Real Reviews that get Real Results: Best practices for CRP's working with their local Department and how to get them to the table

> Nicole DeWitt, MM Seth Persky, MSW

## Who are we?

Nicole is the coordinator of Michigan's CRP on Child Fatalities. Her background is in foster care. She Works for a private agency in Lansing.





Seth is the director of the Office of Family Advocate at the Michigan Department of Health and Human Service. He is a member of all three CRP's in Michigan

### Table Talk

• 1: Would you say that your state Department is very, somewhat, or not at all responsive to your CRP(s)?

• 2: If you're in a <u>responsive state</u>, what have you done to successfully garner state support?

If you're in a <u>less or not at all</u> <u>responsive state</u>, what have you tried to get your state to support you?





#### A little bit about the state of Michigan and CPS

Michigan Department of Health and Human Services. "Children's Protective Services: Comprehensive Report: (FY2019 Appropriation Act - Public Act 207 of 2018). March 2019

#### 140,000-150,000

Approximate annual calls to our CPS intake hotline

#### 96,084

Total reports of abuse or neglect assigned for investigation in 2018

#### 4,432

Total number of cases with a Category I disposition

#### 6,819

Total number of cases with a Category II disposition

Removal occurs in less than 5% of all substantiated investigations.

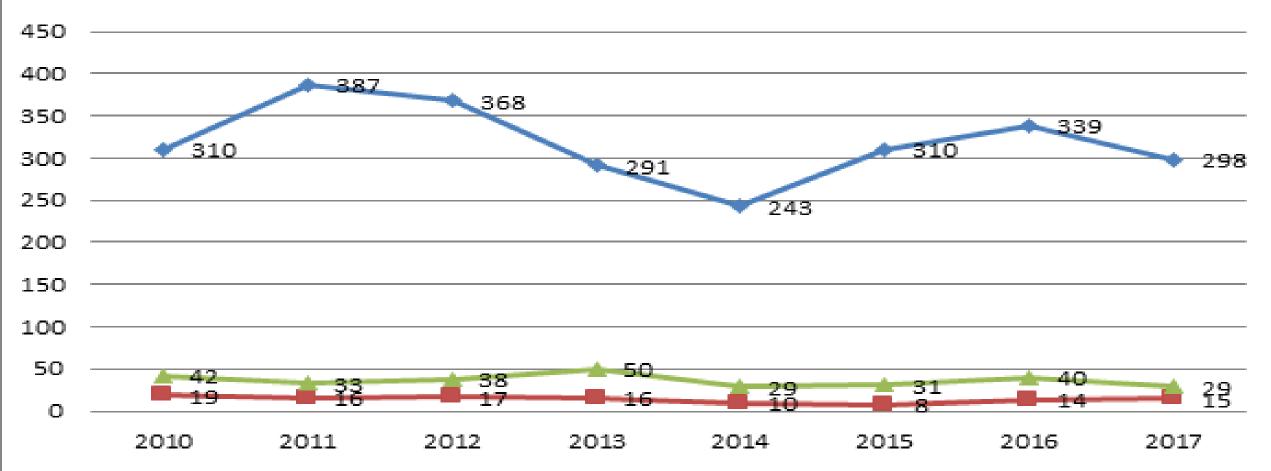
### **Michigan Statistics**

From 2012-2017, the number of Michigan children experiencing child maltreatment increased from 33,394 to 38,064, and a yearly average of 70 children died from maltreatment

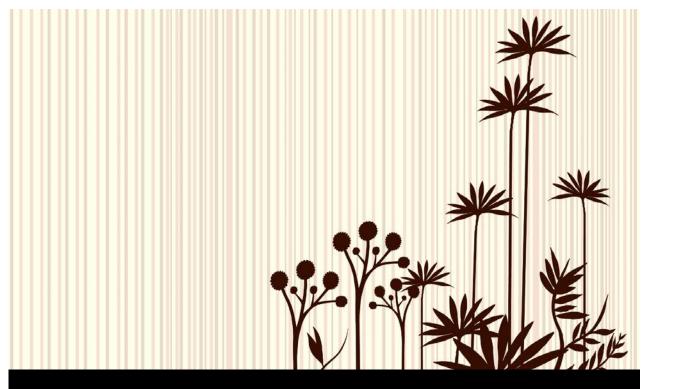
Michigan's Victims of Child Abuse and Neglect, 2012-2017

