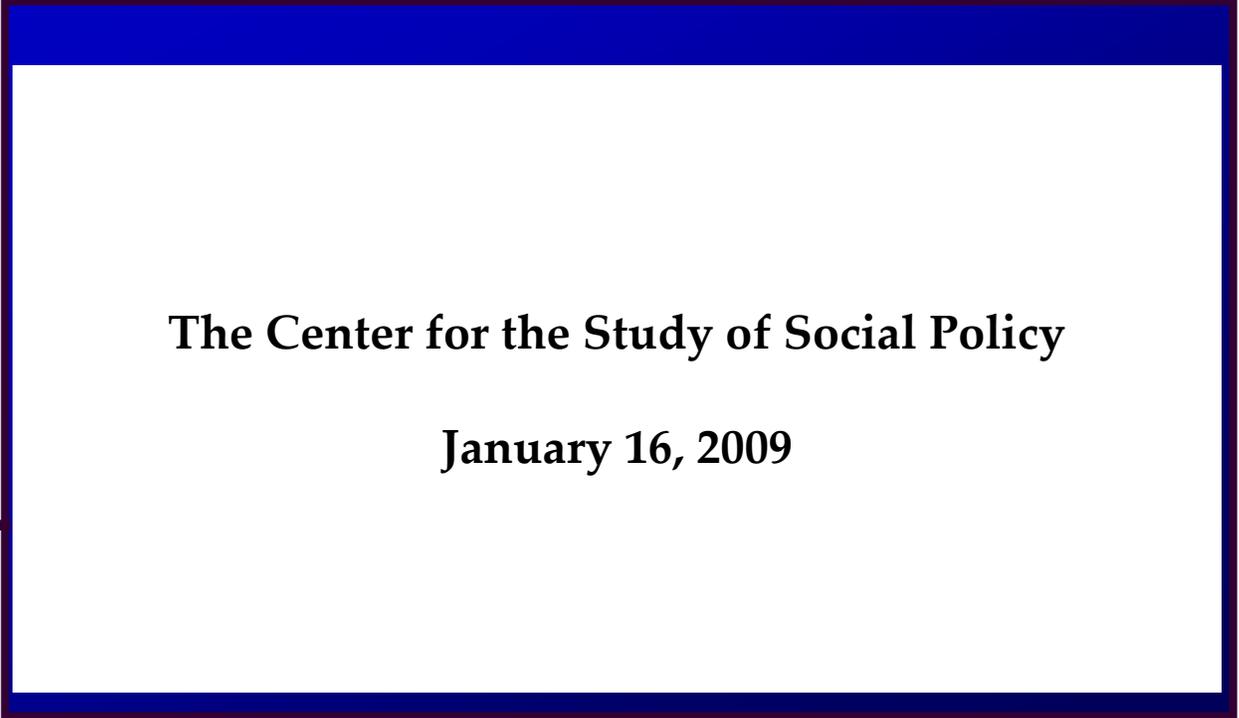




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**Race Equity Review:  
Findings from a Qualitative Analysis  
of Racial Disproportionality and Disparity  
for African American Children and Families  
in Michigan's Child Welfare System**



**The Center for the Study of Social Policy**

**January 16, 2009**





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## EXECUTIVE SUMMARY

National data show that African American children and families are disproportionately represented in almost all child protective systems in the United States. Once involved with these systems, African American children are more likely to be removed from their homes, spend longer periods of time in out-of-home care, and oftentimes their families have less access to relevant and helpful social services.

In a courageous step to examine racial disproportionality and disparity, the State of Michigan's Department of Human Services (DHS) undertook to have their policies and protocols analyzed by a team of national experts, local leaders, and stakeholders. This team, led by the Center for the Study of Social Policy, designed and implemented a qualitative Race Equity Review (Review) to assess the *institutional* features of Michigan's child protective system that directly produce or contribute to racial disproportionality and disparity.

Throughout the course of the Review, the environment for child welfare practice in Michigan was and remains very challenging. The economic climate of the state is poor and has resulted in significantly reducing the resources available for many public services, including child welfare services. In addition, a national child advocacy group sued the state for failing to meet the needs of children in the foster care system. State leadership participated in discovery, depositions and negotiations during the Review and ultimately, this lawsuit reached a settlement agreement in July 2008. These two powerful forces placed the agency and child welfare services under tremendous pressure and have challenged morale of workers and the quality of practice. In this context, workers who come to work everyday with the intention of improving the conditions of children are asked to do so with fewer resources. Workers frequently sense that their efforts are not valued or appreciated by the community. Further many feel powerless and unable to impact the systemic issues that compromise their work.

Despite the environment described above, in the spring and fall of 2007, two counties—Saginaw and Wayne—allowed a large group of reviewers to observe their daily work routines, have unfettered access to staff, read case files, and analyze administrative procedures and directives. Their courage to allow such an intense review, and for the most part acknowledge that racial disproportionality in the child welfare system exists, is notable. It reflects a sophisticated understanding that the responsibility for the overrepresentation of children of color in the child welfare system does not solely rest in the individual attitudes or biases of individual practitioners. Rather, this phenomenon is produced by the institutional features of the child protective system *and* extends to its interaction with other child and family serving systems. This understanding is one of the premises of structural racism which is also a grounding assumption of the Review.

The Review identified specific policies and practices that directly negatively impact African American children and families. In addition, there are institutional features of Michigan's child welfare system that negatively impact all families, but have even worse consequences for

African American families. Broad themes identified in this assessment include a lack of belief in the ability of African American families and communities to care for children, limited case and community advocacy for African American families, the failure to build an infrastructure of policy, practice and resources that contributes to fair outcomes for African American children and families, and the lack of accountability for results.

DHS has adopted a child welfare philosophy, dated March 30, 2006, which is designed to guide the delivery of services.<sup>1</sup> The philosophy emphasizes safety of children, the commitment to respond to each child's individual needs, the importance of family engagement and family participation in decisions affecting them, and building on family strengths. It also speaks to the importance of families and communities as resources for children. The philosophy calls on staff to value ethnic and cultural traditions in their work with children and families.

This Review documented a gap between the stated philosophy and the actual practice of child welfare with African American families in Michigan. In fact, the Review documented both stated and operational assumptions that African American children would fare better if removed from their families and communities. Reminiscent of the 19<sup>th</sup> century child rescue ideology that led to the separation of tribal and immigrant children from their families and communities, this way of thinking has a long history in child welfare. This powerful belief system allows the child welfare system to operate in ways that disadvantage African American families. To a large extent, these practices have become standard operations and are not recognized or questioned by individual workers.

The belief that African American children are better off away from their families and communities was seen in explicit statements by key policy makers and service providers. It was also reflected in choices made by DHS. The lack of prevention and intervention services in the African American communities was evident in both Saginaw and Wayne Counties, although different strategies created this situation. The lack of faith in families' ability to keep their children safe was also reflected in the number of removals from families, the limited effort to secure authentic family participation case planning processes, and DHS' willingness to permit long delays in resolving issues that prevent reunification of children with their parents or expedite temporary placement of children with their relatives. Policies and practices resulted in little attention paid to family strengths, community based non-traditional resources, or the potential for placements within extended family.

Many of the policies and practices designed to assure fairness for African American children were not used as intended and therefore created limited opportunities for their families. These practices include a risk assessment tool and Team Decision Making meetings. Practice expectations were often unclear and there was confusion about the application of pertinent policies. The imprecision about policy and practice created large areas of discretion that operated against African American families.

DHS demonstrated limited accountability to families and children for overall results and the quality of service provided. At numerous points in the handling of cases, there seemed to be little oversight focused on the quality of work, the appropriate application of policies and/or the outcomes for African American children and families. The lack of accountability to the families, to the system, and to the public was reinforced by a lack of robust advocacy by and on behalf of families and children as well as a lack of community or systems-based advocacy for families, particularly African American families. The combination of these factors allowed poor practices and counter-productive policies or policy implementation to go unchallenged.

This Review looked briefly at the complex needs of youth involved simultaneously with the child welfare and juvenile justice systems (dual wards). Dual wards are subject to all of the problems documented for children in this Review and also face additional challenges due to the lack of systems integration. Further inquiry into the unique needs of this population and corrective action are necessary.

DHS has recognized the need for child welfare reform and is undertaking a number of activities to improve outcomes for all children. However, the policies, practice expectations, infrastructure, and accountability mechanisms that would support direct service workers and assure better outcomes for all children are not yet in place. As a result, fairness and consistently good work on behalf of and with families and children, especially African American families, were not evident in the Review.

*The Review found the following:*

- 1. African American families do not receive necessary supports that could prevent or divert their involvement with the child protective system. Once involved in DHS, African American families often experience the services offered to them as irrelevant, difficult to access, or inadequate to support and strengthen their families.**

There are numerous systemic factors that contribute to this experience; however, the Review found that African American families were specifically disadvantaged due to societal features that result in a lack of basic resources in their communities and problematic allocation of existing resources by county and state leaders. Further, for families involved with DHS, there are limited services and providers available which results in poor access and sometimes poor quality of services delivered to African American parents and children.

- 2. African American families experience child welfare systems as intrusive interventions that do not fairly assess and appreciate their unique strengths and weaknesses and fail to adequately explore the least restrictive placement options for children.**

African American families experience differential screening and reporting by mandated reporters of suspected child maltreatment. Once they become involved with the DHS' Child Protective Services, the system does not correct for this differential screening and reporting. Poor oversight of intake practices, problematic use of their risk assessment tool, and misuse of Team Decision Making (TDM) meetings are institutional features that result

in African American children being more likely to be removed from their homes. Further, the widespread misapplication and misinterpretation of legislation/policy and the lack of a clearly articulated and functional case practice model compound negative outcomes for African American families.

- 3. African American youth and families are negatively characterized or labeled by workers in the child welfare system. Some of these labels follow them through their interactions with various new workers and ultimately negatively affect the outcome of their cases.**

The system, as it currently operates, does not protect against the negative labeling of African American families. Labels are applied without sufficient evidence. And specifically, the system's policies and practices do not direct workers to contextualize parental behavior, specifically their expressions of anger at the removal of their children. Without a clearly articulated and implemented case practice model, in line with the DHS' current stated philosophy, negative labeling is likely to continue.

- 4. Advocacy on behalf of African American families and children is insufficient in helping them participate in, challenge, and negotiate the child protective system.**

Team Decision Making (TDM) meetings as currently implemented do not consistently and adequately promote the authentic participation of parents and youth. Thus, this first opportunity for advocacy is lost for many families. Further advocacy is limited by problematic Family Court protocols that restrict and in some instances mute the voices of parents and youth and by weak systems of legal representation of both parents and children. The Review found that inaccurate petitions and policy misinterpretations regularly go unchecked by judges, referees, and lawyers. Finally, the system as it now exists provides parents and youth with limited access to other forms of advocacy.

- 5. There are inadequate mechanisms for African American parents and youth to hold DHS, providers, and advocates accountable for equitable treatment and quality services.**

The Review found that DHS initiated dependency proceedings for African American children and families based on a wide range of situations which may or may not have been related to child safety or elevated risk of harm. No qualitative assurance mechanisms were found to correct for this. Additionally, the system does not hold workers and service providers accountable for the quality of their practice and the timely delivery of services. No mechanisms exist for ensuring that community based providers deliver their services to all families regardless of the communities in which they live. Finally, the system does not provide a means to ensure that the court appointed lawyers and judicial officers are accountable to the parents and children they encounter.

### ***Recommendations***

The following recommendations are made based on the findings in the Review. These recommendations are designed to be implemented together to create institutional change that will assure racial equity for children and families who come into contact with the child welfare system.

