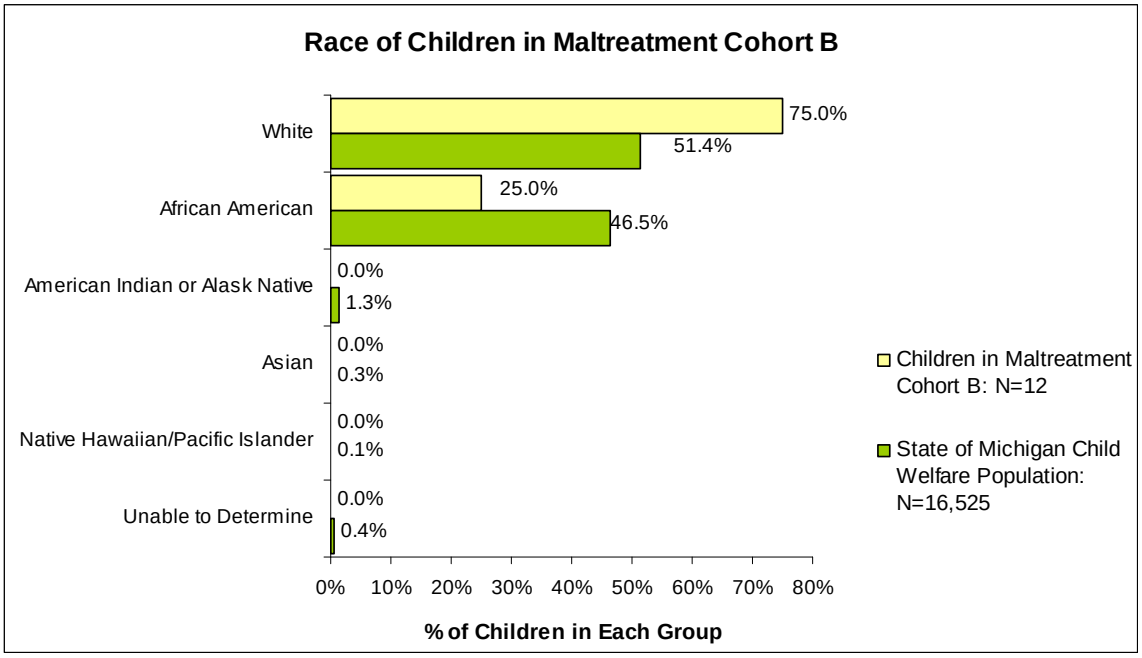
- 81.8 percent were no longer in the placement where the allegations of maltreatment were alleged to have occurred.
- 18.2 percent of the cases had allegations that were not against the current placement and therefore did not meet the criteria of 3 or more allegations in a foster home and the child remained in the home in which the maltreatment is alleged to have occurred.

The average age of the children in this group was 6.9 years. The average age of the children in the child welfare population in Michigan is 8.8 years. All of the children in this cohort were below the age of 16. The graph below illustrates the age of the children and how they compare to the ages of children in the general child welfare population in the state of Michigan.

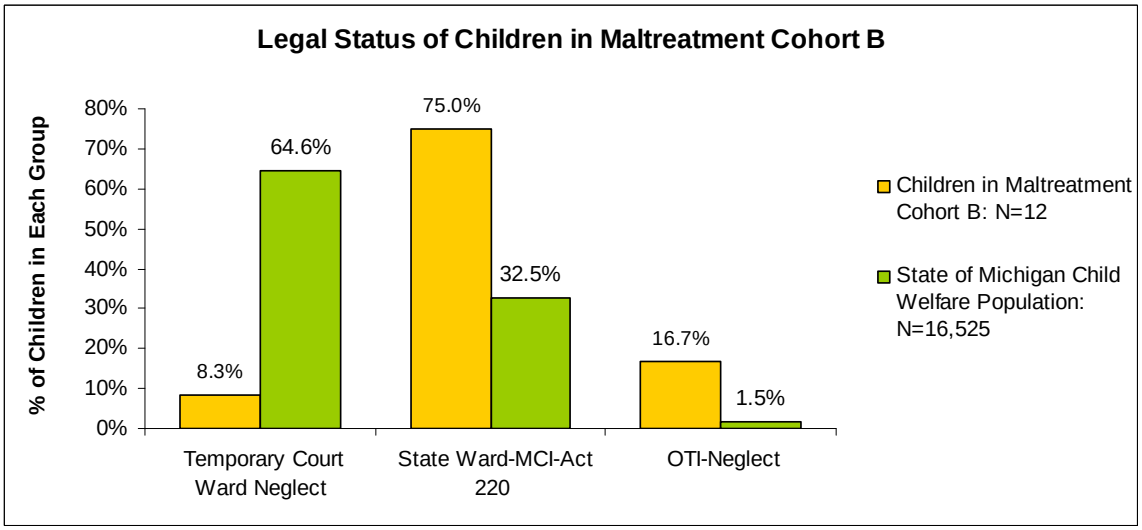


58.3 percent of the children in this special review category were female and 41.7 percent were male.