	Number of Victims of Child Abuse and Neglect	Number of Deaths due to Child Abuse and Neglect
2012	33,394	63
2013	33,938	59
2014	30,705	76
2015	34,729	83
2016	37,293	85
2017	38,064	51

#### Child Fatalities in the State of Michigan



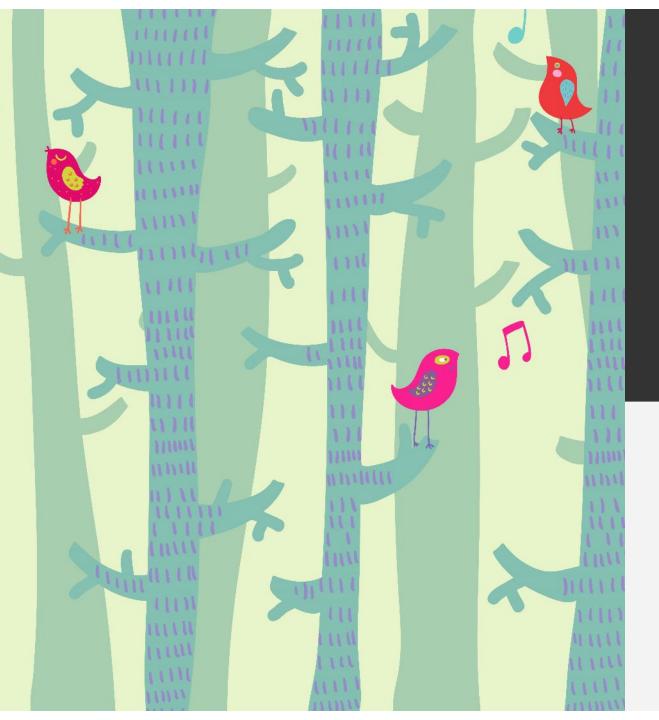
- # of overall complaints CPS Centralized Intake received alleging a child may have died from possible abuse and neglect
- # of children who died while under court jurisdiction for child abuse or neglect (regardless of placement)
- # of children who died under suspicious circumstances while living in the parental home and the parents had at least 1 CPS complaint in the previous 2 years



## The Lawsuit

In 2006, a lawsuit was filed against MDHHS by the advocacy group Children's Rights. The current version of our improvement plan, the Implementation, Sustainability and Exit Plan was approved in U.S. District Court in February of 2016

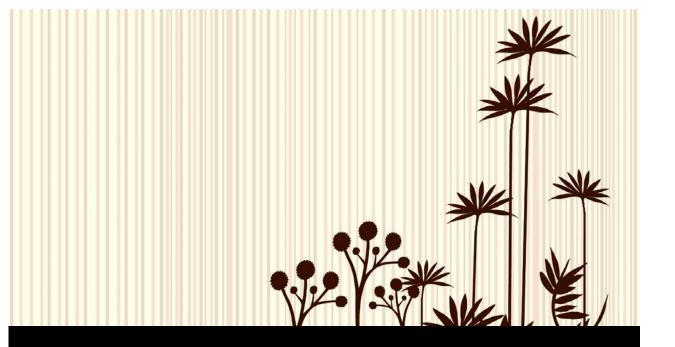
Over the last 10 years, practice and policy has changed significantly in the child welfare system due to the lawsuit. The Department welcomes input from committees such as the CRPCF.



Michigan has several state best practice protocols regarding the coordination of CPS investigations.