- 1. DHS must build the internal leadership capacity to ensure that the Department functions in an equitable, fair, and responsive manner.** DHS staff development at all levels is necessary to improve outcomes for the families DHS serves. Top leaders must be trained on the dynamics of race and child welfare using an “anti-racist” structural approach, such as that used by participants in the Race Equity Review. DHS must create an environment which promotes leadership’s ability to address institutional racism. Efforts to create such an environment include the development of a communication strategy for these leaders so that there is consistent way to talk about these issues with the larger community. Additionally, specialized training for supervisors and frontline staff on the dynamics of race and child welfare and its practice implications should be developed. Further, DHS must develop and adequately support an internal leadership group that provides strategic direction for the racial equity work.
- 2. DHS must use relevant and reliable data driven management for racial equity.** DHS must develop a strong capacity to examine child welfare data by race/cultural group at various critical decision points in a case (such as substantiation of abuse or neglect, decision to remove, etc...). DHS leaders should use this data to manage their system performance down to the unit level. Data on the progress toward improving racial equity in child welfare should be provided to the public annually.
- 3. DHS must clearly articulate and implement a case practice model which translates DHS’ philosophy into policies and practices.** This case practice model must be informed by an understanding of racial inequities. The model must engage families in the decisions being made about their lives and work with families in a culturally appropriate manner. System structures, such as work hours, will need to be amended to support the active participation of family members and community based providers in TDM meetings and other case planning activities. Supervisors and workers must be held accountable through personnel appraisals for implementing the case practice model-as measured by the quality of their practice, cultural competency, and outcomes for parents and children on their caseload. DHS must build an internal quality assurance review process that annually evaluates the quality of case practice and examines racial differences in outcomes.
- 4. DHS must correct policy misinterpretations that disadvantage children and families of color. Further, DHS must build the capacity to regularly evaluate the fairness and equity of their policies.** The policy misinterpretations of the Binsfeld legislation and the kinship care requirements must be corrected. Quality assurance mechanisms should be implemented to regularly evaluate that policies are being interpreted as intended and are not disadvantaging families of color.
- 5. DHS’ risk assessment tool must be further examined and its implementation improved.** The risk assessment tool and protocol need to be rigorously evaluated to ensure that the weighting/scoring system does not inappropriately disadvantage families of color. Supervisors must be trained and supported in making sure that the protocol is implementing as intended. Quality assurance reviews of the implementation of the risk

assessment protocol must occur and feedback to staff provided. The tool itself must be recalibrated regularly.

- 6. Resource providers that contract with DHS must provide fair and equitable services.** DHS must ensure that an array of contracted agencies provides relevant, needed services in all geographic areas of a community, paying particular attention that these services are provided to and accessible by the African American communities from which children are most likely to be removed. The DHS contracting process must include evaluation of the ability of providers to meet the needs of discrete racial, cultural, and linguistic populations.
- 7. DHS must build external partnerships in working for equity.** The Taskforce on Racial Equity must be reconvened and findings of this report shared. DHS must work with the Taskforce to develop a strategic plan to accomplish racial equity, monitor progress, report to the public, and advocate for the changes necessary to better respond to the needs of families and children of color. DHS should also invest in a prevention system for families. A sufficient array of community-based supportive resources for families must be identified and supported. Given the significant reporting rates from public schools, a set of DHS workers should be redeployed as prevention workers in those schools with the highest referrals to child protective services. These workers will provide information and referral to appropriate community-based prevention services for families in need.
- 8. DHS should collaborate with the courts to improve the quality of legal oversight.** Using resources of the Michigan State Court Improvement Project and the National Council on Juvenile and Family Court Judges, cross training for judges and child welfare administrators must be developed that will provide information on racial disparities and disproportionality in child welfare and juvenile justice systems. Courts should track their performance on child welfare and juvenile justice cases by racial/cultural groups.
- 9. Michigan's child welfare and juvenile justice system leaders must work collaboratively to explore policies and practices which meet the specific needs of dual ward youth.** Joint case planning conferences need to be held involving representatives from the child welfare and juvenile justice system, the youth, and the parent or caregiver. These conferences should result in a coordinated plan and clarification of assessment and case planning responsibilities. Law enforcement protocols must be modified to be age appropriate and to minimize trauma to youth. Accurate data must be kept of the dual ward population. Further study on dual wards should be conducted to identify the policies and practices that contribute to the problems in serving these youth across systems.

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# INTRODUCTION

## Overrepresentation of Children and Families of Color in Child Protection Systems

### *A National Phenomenon*

African American and Native American children and families are overrepresented in nearly all child protection systems across the country.<sup>2</sup> Research shows that families of color are no more likely to abuse or neglect their children than Caucasian families, within similar income groups.<sup>3</sup> However, African American and Native American children are involved in child protection/protective systems<sup>4</sup> at a rate that is disproportionate to their presence in the general population (i.e., *racial disproportionality*). National and state data repeatedly demonstrate that African American and Native American children and their families experience higher rates of reports alleging maltreatment to child protection agencies, higher rates of assignment of alleged reports for investigation by child protection agencies<sup>5</sup>, and higher rates of out-of-home placement than Caucasian children and their families.<sup>6</sup> While it is believed that child protection data may undercount the rate of Latino children in that system, Latino children are also disproportionately present in several jurisdictions across the country.<sup>7</sup> Children and families of color have less access to services and time spent in temporary out-of-home placement is lengthier for children of color than their Caucasian counterparts (i.e., *racial disparity*).<sup>8</sup>

Racial disproportionality and racial disparity are not unique to the child protection/protective system. Education, health care, juvenile and criminal justice are just a few other systems that manifest a similar phenomenon. The social cost of this inequity is devastating to children of color, their families, their communities, and society. Research predicts a bleak picture for youth who remain in child protective custody/foster care for long periods of time. Youth often “age out” and have high rates of juvenile and adult incarceration, episodes of homelessness, substance abuse, mental health concerns, and income insecurity.<sup>9</sup>

Many jurisdictions across the United States have decided to examine racial disproportionality and racial disparity in the child welfare and protection systems and implement strategies to eliminate these differences. The Alliance for Racial Equity in the Child Welfare System and the Casey Family Program’s Breakthrough Series Collaborative have led national efforts to learn about and promote change.<sup>10</sup> A recent Government Accounting Office report entitled, *African American Children in Foster Care: Additional HHS Assistance Needed to Help States Reduce the Proportion in Care*, has also examined this issue and made significant recommendations.<sup>11</sup>

### *Michigan’s Child Welfare System*

As a result of noteworthy efforts by state child advocates and their public and private sector partners, Michigan’s legislature required that in fiscal year 2005, the Department of Human Services convene an advisory committee to study the overrepresentation of children of color in the state’s child abuse and neglect and juvenile justice systems. An Advisory Committee (Committee) was formed in the summer of 2004 and embarked on a year-long effort of intensive

fact-finding activities, including reviewing national, state and local data, consulting with state and national experts on disproportionality and child welfare, and holding numerous focus groups and public hearings across Michigan.

In March 2006, the Committee issued a report entitled: *Equity: Moving Toward Better Outcomes for All of Michigan's Children*. Data cited in the report reveal that rates of racial disproportionality and disparity are significant in Michigan's child protective system. For example, although African American children represented just slightly less than 18 percent of all children residing in Michigan in 2003, they represented more than half of all of the children in the child protective custody, as Table 1 below depicts.

**Table 1**  
**Children residing in Michigan and in Foster Care by Race (2003)**

	Total Children		Foster Care	
	Number	Percent	Number	Percent
White	1,832,802	72.1%	7,444	38.8%
African American	445,734	17.5%	10,223	53.2%
American Indian/Alaskan Native	14,770	0.6%	194	1.0%
Asian	54,094	2.1%	78	0.4%
Multi-Racial	64,623	2.5%	547	2.8%
Hispanic	130,836	5.1%	680	3.5%
Other	625	0.0%	39	0.2%
	2,543,484	100.0%	19,205	100.0%

Source: *Equity: Moving Toward Better Outcomes for All Michigan's Children*. Report from the Advisory Committee on the Overrepresentation of Children of Color in Child Welfare (March 2006).<sup>12</sup>

Not only were African American and Native American children found more likely to be involved with the state's child protective system and removed from their parents' or other legal caretaker's custody, but once in foster care these children are less likely to be reunited with their parents and spend more time in out-of-home care than their Caucasian peers.<sup>13</sup>

The Committee also made clear the longer-term risks to children and youth in these situations:

“Overrepresentation in the protective services system helps feed disparities in juvenile justice. The high stakes for children in foster care are most apparent when youths make the transition from state supervision to independence. More than one-half of the young people leaving foster care have diagnosed mental health disorders, one in five has been homeless at some point, half have not completed high school, and one-third lives below the poverty level.”<sup>14</sup>

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The Committee’s report describes racial disproportionality and disparity as a complex, not completely understood but wholly troubling fixture of the state’s foster care system. Several potential contributors to this problem were identified, including inequity in access to culturally competent services, lack of support for extended families, public confusion about the distinction between poverty and neglect, and failure to include families and youths in important decisions about their lives.

Finally, the Committee called for urgent action to ameliorate these inequities and offered a blueprint for change that includes:

- ongoing open discussions of racial disparities and the establishment of systems to ensure accountability for its elimination,
- increasing collaboration among stakeholders at the state and local levels and integration of effective and services of approaches in addressing the problem of overrepresentation,
- focusing attention and resources on the most vulnerable families and communities with the highest rates of overrepresentation,
- providing sufficient and accessible community based services for families,
- increasing capacity inside the Department to address disparities through appropriate policies and practices, and
- including families and youth in decision making.

The final recommendations of the report are listed in Table 2 below.

**Table 2**  
**Recommendations from Michigan Advisory Committee on the**  
**Overrepresentation of Children of Color in Child Welfare**

- |  |
|--|
| <ol style="list-style-type: none"><li>1. Identify and target funding;</li><li>2. Maximize Title IV-E Administrative funding;</li><li>3. Pursue a Title IV-E Waiver to expand services to families;</li><li>4. Review the impact of all policies, programs and procedures on children and families of color;</li><li>5. Ensure culturally proficient practices;</li><li>6. Engage families as partners;</li><li>7. Address the basic needs of families;</li><li>8. Focus resources on the most vulnerable families;</li><li>9. Build community support for reducing overrepresentation;</li><li>10. Monitor the state’s progress in reducing overrepresentation; and</li><li>11. Ensure local accountability.</li></ol> |
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Source: *Equity: Moving Toward Better Outcomes for All Michigan’s Children*. Report from the Advisory Committee on the Overrepresentation of Children of Color in Child Welfare (March 2006).

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In response to the fourth recommendation, DHS requested that the Center for the Study of Social Policy (CSSP) *design and coordinate an external Race Equity Review of Michigan's child welfare policies, procedures, programs and contracts to determine if they disadvantage children, youth and families of color.*

As part of this Review, CSSP and its partners also followed youth who interacted with both the child welfare and juvenile justice systems in Wayne County. Conflicting policies and protocols proved problematic for many youth and additional study of the unique needs of this population in negotiating two systems is required (Appendix A provides a more in-depth analysis of dual wards).

This report discusses the methodology, process, findings, and recommendations of the Race Equity Review. The Review specifically focuses on the experiences of African American children and families, but recognizes that other families of color experience disparate treatment. Future reviews, particularly of the experiences of Native American families in Michigan, should be conducted as findings may be different for these families.

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## REVIEW QUESTION

The Race Equity Review (Review) relies on qualitative methodologies to assess institutional factors which produce racial disproportionality and disparity. The Review assumes that families who become involved in the child welfare system have different experiences of advantage and disadvantage and that these experiences are based on a history of structural and institutional racism in the United States. Specifically, the Review has the following assumptions:

- African American families, like all other families, desire to provide a good life and opportunities for their children.
- Child maltreatment is evenly distributed across racial groups; therefore, race should not predict individual outcomes to the extent reflected in race-based data of child welfare systems.
- In American society, opportunity is produced and regulated by institutions, institutional interactions and individuals, jointly and differentially, providing and denying access along lines of race, gender, class and other markers of social difference.<sup>15</sup>
- African American families are subject to systemic and structural disadvantages in terms of income, education, housing, and other such opportunities/resources and services that contribute to stability and advancement and which may affect their ability to parent their children.
- Service delivery systems incorporate the values and attitudes of the larger society into the policies and practices leading to the creation of systematic disadvantage to certain populations.
- Institutional racism occurs when the policies and practices of an organization systematically disadvantage African American and/or other families of color.
- Structural racism accounts for inter-institutional dynamics or *joint* operations of social institutions which systemically disadvantage African American and/or other families of color.