Nine of the children were white and three were African American. The graph below shows the ethnicity breakouts and how they compare to the state of Michigan child welfare population.

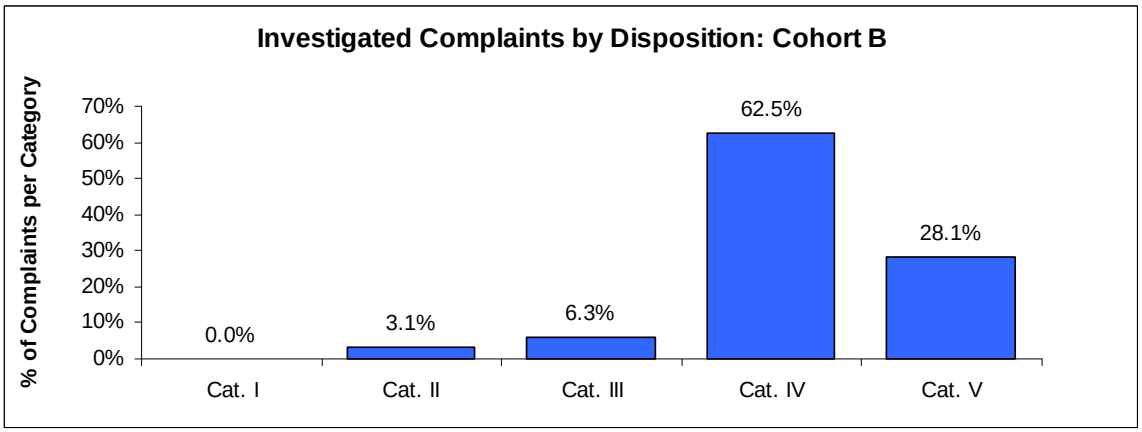


The legal status of nine cases reviewed was MCI wards. Two were out of town inquiries (OTI-Neglect) and one was a temporary court ward. The graph below illustrates legal status and how it compares to the state of Michigan child welfare population.



Five of the children were living in a licensed unrelated foster home and seven were living with a licensed/unlicensed relative. 83.3 percent of the 12 children had a federal permanency planning goal of adoption. 8.3 percent had a goal of reunification and 8.3 percent had a goal of permanent placement with fit and willing relative.

The disposition of complaints for the cases reviewed show a high number of unsubstantiated (Cat. IV), 62.5 percent and denied-no basis (Cat. V), 28.1 percent. A total of 32 complaints were reviewed. The chart below demonstrates the disposition pattern of all complaints reviewed regarding the identified Cohort B cases.



Administrative Reviews

CQI analysts identified 13 cases that had specific safety issues, which warranted further review. The QA Unit initiated administrative reviews that were conducted to assess the safety risk to the child and to provide a basis to continue the dialogue for improvement of services. Field Operations Administration was notified and actively involved in carrying out the reviews. Responses to the 13 cases included:

- Further investigation demonstrated that the child was safe in the placement (1).
- Children remained in the placement, but with additional supervision and or services (4).
- Replacement of the children occurred to ensure safety (4).
- Adoptions pended for further study by the courts and local offices (4).

One approach utilized by local offices to improve the quality of services included case conferences with CPS and FC case workers assigned to the case and with first line supervisors. In the meetings, relevant policy was reviewed and discussed as well as the actions taken or not taken by the workers processing the case.

Findings

There are inconsistencies with regard to investigators making contact with either the assigned foster care workers and /or the licensing workers associated with their cases. In 55.4% of the complaints reviewed, there was documentation showing that contact was made with the assigned foster care worker during the CPS investigation. In some cases there was documentation that workers have at least attempted to make contact, leaving messages, yet failed to follow through in actually speaking to the foster care or licensing worker for the child. Some cases reflect no contact (or attempts) with these individuals.

Coordination of investigations between CPS and the foster home certification workers appear to happen rarely with the exception of a few cases where a CPS worker made home visits with the licensing worker. In 32.3 percent of the complaints reviewed, there was documentation showing contact made with the foster home certification worker. Most collaboration took the form of information sharing before disposition of their respective cases.

Few foster care and/or licensing files included copies of the CPS investigation report. In many foster care cases there was no documentation to indicate knowledge of CPS involvement. There were no CPS documents filed or written documentation in the relevant Updated Service Plan for the period covering the allegation. In some cases there were copies of the CPS intake complaint, but nothing else to inform of any type of CPS involvement or outcome. Some foster care cases contained copies of the complaint and a copy of the investigation. Reviews of other cases noted that there was documentation contained in the foster care Updated Service Plan indicating the involvement of CPS investigating the complaint, but no actual CPS documentation in the file.