The protocols focus on multi-disciplinary coordination to ensure complete and thorough maltreatment investigations

https://www.michigan.gov/mdhhs/0,5885,7-339-73971\_7119\_50648\_66367---,00.html



## Players in the Sandbox

Statewide Local Child Death Review (CDR) Teams MDHHS' Office of Family Advocate Office of the Children's Ombudsman CRP on Child Fatalities

- When it comes to fatalities, there are multiple child fatality review processes currently functioning in Michigan. Each has its own purpose, parameters, and limitations, but all emerged from the general mission of improving the state's systems that serve children most at risk
- What would make Michigan's CRPs stand out? What would make the state's Department support us even though so many other review processes exist?

## Let's Start with History: Michigan Child Death Review

Established in 1997 through a partnership between the MDHHS and MPHI, which still thrives today

#### Purpose

The team meets to discuss the response/investigations in the children's deaths, service delivery to families and communities and child death prevention efforts National CDR Case Reporting System

Each county has a local coordinator with over 1400 professional volunteer team members. During the meeting, team members bring their case specific case notes and openly shares the history on the child. That data is entered into the national database.

#### Sustainability

MPHI works to ensure that CDR team membership remains stable so that key stakeholders are at each discussion, and can share information freely.

### Michigan's CRP on Child Fatalities

This CRP is charged with examining child fatality cases where a CPS referral was made at the time of the child's death and the family had previous interaction with the child protection system

#### **Risk Factors**

#### State Policies and Practices

The panel reviews these deaths to gain a better understanding of the risk factors present at the time of death The panel examines how state policies and practices affected the response to the death

#### Protection

The panel explores how the state can better protect other children from harm



## Membership

Panel membership must be composed of volunteers broadly representative of the state and community with a majority from outside the public welfare system.





CPS and Family Preservation Programs Office of Family Advocate State Court Administrative Office University of Michigan Dept. of Pathology Michigan Public Health Institute

Program Manager

Director

Director

Medical Examiner Coordinator/Facilitator (Chair)

## How CRP Helps

The reviews of specific cases are conducted, not to respond to any one specific case, but rather to develop recommendations based on the patterns or trends identified as common to the cases reviewed.



#### The Process

Case files are requested on previous year fatalities where there was a CPS referral at the time of death AND the family had previous CPS involvement

Coordinator conducts full review of each case to determine what goes on to full review with panel members Entire contents of case file are scanned and saved as a PDF, and uploaded onto a password protected Iron Key. Two to four workgroup meetings are held per year reviewing 6-20 cases

Palusci, V. J., et al. Effects of a Citizens Review Panel in preventing child maltreatment fatalities. Child Abuse & Neglect (2010), doi:10.1016/j.chiabu.2009.09.018

## Confidentiality

Established by Public Act 220 of 1997 and functions under the authority of the Michigan Child Protection Act, Section 7. Section 7 requires:

All deliberations are confidential

Members sign a confidentiality agreement at the beginning of every meeting Case specific information is confidential

No participating member of the panel can discuss or disclose any case specific information outside of the panel meeting Meetings are closed to the public

The panel is not subject to either FOIA or the Open Meetings Act

### How to Ensure a Successful Workgroup Meeting

#### Environment

- Ensure confidentiality
- Ensure comfortability
- Ensure productivity

The coordinator of this panel must be comfortable facilitating meetings

**Facilitation** 

#### **Content Experts**

- The coordinator should have an advance child welfare understanding
- The members should be considered content experts in their field



- Six year old black female in kindergarten
- Referral on death: Deceased child with multiple wounds at different stages of healing covering her entire body
- Family CPS hx: Multiple investigations for suspected physical abuse and improper supervision
- Cause of Death: Bilateral Bronchopneumonia Associated with Neglect and Abusive Injuries
- Manner of Death: Homicide