As reflected in Table 3 below, race serves as a predictor for how cases are processed in Michigan's child protective system. In 2005, African American children were involved in 36.4% of all child protective services investigations in Michigan and represented 41.6% of all children removed from their homes as a result of an investigation. In addition, Michigan data reflects that African American children constitute the largest number of children initially placed with non-relative caretakers or in emergency shelters. Caucasian children make up the greatest number of children who are initially placed with relatives or who remain at home with a parent following a substantiated report of maltreatment.

**Table 3**  
**Children involved in Child Protective Services Investigations**  
**and**  
**Disposition by Race: Calendar Year 2005**

Michigan Children's Services Data Analysis	Total #/% of Children by Race as Defined by Investigation Process											
	Alaskan Native or Native Am.		Asian/Pacific Islander		African Am./ Black		Hispanic		Unable to Determine		White	
Children involved in CPS Investigations	282	0.8%	146	0.4%	13,248	36.4%	1,290	3.5%	491	1.3%	20,940	57.5%
Children w/ Substantiated Investigations	235	0.9%	98	0.4%	10,300	37.6%	931	3.4%	349	1.3%	15,476	56.5%
Children w/ Opened CPS Case—No Removal	146	0.8%	83	0.4%	6,900	35.8%	682	3.5%	264	1.4%	11,197	58.1%
Children Removed from their home: Substantiated Investigation	91	1.1%	15	0.2%	3,341	41.6%	233	2.9%	84	1.0%	4,266	53.1%

Source: Michigan Department of Human Services

Based on this data, the Review focused on the following question:

*“How does it come about that, after a substantiation of child neglect, African American children are more likely to be removed from their homes?”*

The child protective system does not directly control the disproportionate rate of reports of suspected maltreatment of African American children. Data show the next decision-making point where racial disproportionality is most prominent is the decision to remove a child from their home. The Review question focuses on substantiations of child *neglect* and subsequent decision-making regarding removal of a child from his/her home since data from Michigan, similar to those of other states, also show that a substantiation of child neglect (rather than a substantiation of physical or sexual abuse) is more likely in investigations involving African American and Native American children.<sup>16</sup>

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## METHODOLOGY

The Review relied on two methods for gathering data—the Institutional Analysis and the Quality Service Review—as well as training on issues of race and racism for those who participated in conducting the Review. Appendix B - *Designing and Implementing the Michigan Race Equity Review* provides a more detailed description of the Review process.

### *The Institutional Analysis*

The Institutional Analysis (IA), originally designed to review the handling of domestic abuse cases in the criminal justice system<sup>17</sup>, assumes that individual workers do not independently decide how they are going to talk about, act on, or process cases. Regardless of the idiosyncratic beliefs of an individual worker, institutions create mechanisms that are designed to ensure that cases will be processed in an acceptable and fair manner. In child protection systems, there are specific decision making points when processing a case—such as accepting a hotline referral for investigation or substantiating an allegation of child abuse or neglect. Each of these points is designed by federal, state, and local policymakers and administrators to be carried out in specific ways.

In order to promote the acceptable processing of cases and produce specific outcomes, institutions rely on management practices. Institutions organize workers to think about and process cases through eight primary or *core standardizing methods* as shown in Figure 1 below.<sup>18</sup> Appendix C of this report provides further description of each of these Standard Case Processing Structures.

**Figure 1**  
**Standard Case Processing Structures**



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The IA uses the *core standardizing methods* as trails to investigate how racial disproportionality and disparity are produced.

Initial work in the IA involved identifying or “mapping” the sequence of institutional actions or steps that occur in the course of taking reports alleging child maltreatment, assigning reports for investigation, investigating allegations, and making decisions about whether or not to remove children from the custody of their parents or caregiver. The map defined the purpose and functions of each step in the sequence and identified key actors, policies, regulations, and practices. The mapping process honed in on which core steps are most likely to contribute to racial disproportionality/disparity and provided a framework for implementing the Review. The next step in the IA involved gathering data through a series of individual and group interviews, observations, and reviews of policies and administrative documents. The data analysis process focused on identifying the institutional, or structural, production of racial disproportionality/disparity rather than looking for individual acts of racism among practitioners.

### ***The Quality Service Review***

The Quality Service Review (QSR) is a case-based assessment of the effectiveness and quality of human services interventions with children and their families. A QSR protocol is used for conducting a guided professional appraisal of the:

- Status of a child receiving services
- Status of the parent/caregiver, and
- The connection between the problems of a family, the assessment, service planning and implementation and the results for the children.

The protocol guides the reviewer to examine recent outcomes for a specific child and his/her parents/caregivers and the contribution made by the local service system in producing those outcomes or results. The process and its related conceptual framework influenced the design of the federal Child and Family Services Review, the evaluative methodology utilized by the Administration on Children, Youth and Families to review all 50 state child welfare programs.<sup>19</sup> Case review and other findings are used by local agency leaders and practice managers in quality assurance, organizational development, and practice improvement efforts, as well as in efforts to provide mentoring and coaching to staff. A basic QSR protocol was adapted for the Michigan Review. Appendix D provides a summary of each assessment item in the protocol and further description of the QSR process.

### ***Undoing Racism Training***

Prior to the Review in the two counties, each reviewer participated in a two-day workshop entitled *Undoing Racism*, conducted by representatives of the People’s Institute for Survival and Beyond.<sup>20</sup> The workshop primarily addressed structural and institutional racism and how they perpetuate embedded racial inequity and disadvantage. Participants were also asked to make a personal investment to understand their own biases and socialization around the issues of race

and racism. Participation in the workshop was a way to aid participants in effectively and respectfully discussing the issue of racial and ethnic disproportionality and disparity in child welfare. The trainers added a presentation and discussion of the history of child protection theories, concepts and practices in the United States. Ultimately, the goal of the *Undoing Racism* workshop was to provide a foundation for and commonality among reviewers as they embarked upon this work.

***Conducting Phase I of the Michigan Race Equity Review—the Quality Service Review***

The QSR in Saginaw County involved 12 families who had experienced a Child Protective Service (CPS) investigation during either November or December 2006 or January 2007 which resulted in a substantiation of child neglect. Six cases involved Caucasian families; six were African American families. In six of the 12 cases, children were removed from their home; three of the children removed were from African American families, three were from Caucasian families. The process was repeated with cases selected from two offices in Wayne County of 12 children and families who had experienced a child protective service investigation in February, March, or April of 2007 resulting in a substantiation of child neglect. Five cases involved Caucasian families; five were African American families; and two were biracial (Caucasian and African American) families. In six of the 12 cases, children were removed from their homes. Of those six cases, three involved African American families and three involved Caucasian families. All of the remaining children were residing with one or both of their parents. Four additional cases of African American youth involved in both the juvenile justice and child protection system added to the QSR to learn about the experiences of these children. All four of these children had been removed from their homes. See Table 4 below for a summary of select information about the cases reviewed through the QSR.

**Table 4  
Summary of Cases Selected for Quality Service Review**

<b>Quality Service Review</b>		
	<b>Saginaw County</b>	<b>Wayne County</b>
Number of Cases Reviewed	12 children 6 Caucasian 6 African American	16 children/youth 5 Caucasian 5 African American 2 Biracial (Caucasian and African American) 4 African American Youth involved in both the child protective and the juvenile justice systems (dual wards)
Number of Cases Involving Removal of a Child	6	10 6 children in DHS custody 4 children simultaneously involved in both the child protective and the juvenile justice systems
Number of Informants Interviewed by Reviewers	101	104

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### ***Conducting Phase II of the Michigan Race Equity—the Institutional Analysis***

An Investigation Team of local and national consultants collected data on the institutional features of the child welfare system that could contribute to racial disproportionality and disparity. In Saginaw, team members were divided into four groups, with each group responsible for conducting interviews, focus groups, case record reviews, and observations. The groups examined the following:

- Group 1 - intake and investigation of child abuse and neglect cases, including examining the Structured Decision Making® tool.
- Group 2 - the decision making process around removal, family team meetings, and how placement occurs.
- Group 3 - the court process, including the legal representation of parents and children.
- Group 4 - community based providers contracted by DHS to provide services to families and children.

This process was repeated in Wayne County with a 5<sup>th</sup> Group added to focus on youth involved in both the child protective and juvenile justice systems. The focus on juvenile justice was added to begin to examine the overlapping issues of youth simultaneously involved in both systems. See Table 5 below for the types of data collected through the Institutional Analysis.

**Table 5  
Summary of Activities for Institutional Analysis**

Type of Activity	Saginaw	Wayne County
Interviews	50	106
Observations	Hotline, investigations, Team Decision Making (TDM) meetings, family court	Hotline, investigations, Team Decision Making (TDM) meetings, family court, juvenile detention
Focus Groups	Birth parents, youth, and foster parents	Birth parents, youth, foster parents, Assistant Attorneys General, protective services specialists, protective services supervisors, and TDM meetings facilitators
Review of Case Files	40 child protective cases	20 16 child protective cases and 4 children simultaneously involved with the child protective and the juvenile justice systems

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The information gathered through the QSR and IA provided an assessment of both case-based current practices and outcomes and system structures which direct the processing of cases. These data were analyzed to understand how the system is structured to produce those practices and outcomes.

The following sections provide the specific findings and recommendations based on the Review as well as “snapshots” of three families assessed as part of this process.



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## SNAPSHOTS: FAMILY STORIES

The Review examined 60 individual case files through either the Quality Service Review or a case record analysis. Below are three summaries of cases assessed during the QSR that illustrate the interaction of families with the child welfare system. These stories describe the real and complex dynamics of families that the child welfare system is challenged to address. These stories are not exceptional in the pool of cases reviewed and they provide context and examples in the discussion of findings.

### Matthew:

*FAMILY STORY - Sarah, 18 years old, and Jamal, 19, had been living in a small apartment in Saginaw County. Both Sarah and Jamal identify as African American and both have been diagnosed as cognitively delayed. Sarah did not complete high school. Sarah and Jamal have a young son, Matthew who was 3 months old at the time of the Review. Before Matthew's birth, Sarah sought assistance for her family from a teen parenting program, but was placed on a waitlist. After Matthew's birth, Sarah had trouble understanding how to mix formula with water and requested and received pre-mixed formula from the Women Infant Children program.*

*Matthew is Sarah's second child; she had her first child when she was a minor and her legal rights to that child were terminated by the child protective system. DHS became aware of Matthew's birth through a statewide mechanism ("birth match") for identifying women who have given birth to a child and who have had their legal rights to a previous child terminated. DHS staff met with Sarah, Jamal and Matthew soon after Matthew's birth, determined that Matthew was safe and that his parents were adequately caring for him. At that time, Sarah requested support services from CPS but no services were provided.*

*One afternoon, Matthew began having seizures and his parents rushed him to the hospital. At the hospital, the doctors determined that his medical problems were due to "water intoxication". Sarah had run out of formula and had given him 3-4 feedings of water in the morning. The hospital made a referral to child protective services.*

*At the time of the Review, Sarah was not living with Jamal and was experiencing housing and financial challenges. There had been a fire at her home requiring her to move to a sparsely furnished apartment. This new apartment cost \$600 per month. Her only income was SSI at \$624 per month. Her food stamp allocation had been discontinued for reasons unknown to her.*

*SYSTEM RESPONSE - DHS removed Matthew from his parents' custody at the hospital and placed him in a foster home with his older half-brother. DHS filed a petition with the court to terminate Sarah and Jamal's parental rights. Documentation in the case file stated that Jamal violated his agreement with DHS by leaving his son in the sole*

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care of Sarah, “thereby placing his son at risk of physical and emotional harm.” However, Sarah states she had no knowledge of this agreement.