In almost all instances the foster care files and the associated CPS cases lacked documentation regarding special licensing investigations. In some instances, there was documentation of verbal contact between the licensing worker and CPS/foster care workers; however, the case files do not contain the authorized written investigative reports.

There were many instances in which a CPS report included specific and significant contacts with the active foster care worker but the corresponding foster care update service plan (USP) did not list this contact or indicate there had been a CPS investigation. In one particular case a foster care USP documented a discussion with the foster parent regarding the allegations of child abuse and neglect and the foster parent made admissions. Review of both the CPS and foster care case files indicates there is no documentation that this admission was ever shared with the CPS worker during the course of the investigation.

Quality Assurance Assessment:

The process of reviewing high risk cases revealed specific concerns which affect services. Quality assurance concerns were identified regarding case documentation and general policy compliance.

Case Documentation:

The well-being of all children was not documented, as required by CPS policy on face-to-face contact, which states, “All complaints must have a face-to-face contact with all children or, at least, verification of the safety and whereabouts of all children, including children who reside in another location.” The reasons for not interviewing a child were not adequately documented. There was a failure to document the steps taken to check a child for evidence of physical abuse. For instance, in some cases, there were only the most generalized statements such as “*the child had no evident marks or bruises,”* which does not speak to what parts of the body were viewed or not viewed by the worker.

Policy Compliance:

Law enforcement agencies were not contacted in cases where such contact is relevant, including cases involving allegations of domestic violence or drug sales. Relevant contacts were not made with collateral sources of information outside the immediate family, when gathering case evidence, such as making contact with doctors when investigating possible medical neglect, or contacting school personnel when evaluating child abuse or neglect. In some cases reviewed, there was a failure to interview the alleged victims and adult caretakers separately.

The incorrect use of category dispositions, especially Category V, which according to CPS policy on completion of field investigation, should only be utilized for cases “in which all allegations were based on false or erroneous facts, when unable to locate the family, or when the court is asked to order cooperation but declines.” Most, if not all of the reviewed cases which documented a Category V disposition would have been more appropriately disposed of as a Category IV, which indicates a preponderance of evidence did not exist to substantiate child abuse/neglect.

There was a failure to make face-to-face contact with the child victim within the mandated timeframes set forth in CPS policy and a failure to make contact with various individuals as required by policy including all parents and non-custodial parents.

Safety Issues

Non-compliance with CPS investigation policy mandatory standards has negative implications for child safety. Clear communication and collaboration between parties as required by these policies is required to establish the safety and well-being of the children in care. Protective services policy regarding face-to-face contact and a new complaint when a child is in foster care were not completely followed:

- The CPS investigation report did not consistently document that the investigation worker verified the safety and well-being of all the children in the foster home by interviewing all family members and making collateral contacts.
- The CPS investigation report was not in the foster care/licensing file and CPS investigations are not being mentioned in the updated service plan. This loss of information can affect the outcomes of an investigation and services to the family, and could have adverse affects to the child's safety.
- There was limited or no contacts in SWSS which made it unclear what the progress of the case was or if the safety of the child was in question.
- There is a lack of contact between CPS and foster care staff as part of the investigation which can result in CPS not having crucial information.
- Child and provider not being observed in the home setting.

Recommendations

1. It is recommended that training in key policy areas, including in the use of on-line policy manuals, take place at both the worker and supervisory levels.

2. An ongoing in-service training program should be developed and implemented which emphasizes best practice and mandatory standards. The aim of this program should be preventive and proactive to reinforce training of CPS policy on face-to-face contact, CPS policy on a new complaint when a child is in foster care and Children's Foster Care policy on the foster care case record (PSM 716-9, FOM 722-5, and PSM 713-3).

3. The preliminary and/or field investigation initiated by the CPS worker must include contact with the direct foster care worker and if appropriate, the foster home certification worker. Supervisors must ensure that this step has been made before authorizing any disposition of a case.

4. If there is an ongoing investigation being conducted by the foster home certification worker, we recommend that, at a minimum, a case conference with all active workers (CPS worker and foster care worker) be completed before any dispositions are completed. This should: reduce duplication of interviews for the children; allow for collaboration regarding any actions needed to protect children; and will prevent conflicting recommendations.

5. Policy indicates that all household members, both adult and child, should be interviewed and that collateral contacts such as therapists, schools, law enforcement, neighbors and relatives residing outside the home be made to verify the statements made by household members. Review of this policy should be made with all staff and measures should be taken to ensure that this policy is followed before case disposition.

6. All complaints must have a face-to-face contact with all children or, at least, verification of the safety and whereabouts of all children including children who reside in another location. The parents (including non-custodial parents) and other persons responsible for the health and welfare of the child and the alleged perpetrator, all other appropriate children, and significant adults must be interviewed or the reason(s) for not doing so must be documented in the CPS investigation report. The Forensic Interviewing Protocol must be followed when interviewing children during the CPS investigation. Review of this policy should be made with all staff and measures taken to ensure that this policy is followed before case disposition.