- Previous services referred during an open case described mom as "non-compliant"
- Bio mom's request for her name to be removed from Central Registry was granted after she rallied to participate for five weeks, no hearing required
- Child was suspended from school after repeatedly stealing food from other students
- Mom never brought child back to school after suspension and reported she was "home schooling"
- Mom's LTP was mentioned in previous CPS investigations but was never listed as a perpetrator
- Decedent was seen by a dentist five days prior to death for swollen gums and a loose tooth



### **Panel Findings**

00

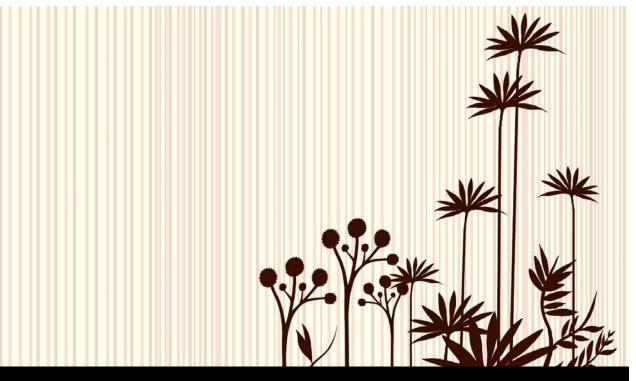
Failure by Mandated Reporters to make necessary referrals



Removal of name off Central Registry was inappropriate

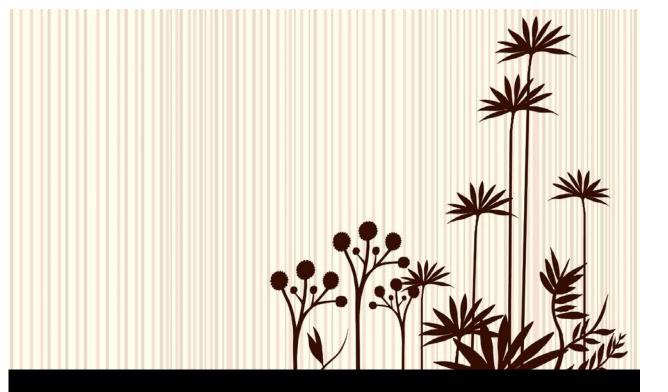


No monitoring system in place for home school children



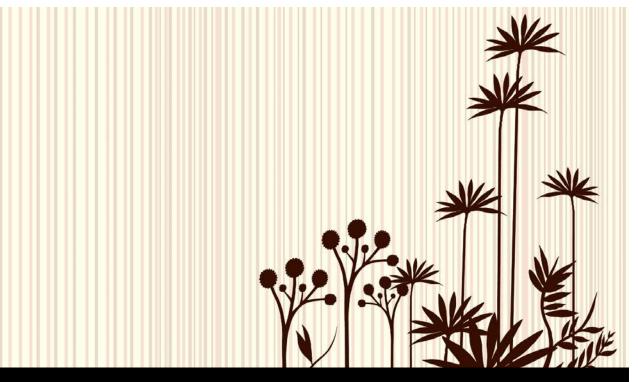
## Annual Report Recommendations

A multidisciplinary team (i.e: MDHHS, schools, court, mental health, public health) should study repeated neglect cases (typically related to hygiene and safety concerns in the home) to determine what underlying circumstances may exist and explore alternatives for servicing these families. Rationale: The panel reviewed many cases that documented repeated environmental neglect referrals for families who thrived when in-home services were provided, but whose living environment would revert to its original condition once the services were no longer in place. The panel found that although living in such conditions as the norm is likely a marker for other more basic underlying risk factors (unmet mental health needs, chronic substance abuse, lack of social supports), often the physical condition of the home is the only factor focused on in the case, leaving the more primary risk factors unaddressed. A multidisciplinary team convened to more closely examine the nuances of these cases may lead to improved policy and prevention efforts.