During Matthew’s first month in protective custody, he had no visits with his mother. It was standard practice for visits between children and parents to be suspended upon the filing of a termination of parental rights (TPR) petition<sup>21</sup>. The judge ultimately rejected the petition and ordered DHS to work to return Matthew to the custody of his parents. At the time of the Review there were one hour per week supervised visits between Matthew and his parents.

**Imani:**

FAMILY STORY - Vicky, 19, and Sam, in his early 30s, met at a homeless shelter. Vicky identifies as biracial (African American and Caucasian) and Sam is African American. As a young teenager, Vicky was sexually abused by her mother’s boyfriend and taken into DHS custody. Soon after entering protective custody, Vicky left her placement and lived with whomever she could find to take her in. She was sexually abused in one of the homes and had two children by her abuser. Both of these children are in DHS custody, placed with their paternal grandmother. The father of those children is incarcerated for the statutory rape of Vicky. Both children were taken from Vicky’s care by a DHS worker in an unexpected manner. The first child was taken from her at a homeless youth shelter after she was told the social worker was coming to “visit” with her. The second child was removed shortly after birth at the hospital. At the time of the Review, Vicky expressed interest in voluntarily relinquishing her parental rights to both of these children so that they could remain with their paternal grandmother. After Vicky gave birth to her third child, Imani, she expected CPS to take physical custody of her child from the hospital. Despite the “birth match” protocol, DHS was not alerted to Imani’s birth. Vicky, Sam, and Imani lived together in temporary housing at a motel. Vicky breastfed Imani at night and fed her formula during the day. Worried about DHS finding out about their child, Vicky and Sam sought housing and other support services through a community based men’s program. The director assisted them in obtaining housing, food and items for the baby. However, the receptionist at this program, who had a verbal confrontation with Vicky, called the child abuse hotline to report that the family was homeless and not able to adequately provide for their baby.

SYSTEM RESPONSE - An investigation worker tried several times to contact Vicky to conduct a safety assessment. She reached Vicky after having the family’s Temporary Assistance to Needy Families (TANF) worker suspended their benefits. When Vicky and Sam contacted their TANF worker, that person directed them to call the DHS CPS worker. The worker visited Vicky, Sam and Imani and determined that their child was safe and well cared for. However, believing that Michigan law required the removal of an infant when a parent fails to reunify with previous children, the worker and supervisor decided to remove Imani from her parent’s custody. CPS contacted Vicky and asked her to participate in a team decision making (TDM) meeting to discuss Imani’s care. Because

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*the parents were asked to come to a DHS office with their baby for the TDM meetings, they were suspicious about the true purpose of this meeting and did not attend. The meeting was held without them and staff determined that Imani should be removed from her parent's custody. A CPS worker, accompanied by a police officer removed Imani from her parents late one night. Both Vicky and the CPS worker reported that the police yelled at Vicky and Sam to "get down on the ground" while the social worker entered the room and took the baby. Vicky and Sam attempted to provide the worker with clothing and food for Imani, but were told to stay on the ground. Imani was taken to a non-relative foster care placement. The foster mother had to provide Imani with clothing and formula.*

*Vicky and Sam went to court the following day extremely upset. Vicky yelled at the judicial officer and social worker. The court suspended visitation between Vicky and Imani until Vicky received a psychiatric evaluation to determine if it was safe for her to visit with Imani. Sam was told that because he was not married to Vicky or listed as the father on Imani's birth certificate he needed to establish his paternal rights in order to participate in future proceedings and visit with Imani.*

*During the Review the worker was already looking for a non-relative adoptive placement for Imani.*

**Nykia:**

*FAMILY STORY-- Nykia, an 11 year old African American girl, lived with her paternal grandmother Lily, her legal guardian since infancy, a younger brother, and two of her cousins. Due to her poor health, Lily relied on Nykia to care for her and the other children in the home. Nykia's father lived with his girlfriend in an apartment above the family. He rarely visited with Nykia and her brother; however, Lily relied on him to discipline the children. According to Nykia, both her father and his girlfriend had hit and kicked her, pulled her hair, and knocked her to the ground. Recently, a school social worker reported to CPS that Nykia feared returning home due to an impending "beating" by her father. Nykia's fear escalated to the point that the police were called twice in a single day to deal with her disruptive behavior at school. She pleaded with the police to take her to detention, rather than let her return home. The police declined to take her to detention and she returned home.*

*When Nykia was 8 years old, she was referred by her school for psychological and psychiatric evaluations due to problems concentrating. As a result of the evaluations, Nykia began individual therapy and medication for Attention Deficit Hyperactivity Disorder (ADHD) and depression. Nykia had been a good student; however, she felt that since taking medication, her grades had dropped because she was too tired to focus in class. Nykia did not take her medication regularly complaining of debilitating side effects. At the time of the Review, her psychiatrist believed that Nykia was showing symptoms of bipolar disorder.*

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*Her grandmother and Nykia have had a turbulent relationship and had four physical altercations in the eight months prior to the Review. Each time the police were called. Nykia was placed in juvenile detention for one of these incidents and had a pending "domestic violence" charge. Nykia's grandmother believed that these altercations were due to Nykia's mother reappearing in her life. Nykia expressed that she fights with her grandmother because she does not want her to have her father discipline her.*

*A little over a year ago, Nykia's mother reconnected with her after being completely absent for several years. Her older sister, who has custody of several of Nykia's siblings, frequently invites Nykia to her house so that she can visit with her mother. Nykia wants to develop a relationship with her mother, her older sister, and those siblings. Nykia's mother has lost parental rights to her other children; however, her rights to Nykia have never been terminated. She has told Nykia that she wants to get to regain custody of her.*

*Four months prior to this Review, Lily called the paramedics because she was feeling ill after a verbal confrontation with Nykia. Nykia began to fight with her grandmother when the emergency medical service providers came to the home. These providers were so disturbed by Nykia's behavior that they transported her to Children's Hospital for a psychiatric evaluation. When she was determined to not be of danger to herself or others and was ready for release, her grandmother refused to pick her up, the hospital contacted CPS, and Nykia was placed in foster care.*

*SYSTEM RESPONSE -- Nykia was temporarily involved with both the juvenile justice and child welfare systems. About two days after Nykia was placed in foster care an initial TDM meeting was held with Nykia, her grandmother, DHS staff, and a few other professionals (none of whom were from the juvenile justice system). Everyone present agreed that Nykia could return to her grandmother's care and intensive counseling services would be put into place. However, at the court hearing, held a few days later, Nykia expressed uncertainty about returning home so the court referee decided she should remain in foster care. Nykia then "acted out" in the courtroom by stomping her feet, smacking her lips, and rolling her eyes. The court referee hearing the child protection matter revoked Nykia's bond issued by juvenile court for her domestic violence charge. Nykia returned to detention. By policy of the juvenile detention center, all medication is temporarily discontinued. After seven days, girls receive a pregnancy test and are re-evaluated for medication. However, a different juvenile court referee sent Nykia home after five days in detention. Nykia was sent back to live with her grandmother without the benefit of reevaluation or medication. Nykia's mother appeared at the juvenile court hearing, asked to be heard, and stated that she wanted to plan for her daughter to return to her care. The court referee did not acknowledge Nykia's mother or the idea of her caring for her daughter.*

*Nykia has received therapy once every other month due to health insurance restrictions (she is allowed 20 mental health visits per year including psychological and psychiatric*

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*counseling). Because she must visit the psychiatrist once a month for a brief medication review, her health insurance plan allows for only eight additional appointments per year for mental health counseling. At the time of the Review, she also was receiving services from a community-based program that works with youth on probation. This is "intensive in-home counseling", where service providers visit or call the family once a week. At a subsequent juvenile court hearing with yet another court referee, Nykia's attorney asked that her mother be included in intensive family counseling and this referee granted the request. However, at the time of the review her mother had yet to participate in these sessions. The neglect petition was ultimately dismissed as sufficient services were considered to be in place through the juvenile justice system. Nykia was adjudicated a delinquent and CPS closed the case.*



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## FINDINGS

The Race Equity Review is a significant step Michigan has taken to rigorously examine institutional features that contribute to the overrepresentation of children of color in their child protective system. During the Review process, leadership in the State of Michigan's Department of Human Services (DHS) repeatedly demonstrated their commitment to address racial disproportionality and disparity through their assistance in organizing the Review and devotion of staff time to the process. With a few exceptions, local practitioners met with reviewers for lengthy interviews and took great care to assure that reviewers understood the features of the system and issues faced when working with families. This openness was tremendously valuable in gaining insight into Michigan's child welfare system and how the system often disadvantages African American families needing support.

As stated previously, the Review analyzed the following question: *"How does it come about that, after substantiation of child neglect, African American children are more likely to be removed from their homes?"* As part of exploring this question, the Review analyzed DHS' current child welfare philosophy which guides the delivery of services to families. The current philosophy emphasizes safety of children, the commitment to respond to each child's individual needs, the importance of family engagement and participation in decisions affecting them, and recognizing and building on family strengths in case planning. It also speaks to the importance of families and communities as resources for children. The philosophy calls on staff to value the ethnic and cultural traditions in their work with children and families.

This Review documented a gap between the stated philosophy and actual practices with African Americans. In fact, the Review documented both stated and operational assumption that African American children would fare better if removed from their families and communities. Reminiscent of the 19<sup>th</sup> century child rescue ideology that led to the separation of tribal and immigrant children from their families and communities, this way of thinking has a long history in child welfare. This powerful belief system allows the child welfare system to operate in ways that disadvantage African American families. To a large extent these practices have become standard operations and are not recognized or questioned by individual workers.

The belief that African American children are better off outside their families and communities was seen in explicit statements by key policy makers and service providers. It was also reflected in choices made by DHS. The lack of prevention and intervention services in the African American communities was seen in both sites, although different strategies created this result. The lack of faith in families' ability to keep their children safe was also reflected in the number of removals from families, the limited effort to secure their authentic participation the planning process, and DHS' willingness to permit long delays in resolving reunification of children with their families or temporary placement of children with relatives. Policies and practices resulted in little attention paid to family strengths, community based non-traditional resources, or the potential for placements with in the extended family.

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Many of the policies and practices designed to assure fairness for children of color were not used as intended and therefore created limited the opportunities for these families. These practices include a risk assessment tool and Team Decision Making meetings. The practice expectations were unclear and often there was confusion about important policies. This lack of policy and practice clarity created large areas of discretion that operated against African American families.

The child welfare program demonstrated limited accountability to families and children for overall results and the quality of service provided. At numerous points in the handling of cases, there seemed to be little oversight focused on the quality of work, the appropriate application of policies and/or the outcomes for African American children and families. The lack of accountability to the families, to the system, and to the public was reinforced by a lack of robust advocacy by and on behalf of families and children as well as a lack of community or systems-based advocacy for families, particularly those of color. The combination of these factors allowed poor practice and counter-productive policies or policy implementation to go unchallenged.

Finally, the policies and practices which drive the processing of cases result in the slow provision of services to families. This manifests as an overwhelming lack of urgency to help parents and children— for example, visits with children are delayed because of waiting for psychological evaluations (which are scheduled weeks to months after a removal) and service provision in Wayne County is delayed until receipt of a signed court order, a process which can take a minimum of six weeks.

The following is a more in depth discussion of the specific institutional policies and practices that have a disproportionate and negative impact on African Americans. A part of the review looked at the experiences of youth who were involved in both the child welfare and juvenile justice systems. A supplemental analysis of this population is provided in Appendix A.

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## Summary of Findings

- 1. African American families do not receive necessary supports that could prevent or divert their involvement with the child protective system. African Americans families and youth often experience the services offered to them by DHS as irrelevant, difficult to access, or inadequate to support and strengthen their families.**

The systemic factors that contribute to this experience are:

- Fundamental lack of basic resources,
- Problematic allocation of existing resources,
- Poor access to appropriate and quality services and resources for parents and children.