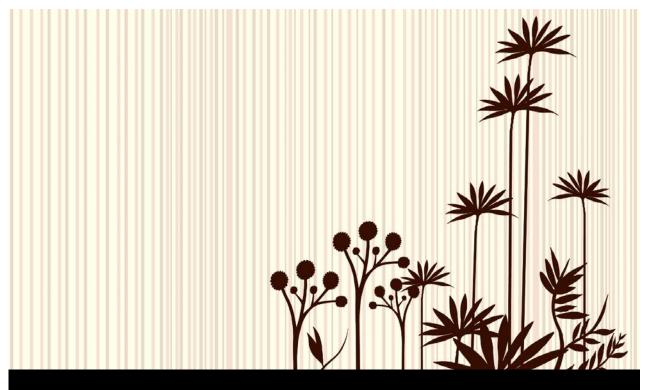
## **MDHHS Response**

MDHHS agrees that an assessment of these types of neglect cases and unaddressed risk factors could assist in the development of improved policy, practices, and more adequate training for staff. This recommendation will be brought to the SOFAC Safety sub team for discussion. The Safety sub team will request participation from a Child Fatality Committee member to assist in providing a coordinated recommendation to the executive SOFAC Committee following discussion.



## Annual Report Recommendations

Revise the state model child abuse protocol to include a medical neglect section that provides workers with enhanced guidance beyond wordfor-word policy, including options for different ways to engage medical experts in case consultation. Rationale: The panel noted multiple cases where complex medical issues on the part of the child hindered good case investigation and response. Therefore, the panel suggests that the department utilize the Medical Advisory Committee to assist in establishing more explicit guidance for medical neglect on the revised Safety and Risk Assessment tool. The questions to engage with experts should be specific to the child's medical needs. For example, some questions to ask a doctor of a child who has Diabetes could be "What is the targeted A1C level for this child?" "Has this child maintained their targeted A1C level?" "If not, why and what are your concerns?" The lack of this level of specificity can add to the risk for the child victim.



## **MDHHS Response**

MDHHS agrees with this recommendation. The Governor's Task Force on Child Abuse and Neglect (GTFCAN) is responsible for the updating of this publication, and therefore MDHHS will recommend these revisions be considered at the next quarterly meeting. MDHHS will also be a part of the revision committee and report back to this CRP regarding the revisions and any additional feedback received from the GTFCAN.

### Accomplishments









Improvement in joint investigation protocols

Changes in CPS Policy Changes in CPS worker and supervisor training practices Improved data systems

### **Other Wins**

Other improvements to the child welfare system have been implemented over the years not as a result of one specific recommendation, but rather further in-depth knowledge gained internally based on the CRPCF process

#### **Birth Match**

#### Threatened Harm

Based on the idea of

"anticipatory" harm;

upheld by Michigan

Supreme Court

## Generated by hosptials

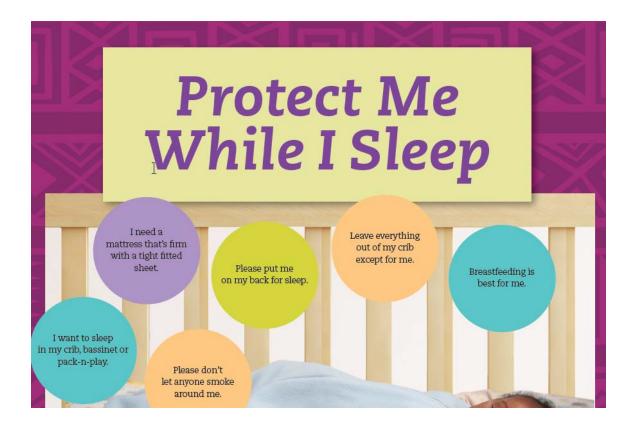
Computer systems match daily

## **Substantiations**

Substantiating on a birth match investigation requires the dept to file for termination



#### Table Talk 2



For those that have good state involvement, what are tips for getting the state Department involved?

# Thank You

Nicole DeWitt ▲<br/>ndewitt@mphi.orgSeth PerskysPerskys@Michigan.gov