- 2. African American families experience child welfare systems as intrusive interventions that do not fairly assess and appreciate their unique strengths and weaknesses and fail to adequately explore the least restrictive placement options for children.**

The systemic factors are:

- Differential screening and reporting of African American families by mandated reporters of suspected child maltreatment,
- Poor oversight of intake practices,
- Problematic use of the SDM® Family Risk Assessment tool,
- Misuse of Team Decision Making (TDM) meetings,
- Policy Mythology: Widespread misapplication and misinterpretation of legislation/policy, and
- Lack of a clearly articulated and implemented case practice model.

- 3. African American youth and families are negatively characterized or labeled by workers in the child welfare system. Some of these labels follow them through their interactions with various new workers and ultimately negatively affect the outcome of their case.**

A systemic factor is:

- The lack of a clearly articulated and implemented case practice model which translated DHS' philosophy in to policies and practices.

- 4. Advocacy on behalf of African American families and children is insufficient in helping them participate in, challenge, and negotiate the child protection system.**

The systemic factors are:

- Inconsistent and often inadequate participation of parents and youth in TDM meetings,
- Problematic court protocols that limit and in some instances mute the voices of parents and youth,
- Weak legal representation for parents and youth, and
- Limited access to other forms of advocacy.

- 5. Inadequate mechanisms exist for African American parents and youth to hold DHS, providers, and advocates accountable for equitable treatment and quality services.**

The systemic factor are:

- Differential treatment of African American families with minimal risk factors,
- Weak systems of monitoring existing services and holding providers accountable for quality services delivered in an equitable manner, and
- Mistaken petitions and policy misinterpretations, and
- Little or no accountability of court appointed lawyers and judicial officers to the parents and children they encounter.

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**Finding 1: African American families do not receive the necessary supports that would prevent or divert their involvement with the child protective system. African Americans families and youth often experience the services offered to them by DHS as irrelevant, difficult to access, or inadequate to support and strengthen their families.**

African American families do not have consistent access to prevention and early intervention services that would address concerns before they become issues of suspected maltreatment. At the neighborhood level, the Review found examples of a lack of basic services in communities where African Americans live. At the state level, there was evidence of unequal distribution of resources across counties, resulting in instances of African American communities receiving less support. Further, once families become involved with DHS, their ability to access meaningful services is limited.

***Fundamental lack of basic resources***

Interviews, focus groups, and case record reviews all revealed that both Caucasian and African American families involved in the child welfare systems in Saginaw and Wayne Counties lacked many basic necessities to adequately and safely live. Community providers focused on supporting other needs of families such as counseling, after school activities, and parenting skills while families struggled to find and maintain suitable and affordable housing, reliable transportation, and a legal source of regular income.<sup>22</sup>

While both Caucasian and African American families were living in poverty, this Review observed the particularly pernicious effects of poverty on African American families. For example, in Wayne County, there are very limited, meaningful housing opportunities for homeless families (who are predominantly African American). Community providers described a 7-10 year waiting list for subsidized housing and, though there is extensive vacant housing in Wayne County, there are virtually no affordable housing options for families living in or at the brink of poverty. In Saginaw, African American families were more likely to be living in an urban setting where affordable housing options were limited, while Caucasian families living in more rural settings received housing assistance much faster. During a focus group of parents who were involved in Saginaw’s child protective system, parents reported struggling with housing issues. An African American mother described losing her subsidized housing when her daughter was placed in foster care and living with extended family as a result. She has been on a waitlist for a two bedroom apartment; in the meantime, this lack of housing has delayed her reunification with her daughter. A Caucasian mother described a similar situation, however, she lived in rural Saginaw County and her worker was able to provide her with a housing voucher immediately. Soon after she secured this housing, she was reunified with her child.

Michigan, a state known for car manufacturing, has a limited public transportation infrastructure. Prevention and early intervention services were often located outside of neighborhoods where African American families live and in places they could not easily access with public transportation. In Saginaw County, a bus stops a half mile away from the drug

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treatment program. In Saginaw and Wayne Counties, no bus stops near the court house. Interviews with court personnel and case workers revealed that the lack of transportation to services from communities where African American families live is known, but addressing this lack of transportation is thought to be beyond their scope of work. Court and DHS leadership have not met with, nor considered meeting with, county transportation officials to advocate for a bus route from certain communities to the court house, to substance abuse treatment programs, etc.

*Sarah used almost all of her income to pay for her apartment. Imani's parents were living temporarily in a motel and were both unemployed. Both sets of parents were actively seeking community based supports. Unfortunately for Sarah, a range of community based supportive services for adults with cognitive delays had been recently disbanded. Further, she was waitlisted for services from a teen mother program. Vicky and Sam initially received services from a community based agency, but that same agency's receptionist, who had a verbal altercation with Vicky, reported the couple to CPS stated they were unable to care for Imani and they were living in a temporary motel. Neither set of parents has reliable and consistent transportation. They relied on buses, taxi coupons and friends to reach services far away from their homes.*

Interviews with case workers and parents and case record reviews exposed that African American families in particular were often reported by community members to DHS and African American parents contacted DHS themselves in an effort to *gain access* to services. Unfortunately, the requests rarely resulted in a concrete service but sometimes resulted in a DHS/CPS investigation. For example, a young African American mother, at the suggestion of her TANF worker, called the child protective services hotline in search of a stove. DHS did not provide a stove, but did investigate her for neglect because of a concern that she could not adequately provide food for her family. Although her children were not removed from her home, she was warned that removal could occur if she did not procure a stove.

Further, hotline and investigation workers are tasked with providing information about community-based resources to support families and children but DHS had no effective mechanisms in place to assure that workers have access to useful, up-to-date information about early intervention and prevention services. *Sarah, who was labeled as cognitively delayed, found her own community based services. The investigation worker referred her to a defunct service outside of her community and re-referred her to the teen mother program for which she was already on the waitlist.*

### ***Problematic allocation of resources***

Based on interviews with community based service providers and DHS central office staff, it is clear that service providers with large staff and budgets, and based outside of Wayne County, receive significant DHS contracts to provide community-based services yet some of these providers did not make their services available near where their clients live. According to parents and community based providers, the service providers outside of the county were not familiar with the dynamics of particular African American neighborhoods, including the strengths of the neighborhood. Further, reportedly smaller community-based agencies based in

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urban, African-American neighborhoods, often did not have the staff infrastructure to respond to DHS requests for competitive proposals even though these agencies had significant knowledge of and ability to serve African American families.

***Poor access to appropriate and quality services and resources for parents and children***

Once families became formally involved with DHS, their case plans focused on what services were readily available, but not necessarily helpful to families. Most plans required the same services regardless of individual circumstances—parenting classes, individual therapy, and psychological or psychiatric evaluations. Sometimes plans also mandated complying with urine toxicology screening for illicit drug use, attending anger management classes, or attending domestic violence classes. DHS services focused on individual issues with little work to ameliorate the pervasive stress associated with poverty. For example, in Saginaw County, a parent who became involved in the child welfare system due to “deplorable” housing conditions was told to clean up her house and was sent to parenting classes. This parent struggled to reunify with her children because she could not make all of the necessary repairs to her home and make the home habitable. No help was provided on the housing issues. Ultimately, she found new housing on her own in order to facilitate reunification.

All of the families observed or interviewed in this Review had case plans requiring the parents and youth to comply with specific DHS approved services. However, services were not readily accessible to families, delivered in a timely manner, and the overall quality of services was questionable at best. Often visitation with children was dependent on the completion of a mental health evaluation. In Wayne County, this was particularly problematic because bureaucratic steps resulted in delayed service provision. Providers required receipt of a signed court order before delivering the service. Orders were made by judicial officers, signed by judges, sent to a central location at DHS, forwarded to the DHS local office, distributed to the individual caseworker, and then sent to the provider before the service could begin. By all reports, this created a minimum delay of 6 weeks from the time of the court order. This institutional delay was frustrating to all involved. One court officer described the delay as particularly detrimental to families. She described families when they first appear before her as “highly motivated to work their case plans”. However, if services do not begin immediately, a significant number become disheartened, depressed, and disengaged from the process. Further, if family visitation is delayed while waiting for service authorization, the negative impact on children is severe.

*Vicky was required to have a psychiatric evaluation before visitation could begin with 4 month old Imani. Unfortunately, that meant for Vicky at least a 6 week delay in visiting with Imani because of the system delay in referring her to this service. A six week delay in an infant’s life is significant.*

*In the case of Sarah, the court ordered a plan for Matthew to be returned to her care. Her case plan required her to attend parenting classes, go to counseling, return to school (with special education services), and obtain a restraining order against Jamal. When reviewers asked Sarah what she most needs to support her in parenting Matthew, she stated she needed affordable and stable housing. Other*

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*providers interviewed reaffirmed this and also stated that she needed the support and assistance of extended family members to adequately parent. Reviewers found no indication in the case plans or activities that DHS was seeking to identify and use her family or friends to assist her in parenting.*

In Wayne County, upon entering the juvenile detention facility, youth who are taking prescribed psychotropic drugs are reportedly denied those drugs for a 7 day period after which the youth is reevaluated by a psychiatrist at the facility. Workers stated that the policy was designed to assure that youth are clear of all drugs and, for girls, a pregnancy test can be performed. Many youth are released before this evaluation. Further, it is often dangerous to remove children precipitously from medications and can lead to significant behavior and other problems. In one case, a 13 year old African American girl was sent twice to the juvenile detention center. She was on medication for treatment of Attention Deficit Hyperactivity Disorder and depression. Each time she entered the facility, her medication was stopped. She was released within a week so that she was never evaluated by the psychiatrist. Not surprisingly, this girl had significant behavioral issues when she first returned home, was not compliant with resuming her medication regimen, and ultimately returned to detention.

**Finding 2: African American families experience child welfare as intrusive systems that do not fairly assess and fail to appreciate their unique strengths and weaknesses, do not examine the detriment of removal to children, and do not adequately explore the least restrictive placement options for their children.**

In an effort to learn about the structural factors at the “front-end” of the child protective system that contribute to racial disproportionality and disparity, the Review assessed the hospital protocols and policies for staff of obstetrical units who frequently contact the child protective hotline to report suspected child maltreatment. The Review also analyzed the child protective system’s intake process where few calls appeared to be “screened out.”<sup>23</sup> Assessment tools and Team Decision Making meetings were analyzed for their effectiveness and bias. Each of these administrative policies, practices and/or tools resulted in increasingly invasive actions being taken with African American children and their families.

***Differential screening and reporting of African American families by mandated reporters of suspected child maltreatment***

Hospital social workers were the third highest mandated reporter sources of complaints to CPS during 2007.<sup>24</sup> In both Saginaw and Wayne counties, interviews were conducted with social work managers of obstetric units in hospitals about their policies and practices for testing women when there is suspicion of illicit drug use and reporting women to CPS. In one hospital women who have had limited prenatal care are *automatically* screened for illicit drug use and if found to be positive, reported to CPS. In another, women who have diabetes or high blood pressure, conditions more likely to affect African American women, are also *automatically* referred for drug screening and if positive referred to CPS. At one hospital, women were *sometimes* tested for use of narcotic prescription drugs. Women found to have suspicious levels of prescription drugs were predominantly Caucasian. Hospital protocol does not require the social worker to automatically refer those women to CPS, but rather policy provides the worker

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with discretion to question the woman about the drug use. The women report having a prescription for the drug due to various ailments but there is no protocol in place at the hospital to require that the prescribing physician be contacted for consult or verification. At this same hospital, policy provided social workers with discretion to call CPS with any concerns about new mothers. Social workers at hospitals reported contacting CPS to “find out” if a woman is “known to” CPS. Additionally, a hospital social worker described her perception that African American mothers in particular did not have enough social supports and may be isolated. This interviewee then gave several examples of African American mothers whom she reported to CPS because she was concerned they were isolated even though these mothers had frequent visits from the infant’s father and other relatives by her own account. However, the *administrative practice* at that hospital was to let CPS decide if those persons were viable sources of support for the new mother and infant. In effect, the policies and practices at the hospitals provided more opportunities for African American women to be tested for drug use and then automatically reported to CPS. In addition, where policies and practices allowed for social worker discretion, African American women were also more likely to be reported to CPS.

### ***Poor oversight of intake practices***

Interviews of DHS hotline workers and supervisors and observations in both Saginaw and Wayne counties confirmed that an overwhelming number of complaints to child protection hotline are assigned for investigation.<sup>25</sup> Data collected showed that many allegations or statements made to intake workers did not rise to the level of neglect or abuse yet were assigned for investigation. For example, as mentioned previously, a case reviewed in the QSR process involved a mother who, on the advice of her TANF worker, called CPS for help in securing a stove. This mother was referred for an investigation, but did not receive help in securing a stove. In interviews, workers reported that many families, particularly African American families, called for help with paying for their heating in the winter and that the workers were then required to investigate these families for child neglect. The systemic conundrum is that CPS investigation is sometimes the only route to services for some families, yet this allows for unwarranted CPS involvement and sometimes no real help for families.

The hotline system has no effective manner of assuring that reports most appropriate for CPS intervention are assigned to an investigator. Rather, the policies and protocols focus on the cases that are screened out—that is, supervisory approval is required to decide not to assign a report for investigation but there is no ongoing system in place to review the appropriateness of reports that are accepted for investigation. In Wayne County, a centralized system exists for receiving reports of suspected neglect and/or abuse and assigning those reports to local offices for investigation. The Review found what was in effect was “open door” system where reports were referred for investigation when they could more appropriately be handled by DHS’ in-house prevention services. At the local offices, a report may still be denied for investigation with managerial approval. However, this practice was highly unlikely. Predominately, the thinking was, as one supervisor described, “better to check and make sure...you never know.” Given that African American families are disproportionately reported to CPS,<sup>26</sup> a system that

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errs on screening in almost all referral will disproportionately impact African Americans. This is the beginning of the child protection systems' compounding, intrusive and sometimes negative interventions with African American children and families.

***Inherent bias and problematic use of the SDM® Family Risk Assessment tool***

Michigan relies on a structured risk assessment tool to guide the decision making process of workers. Risk assessment tools can be helpful in guiding workers to treat similarly situated families similarly. These tools are generally derived from aggregate data based on characteristics of families where there have been subsequent referrals to child protective services, substantiations of neglect and/or abuse, removal of a child from his/her home, and in some instances child deaths. Families newly involved with child protective services (CPS) are assessed for their risk of harming their children in the future based on this aggregated data of other families where there has been significant CPS involvement. Without careful, independent monitoring and evaluation, these tools can be problematic as much of the data they are based on disproportionately includes families of color. African American families, as evidenced by Michigan's data, are disproportionately overrepresented at several key decision points (particularly investigations, substantiations and removals) within the child protection system and using data from these decision points as a basis for assessing future risk may lead to the perpetuation of institutional racism.

Currently, Michigan is one of many states that has implemented Structured Decision Making® (SDM) - a process that uses actuarial tools to estimate the likelihood of subsequent child maltreatment, as determined from research linking the relationship between family characteristics and child welfare case outcomes.<sup>27</sup> In Michigan, following the substantiation or preponderance of evidence of neglect or abuse<sup>28</sup>, an investigative worker completes the SDM Family Risk Assessment tool answering questions about select risk factors that cover a range of family characteristics (e.g., number of prior reports to the child protection system, primary caretaker's age, the number of children in the home, caregiver substance abuse), which demonstrate a strong correlation with child maltreatment outcomes. The Assessment classifies families into risk groups with high, medium, or low probabilities of continuing to abuse or neglect their children.<sup>29</sup>

The Review focused on the SDM Family Risk Assessment tool and Review assessed DHS' *implementation* and *use* of the SDM Family Assessment tool in Saginaw and Wayne counties to guide decision-making on the disposition of investigations. Data demonstrated numerous examples of families rated at "moderate risk" based solely on defined demographic characteristics. These characteristics include: a primary caretaker age 29 or younger, one adult living in the home at the time of the child protection report, three or more children in the home, and one prior investigation by child protective services.

Although seemingly race neutral, in fact, these demographic indicators of risk appear to disproportionately increase the risk rating for African American families. Michigan's most recent census data reflects that African American children are more likely to be raised in single

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parent households than their Caucasian counterparts.<sup>30</sup> Further, data show that African American families are more likely to be reported to child protection agencies than Caucasian families.<sup>31</sup> While representatives of the Children Research Center (CRC), the developers of SDM, state that explicit efforts were made to maintain equity in the development of Michigan's tools and point to research from a study of cases in Minnesota which concludes there is no racial bias in the tools, this Review of 60 case files raised significant concerns that indicators on the SDM tool and SDM scoring resulted in higher risk ratings for African American families.<sup>32</sup>

CRC recommends and DHS policy directs that service decisions be made related to risk level as opposed to whether or not an allegation is substantiated in order to focus resources on those families deemed to be at highest risk of child maltreatment: when the risk rating is intensive or high, those families should be monitored and provided services by the public agency; when the risk rating is moderate or low, those families may be referred for community-based intervention and not monitored by the public agency. Supervisory approval is required for each form and supervisors may override low and moderate risk ratings if there is concern that the risk level is higher. However, neither a worker nor a supervisor may decrease a risk rating for this initial risk assessment. Through record reviews and individual interviews, the review found that cases were substantiated and risk level overridden to high, moderate or intensive in order to provide families with interventions that were only available to families fitting those criteria. Setting a higher risk level may at first seem expedient in an effort to access services for a family but it results in placing a parent or caretaker's name on the state's child abuse registry and ongoing oversight by child protective services. CPS service history is considered a risk factor on subsequent risk assessments.

Demographic characteristics alone do not result in a high or intensive risk rating on the Family Risk Assessment tool. CPS workers are asked to identify other characteristics of primary caretakers such as parenting skills, self-esteem, hopelessness, motivation, and whether the caretaker(s) viewed the situation/investigation as seriously as the worker and cooperated with the worker. These are highly subjective assessments of parents and caretakers during an investigation of child maltreatment while there is a spoken or unspoken threat of a child being removed from parent or caretaker custody. These assessments are weighted heavily in the overall determination of risk of harm to children as well as investigation disposition.

There was no consistent oversight of or quality control on the use and application of the results of the risk assessment tool. Forms were completed incorrectly and without supporting documentation and evidence. Examples include:

- A case where a couple was residing with one of their parents and the number of adults living in the home was recorded as "one" on the tool. One adult caregiver translates into a higher number of points on the tool, and thus is counted towards increased risk.

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- Several cases where the number of prior reports to CPS was incorrectly counted. The greater the number of previous reports (which do not have to be substantiated) translated into a higher number of points on the tool, and thus is counted towards increased risk.
  - Cases where items were rated as problematic and there was no documentation of, for example, how questions of parental/caretaker motivation, self esteem, parenting capacity, and/or view of the investigation were assessed. These items were frequently checked as a concern on the tool, but there was no narrative documenting evidence of what informed the assessments. These items, when viewed as problematic, are counted towards increased risk.

### ***Misuse of team decision making meetings***

In an effort to reduce unnecessary out of home placement and the negative effects of placement on children, Michigan has implemented Team Decision Making (TDM) meetings as part of the state's implementation of the Annie E. Casey Foundation's *Family to Family* initiative.<sup>33</sup> The facilitated meetings are to occur when there is consideration of removing children from their parent's or guardian's custody, when children have been removed from their parent's or guardian's custody, and when children are in protective custody and there is a consideration of changing their placement.

Despite the description above, the Review found that the TDM meetings did not realize their intended benefits with African American families. Specifically, emergency removal and "considering removal" TDM meetings were used to identify placement options and not to explore and develop strategies to keep children safe and prevent their removal from their homes. In interviews with child protective staff, family members, and community-based providers, the general opinion was that TDM meetings were most useful in identifying family members as placement options for children and not for creating safety plans so that children could remain in their homes. *In the case of Imani, the worker and TDM meeting facilitator acknowledged that they were holding the meeting in the hopes that Vicky would bring Imani to DHS and that the infant would be removed from her custody at that time. Because Vicky suspected DHS and did not attend the meeting, the worker stated that she needed the assistance of the police to conduct an emergency removal. Relative placement options were not discussed at the meeting.*

Additionally, the Review found conflict in the practice of TDM meeting facilitators and DHS staff. Both observations and interviews showed that facilitators often recognized that a worker had not provided the family with sufficient information or informed them of their rights to bring supportive people to the meeting. TDM meeting facilitators are not supervisors of DHS case workers. Therefore, it is neither their role to correct problematic frontline practices nor were they particularly successful in attempts to consult with supervisors. In the TDM meetings observed, facilitators effectively engaged with family members and actively planned with them during meetings. While this is good practice, this engagement was not consistently observed in interactions of other DHS staff working with families or documented in case files. This is a

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shortcoming of the system in translating the value of family engagement and involvement in decision making to all processes, not just for use in a TDM meeting. Without an overall institutional value of the engagement of families and youth as exemplified in policies and practices, TDM meetings will remain a promising strategy to prevent the disproportionate removal of children of color from their homes, but not be fully effective.

***Policy Mythology: Widespread misapplication and misinterpretation of legislation/policy negatively affects African American families***

The Review uncovered many instances of misinterpretation of legislation and policy, some of which result in negative consequences for children and families. While DHS issued memos to introduce or clarify policy, the expected application was not reflected in practice and misinformation was not corrected. As a result, staff acted on this misinformation believing it to be policy. There were so many examples of this phenomenon in cases and interviews that it became known during the Review as: “policy mythology.” Again, like intake policies and practices, this mythology contributed to the compounding and negative interventions with African American children and families. Following are two predominant misapplications or misunderstandings of policy: 1) the Binsfeld legislation and 2) placement requirements.

**1. Misinterpretation of Michigan’s child welfare reform legislation**

In the mid 1990s, a Michigan children’s commission (known as the Binsfeld Commission) proposed a series of changes to Michigan’s child welfare statutes. Part of this comprehensive legislation guides the child protection system on when it is allowable to “bypass” the federal standard to make reasonable efforts to prevent removal of children from or return children to the custody of their caretakers. The “bypass” is allowable in cases where a parent has had their legal rights to a child terminated. Some cases selected for the QSR involved parents who had experienced a termination of parental rights (TPR), either voluntarily or involuntarily. CPS policy directs workers to conduct an assessment to determine whether an infant, born to a parent who has experienced a TPR on another child, is safe in the custody of that parent. If the child is not safe, or the parents have not addressed the issues that led to the TPR (for example, substance abuse), then DHS is directed to remove the child, file a neglect or abuse petition and request termination of parental rights at the dispositional hearing.

In both Wayne and Saginaw counties, the practice observed omitted the assessment of current safety and the filing of a neglect petition. The policy has become the justification for the automatic removal of and filing of a TPR petition for infants born to parents who have experienced a TPR on another child. In particular, there were several case examples of unnecessary removal of African American infants. In two of the QSR cases examined, infants were removed at the hospital due to a “birth match”<sup>34</sup> (which showed a prior TPR) but without any safety assessment conducted or specific findings that would otherwise prompt removal of an infant from their parents’ custody. *In the case of Imani, her parents safely cared for her for four months before CPS discovered her existence and removed her. The social worker and supervisor who made the decision to remove the infant described that they had no immediate safety concerns for Imani, but that Vicky was not cooperating with services to reunify with her older children and failure to care for*

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*them meant that she could not care for Imani. In fact, Vicky had developed a permanent plan of adoption by relatives for her older children.*

## **2. Misapplication of placement policies**

In examining the removal of children from their parents, the Review briefly assessed where children were placed.<sup>35</sup> There were several impediments to placement of children with their extended family. In Saginaw County, investigation workers and supervisors reported that they would not place children with older relatives and cited Michigan adoption policy that recommends against placing children with caregivers more than 50 years older than the child. These workers were ruling out older relatives as providers of temporary foster care based on application of the state's *adoption* policy.

Also, in Saginaw County, some workers were confused about Michigan's policy of allowing placement of children with "fictive" kin. "Fictive" kin is a term used to describe extended, but not blood related, family members or close friends (for example, godparents). Workers and their supervisors believed that DHS policy required children to be related "by blood or law" to a relative in order to be placed with them. In an observation of a TDM meeting, an African American grandmother suggested a close family friend as a placement option for her grandson. This friend lived in the same neighborhood as the child and had previously provided informal care for him. The TDM meeting facilitator, however, said that the friend was not an option because she was not a blood relative. This is contrary to Michigan's policy on fictive kin caregivers. Interviews with line staff and supervisors revealed that this policy misunderstanding was widespread despite efforts from DHS central office to clarify the intent of the policy. It should also be noted that interviews with community members suggested that the terminology "fictive kin" was off putting, particular to African Americans who have a long multigenerational history of "aunties", "uncles", and "cousins" who are not blood related but were considered to be family members and may serve as intermittent caregivers for children.

Finally, several relative placement options were denied because of lack of adequate space in the relative's home. DHS policy allows for workers to seek a waiver for many housing obstacles that do not impact child safety (such as the number of bedrooms in the home). However, DHS' central office reported receiving few requests for these waivers. Again, interviews with case workers and advocates reinforced that most do not know of and/or do not request waivers to facilitate placement of children with extended family members. This policy mythology seemingly applies to all families, but may be especially relevant for African American children who are according to Michigan data and the Review less likely to be placed with a relative or family friend.

### ***Lack of a clearly articulated case practice model which translates DHS' philosophy into policy and practice***

Department of Human Services' child welfare philosophy is intended to apply to all DHS policies and contracts related to protective services, foster care, adoption, and juvenile justice.<sup>36</sup>

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The philosophy emphasizes, among other things, the importance of child safety and inclusion of children’s voice in the decisions that affect them. It also states that children and families are to be treated with respect and dignity and their individual strengths and needs are to be considered. Further, communities should be seen as partners by DHS. The Review found little evidence of the translation of this philosophy into a unifying set of policies and procedures that address how workers are to interact with families—in other words, an articulated, coherent case practice model.

For example, despite the articulated philosophy to place children in the least restrictive settings, in their communities, and as close to their schools if possible, interviews with workers, attorneys and judicial officers reflected the predominant pattern and effort of some to place African American children and youth outside their home communities. TDM meetings are supposed to be used as a “gate keeping” function to have a team, which includes family members and their professional and non-professional supporters, evaluate the need for out-of-home placement, develop safety plans if possible to support the child remaining in the home, and if necessary identify alternate caregivers. However, absent a larger reinforcing set of policies and practices (including a case practice model), TDM meetings were often used solely as a forum to discuss out-of-home placements. The Review found that communities in which African American children were placed in foster care were often far away from their homes, making visitation with their parents difficult and requiring children to change schools and lose other ties to their community. There were few institutional mechanisms in place to prevent workers and others from acting on their *personal* belief that placement of African American children outside of their neighborhoods would be beneficial because children would attend better schools and be exposed to a range of cultural experiences.

African American youth involved with both the child protective and juvenile justice systems were placed seemingly unnecessarily in juvenile detention—in violation of a philosophical commitment to placement in the least restrictive setting. African American youth participants in focus groups reported that police were summoned if youth acted out in school. Incidents that might have been considered minor infractions or expected behavior given the context, escalated to youth being incarcerated. In one case, a worker met with a 12 year old African American girl at school and told her that she was being returned to her grandmother’s home even though the girl protested that she did not feel safe there. The girl became angry and started throwing chairs. Instead of professionally deescalating the situation, the school contacted the police who arrested the girl and placed her in juvenile detention. Similarly, a young African American teenager was informed while at school that his parents were no longer his legal parents, essentially rendering him an orphan. He returned to his classroom and instigated a fight with another boy. He was then arrested at school and placed in juvenile detention. Michigan’s child welfare philosophy pronounces the importance of youth involvement in decisions made about them, yet for these African American youth, there was little understanding or support for their specific needs and inclusion of their voice in a decision making process.

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Finally, the Review found no consistent system for monitoring the current state of case practice. When, as described above, policies are misinterpreted and misapplied, there is no formal mechanism to identify the problems or correct them. In the majority of the 60 files reviewed, there was notably insufficient and error-ridden documentation. In one of the cases, the file initially stated that there were stains on the apartment walls from liquids. In subsequent documents, these stains were described as ‘feces smears’ without any explanation to account for this change. The mother of the children in this case explained to the reviewers that the stains were from a drink that spilled. *Additionally, the case file of Sarah and Matthew reported that the psychological evaluation of Sarah found that she had an extraordinarily low full scale IQ. Her IQ score was repeated throughout case file and court documents and was used as evidence to question her ability to ever parent Matthew. However, upon review of the case file, the full psychological evaluation qualified the IQ score due to her low educational level, cultural variance, and that she appeared to need glasses. The psychologist suggested that her functional IQ was significantly higher than the score indicated but this information was lost in subsequent documentation and had serious consequences for decisions in this case.*

**Finding 3: African American youth and families are negatively characterized or labeled by workers in the child welfare system. Some of these labels follow them through their interactions with new workers and ultimately negatively affect the course of their case.**

***Lack of a clearly articulated case practice model that can safeguard such labeling***

The child protection system, by its mandate, demands compliance, requiring families to “cooperate” with the investigation process, with the removal of their children from their custody when that judgment is made, with visitation schedules, and with services identified in case plans. When parents fail to cooperate or comply, their ability to see and care for their children can be terminated. The Review found that oftentimes in the course of assessing compliance, African Americans were characterized or labeled in Court, in case files, and by providers in negative ways not supported by facts. Sometimes these labels were assigned to behaviors without consideration of the context of the behavior. There were differences in the nature and frequency of the use of negative labels for African American parents and children as opposed to Caucasian parents.

For example, there were many examples of African American parents or caregivers becoming upset about the removal of their children by CPS. Language in case files described these parents as “hostile”, “aggressive”, “angry” and “loud” without acknowledging the circumstances for this behavior. *In the case of Imani, her mother and father had been taking a nap when the police began banging on their door at 9:00 p.m. The parents described to the reviewers that the police were yelling at them to get down on the ground while the social worker came in and took their baby away. Vicky came to court the next day distraught and yelling at the judge. As a result, she was told that she could not visit with her child until she received a psychiatric evaluation. The social worker confirmed that this is what happened. Vicky has had previous children taken away from her by CPS. The worker, the attorney for the child, and the therapist all described the mother as having an “anger management” problem. Rather than viewing Vicky as bonded with her child and upset by the removal, her*

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anger at the situation was viewed as pathological. No effective policies or practices are in place to orient workers to contextualize behaviors of parents and children in their overall assessment and in documentation.

Similarly, a caregiver in a focus group described becoming upset with a worker who suggested that she might remove a child from the caregiver if she did not comply with a particular service. The caregiver said that she became upset and yelled at the worker. She believed that she was labeled by that worker and that subsequent workers seemed wary of her and referred to her “aggressive” nature. This woman’s participation in the focus group demonstrated impressive warmth, a sense of humor, and compassion for her grandchildren.

These labels were also applied to African American youth. The Review uncovered many situations of youth leaving their court ordered out-of-home placements and returning to their immediate or extended family. These youth were labeled as “running away.” However, in conversations with representatives of the police department, officers described that they first search for these youth at their families’ homes or their neighborhood and almost always found them there. In observations and as reported to the investigation team, youth whom the police found were shackled and taken to the CPS intake office. Again, some of the case files merely described youth as “running away”, and did not contextualize *to where* they ran and *why*. Rather than assessing the situation, motivation and possibly re-assessing placement options with the youth and family, youth were punished and removed by police and in some cases placed in a detention center. In Wayne County, the majority of the youth whose behavior was criminalized were African American.

In several case files of African American families, workers described a parent as “denies history of substance abuse.” The case file contained no documentation of any past or current substance abuse problem. In case files of Caucasian families with similar documentation, workers described a parent as having “no history of substance abuse.” This nuanced language variation exemplifies a faith or belief in Caucasian families and not in African American families and the variation is not based on any specific evidence in the file.

In addition to the examples above, there are many other instances of labeling, particularly African American families, *without context or justification*— labels such as “incorrigible”, “disrespectful”, “uncooperative”, “vulgar”, “deplorable conditions”, “drug addicted”, “bipolar”, “cognitively delayed”, “victim of domestic violence”, to name a few, were replete in case files. Once used, the label is repeated over and over again in case notes, petitions, and other documentation without providing facts to support this label. Nykia, a petite 11 year old girl, was described in case files as “manipulative” and “menacing” without context. These labels followed her in referrals to community-based service providers, schools, and foster care placement.

Besides this type of labeling, the Review process witnessed how the use of language depersonalized all families. Specifically, workers, attorneys and judges referred to parents as

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“Mom” and “Dad” and extended family members as “grandma”, “grandpa”, “aunt”, “cousin”, etc. rather than addressing individuals by their name. In one observation, in the presence of parents of a child, a judge asked if “Mom understood her rights” and then if “Dad understood his rights.” At a TDM meeting, reviewers heard workers referring to a parent in the room as “mom” throughout the entire meeting. These terms, while seemingly benign and descriptive, do not treat individuals with the basic respect and dignity articulated in Michigan’s child welfare philosophy.

**Finding 4: African American families and children have insufficient avenues and access to effective advocacy in negotiating the child protection system.**

Throughout the course of their interactions with the child protective system, the Review documented limited meaningful advocacy for African American children and their parents.

***Inconsistent and limited participation of parents and youth in TDM meetings***

One of the first opportunities for parents to advocate for themselves is at the TDM meeting where removal of the child is discussed. In the 20 TDM meetings observed, reviewers witnessed youth and parents *spoken about* by professionals but not *spoken with*—that is, they were not engaged as part of the team in a working relationship. Some parents and youth stated that they were never informed by workers that family members or friends could accompany them to the meeting to provide support. Meetings observed were often dominated by service providers. Even when parents and youth shared relevant information about placement options and services, these ideas were often not reflected in the report of the meeting. Parents and youth who did attend were required to sign the report as proof of their attendance. In Wayne County, these reports are forwarded to the Court with the recommended course of action although these reports did not reflect whether families participated and/or agreed with the recommendations. Thus, judicial officers rarely have knowledge of any dissent or alternative ideas presented at the meeting. This problem is compounded by limited advocacy and support for parents in the court, as described below. *The TDM meeting in Nykia’s case was held and all the adults agreed that Nykia should return home to her grandmother with intensive family counseling. Yet Nykia’s concerns about her safety in her home were not heard by the adults at this meeting. When she waffled about going home, the judge determined that she should stay in foster care, causing Nykia to “act out” in the court room. Nykia expressed to the QSR reviewers that her voice was not heard at the TDM meeting or in the court room.*

***Problematic court protocols that limit and in some instances mute the voices of parents and youth***

Parents and youth face many hurdles once they become engaged in the court process. In both Wayne and Saginaw Counties, there is no public transportation to the court houses making it difficult for individuals without cars to attend hearings and advocate for themselves. Persons entering Wayne County Family Court are required to leave almost all personal possessions

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behind and personal property is confiscated. For example, an African American youth sat for a long time outside of the court house with his new cell phone trying to decide if he should enter the court building to attend his hearing or permanently relinquish his cell phone to the court security personnel. Reviewers entering the court had many seemingly random items confiscated including spoons, dental floss, and compact mirrors. Court security officers do not return “confiscated property” (signs are posted advising the public of this). Such measures seem unnecessary and are far more invasive than federal security standards at airports. Judges and lawyers could not provide reviewers with a rationale for this security system. Because of these measures, families feel forced to leave their possessions in their cars—and cars are frequently broken into while families are in court.<sup>37</sup> Again, while this unwelcoming experience is applied to all families, it predominantly affects African American families because they make up the vast majority of families entering the Wayne County courthouse.

Once in the courtroom, parents were observed being unable to address the Court directly. Parents attempted to seek clarity on the court proceedings and offer factual information about their child, their family or the services their family had received. These parents were hushed by their attorneys or directed (sometimes sternly) by the judge to only speak through their attorneys. The court practice is to have parents and youth speak primarily through their attorneys, yet as described below, these attorneys have such high caseloads and limited time that most are unfamiliar with the unique situation and needs of their individual clients.

### ***Weak legal representation for parents and youth***

As in most jurisdictions throughout the country, attorneys for children and parents in Saginaw and Wayne Counties have high caseloads and receive limited financial compensation from the courts for their work. In some instances, attorneys reported caseloads of over 200.<sup>38</sup> Most attorneys also maintain a separate practice of private-pay clients to supplement their contract with the courts.<sup>39</sup> As a result, attorneys frequently engaged a substitute attorney to appear in court due to conflicts in scheduling. Given this scenario, it is not surprising that the Review found minimal evidence of parents’ attorneys and Guardians Ad Litem (GALs) providing zealous advocacy for their clients.

Attorneys identified as key barriers to adequate client-representation the limited compensation from the courts for their time representing clients and the fact that the majority of their compensation is for time spent in court. From the interviews and focus groups with attorneys, it was determined that few, if any, attorneys file written motions in court to ask for the early return of a child to their families of origin, rather attorneys wait until next court hearing (which could be up to 91 days away) to make verbal requests for a child’s return. In Wayne County, attorneys identified a financial disincentive for drafting appeals for their clients. Nearly all of their compensation is for court time, and they are rarely compensated for drafting motions or communicating with clients. Interestingly, most of the appeals regarding court decisions come from the attorneys for parents, yet they receive the least compensation. GALs filed few, if any court motions on behalf of their clients. In cases reviewed and in focus groups, Caucasian

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families appeared more likely to hire private attorneys to handle their cases and were more likely to feel that their attorney's advocated for them sufficiently.

Attorneys also spoke of their compromised capacity to gather information independent of the DHS petition and reports as they do not have resources to hire independent investigators or other professionals or to make collateral contacts with other service providers. Attorneys and parents described inadequate preparation time for discussing a client's case before a court hearing. Most frequently, the only preparation is exchanging information in lowered voices outside of the court room. Private meeting rooms at the court house are quite limited and thus the ability of attorneys to adequately understand issues critical to effective representation is severely compromised.

Fathers of children involved with CPS frequently had no legal advocacy available to them. Under Michigan law, if a man was not married to the mother of his child at the time of their child's birth, was not listed on a child's birth certificate, or had not signed a declaration of paternity, he has no legal standing at court and thus no entitlement to legal representation.

In the state of Michigan, GALs must represent their clients' "best interest." Some GALs also present to court their clients' stated interest if a client's wishes differ from their "best interest" determination. GALs and judicial officers do not encourage youth to come to court because "they would be sitting around, missing school." While this may be true, it severely limits youth's ability to advocate for themselves. This is a serious problem especially because many youth reported rarely interacting with their attorney or even knowing their name and contact information. This was particularly true for youth who were "dual wards", simultaneously involved in both the child protective and juvenile justice systems. It was clear from interviews with GALs and youth that the "best interest" standard is vague and guided by the individual decision of the GAL who may or may not thoroughly understand the case. GALs reportedly received no meaningful training on the "best interest" standard or how to go about making that determination.<sup>40</sup> The potential for racial bias in this area was readily apparent to reviewers. The attorneys working in family court were overwhelmingly Caucasian and lived in more affluent neighborhoods than their clients' communities. In interviews, it was clear that some attorneys recognized the importance of maintaining family ties, but they consistently reported the value of placing children outside of their communities in order to be exposed to better educational and cultural opportunities and were likely to be imposing that view in a "best interest" judgment.

The youth interviewed seemed disengaged from the court process and had insufficient access to court approved plans for their future. Youth separated from their siblings spoke passionately about their desire to reunite with their brothers and sisters. GALs who represented all children in a family did not always let youth know where their siblings were placed. Youth involved in both the child welfare and juvenile justice system spoke of not being visited by their attorney or GAL while in detention, did not know who was or how to contact their attorney, and not being apprised of when they might be released from the juvenile detention facility. Detained youth

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reported they did not know to where they were being transported, often learning of a destination from the bus driver.

*Limited access of parents and youth to other forms of advocacy*

The Review briefly assessed other sources of advocacy. The Parent Partner program in Wayne County is a peer advocacy program to assist parents in negotiating the child protection system. This program is one of the few advocacy programs for parents—one that most saw as a promising strategy to enable parents to successfully negotiate the child protection system and reunify with their children. Court Appointed Special Advocates (CASAs) are also available on a limited basis for children and youth. In a focus group of foster parents, CASA was viewed as particularly helpful in accessing specific services for youth. In Saginaw County, however, this service is disproportionately made available to Caucasian children. Finally, there is an Ombudsperson, a vehicle for registering complaints about the handling of cases for parents and youth. Information about this service is found primarily through the internet. Given the economic limitations of so many parents and youth, particularly African American families, the Ombudsperson is not equitable as an effect route for case advocacy.

**Finding 5: The child welfare system does not have sufficient mechanisms to hold DHS and providers accountable for the equitable treatment of African Americans families and youth.**

*Differential Treatment of African American Families with low or no risk factors*

The Review found that DHS initiated dependency proceedings for African American children and families based on a wide range of situations which may or may not have been related to child safety or risk. No qualitative assurance mechanisms were found to correct for this. In particular, there was great variation in the manner in which African American and Caucasian families were treated when illicit drug use was involved. Case files for African American families did not consistently document what drugs were used by parents, with what frequency drugs may have been used, and how the drug use negatively impacted a parent's ability to safely care for their children. Information gathered from records and focus group participants pointed to marked differences in the system's response to drug use by Caucasian versus African American women in similar circumstances. In a focus group of African American and Caucasian parents with substance abuse issues and who had experienced a CPS removal of a child from their custody, African American mothers described the removal as occurring at the hospital after they had given birth. No African American parent was given the opportunity to have in-home supportive services while parenting their child. Yet Caucasian parents described being given the chance to have in-home supportive services after their child tested positive for drugs at birth. One of these parents received continued support from DHS despite testing positive for drugs over the course of a year while caring for her child in her home.

*Weak systems of monitoring existing services and holding providers accountable for quality services delivered in an equitable manner*

One of the most troubling findings of this Review was that several service providers were not providing services in predominantly African American neighborhoods, even though they were contracted by DHS to do so. For example, DHS contracted with a provider in Saginaw County,

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to support parents with children from birth to 3 years old with home-based services. However, the provider did not provide services to African American families on the “East Side” because of their apparent concern for worker safety. Interviews with workers and community providers exposed that at least two other agencies in Saginaw were failing to provide home-based early intervention services to families living in the East Side.<sup>41</sup> Such a refusal posed an undue burden on African American family members who were required to travel outside of their communities in order to attain services or comply with court ordered services. This phenomenon is indicative of, among other things, a weak system of monitoring contracted providers. While DHS monitors service provider contracts on a yearly basis. This current monitoring did not assess whether service providers were giving services to all clients equitably. As a result, providers were in effect allowed to selectively give services to children and families.<sup>42</sup> The Review briefly examined factors that contributed to DHS’ minimal monitoring of service providers. Based on interviews, it was clear that such a large and poorly resourced organization devoted little time and resources to measure the qualitative, comprehensive interactions between service providers and families.

In addition to examining the equitable distribution of services, this Review found little evidence of monitoring for the *quality* and the *cultural relevance* of the services provided. In particular, the quality of individual therapy, psychological, and psychiatric evaluations appeared insufficient. In both Saginaw and Wayne Counties, case record reviews documented several examples of the names of other clients appearing on psychological evaluations, suggesting that providers were merely “cutting and pasting” reports together. Additionally, several of these evaluations repeated information from the case files that was incorrect, thus raising questions about the extent of time that evaluators spent with clients and whether they asked them for information independent of what they obtained from the caseworker’s file. Again, there was no evidence of institutional policies and practices to hold these practitioners accountable for the quality of their work.

Clients were not consulted in selecting providers and compliance with services seemed to trump behavioral change or other benefits to the client. For example, in a focus group of parents, several of the African American women revealed that they sought out the support of faith-based programs to assist them with resolving their drug addiction. Many of the women failed to remain sober through the traditional drug treatment services to which DHS had referred them but were treated by and remained sober as a result of faith-based programs. However, the DHS workers did not know of these faith-based services, nor did the Review find strong policies and practices that would help a worker recognize the value of such a service in helping clients get and remain sober. The focus group participants spoke of non-traditional services not being acceptable to DHS or the court. Case record reviews found that individuals were referred to the same set of limited contracted service providers by DHS. These faith-based service providers were not contracted with DHS and thus their services were not sufficient proof of treatment for DHS and the courts. Yet these were the very service providers who were identified by parents as effective in helping them remain sober.

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The Review found numerous examples of services or interventions, meant to assist African American families, lacking cultural relevance. Parenting classes, a common service ordered by the court, used a one-size-fits-all curriculum. They were described by parents, caretakers, and DHS caseworkers as not particularly useful or relevant and not based on the unique needs of families. Service providers spoke of altering standardized parenting curricula to fit the reality of African American parents, despite the realization that this was not acceptable practice at their respective agencies.

There was no evidence that workers or clients had an institutionalized means available to provide feedback (both positive and negative) on the experiences with DHS contracted services. Many families and youth expressed frustration with the quality of services and reported their frustrations to their workers and attorneys. However, there were no corrective action steps taken with these service providers, nor alternative services provided to them. In interviews with workers it was clear that they knew that some of the services to which they referred clients were not effective; however, workers described feeling helpless to hold other service providers accountable.

### ***Mistaken petitions and policy misinterpretations***

Based on the case record reviews and interviews and focus groups with parents, a significant number of attorneys failed to object to mistakes in petitions or policy misinterpretations. In the 60 case files reviewed, the vast majority had significant, repetitive errors in documentation. Errors ranged from the number of adults in the home to the services provided to a family by DHS. The predominance of errors in documentation is not only reflective of poor systems of accountability within DHS, but also the lack of accountability for legal advocates and judicial officers. Interviews and observations documented parents' attempts to correct legal petition errors and DHS report errors, but it was clear from the case record review that these efforts, even when successful for a single document, did not translate into a subsequent correction in other case record documentation.

In Wayne County, some judicial officers assume that holding the TDM meeting is evidence that *reasonable efforts*<sup>43</sup> were made to prevent the removal of children. Judicial officers described reading the TDM meeting reports to ensure that efforts were made. However, TDM meetings in and of themselves do not necessarily constitute reasonable efforts. This is a misinterpretation of policy and practice. In fact, many parents chose not to attend TDM meetings because they were uncertain of the purpose of the meeting and intentions of the CPS workers, others felt that workers would not listen to them in this initial meeting. Service providers interviewed for QSRs and the IA echoed this opinion. There was no evidence that attorneys made any objections based on reasonable efforts and one judicial officer reported that any objection on reasonable efforts would be "a losing argument." *Sarah initially received services from a community based agency that worked with cognitively delayed parents. However, when this service was disbanded, she was expected to comply with services designed for much higher functioning parents. There is a question about whether this in fact constitutes reasonable efforts.* The court and attorneys reported that a determination that reasonable efforts were made is based on the services currently available in

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the community—not if the services can be appropriately used by the parent. This interpretation, while applicable to all families, uniquely disadvantages African American families since there were far fewer appropriate services available and accessible in their communities.

Attorneys and judges made few objections to the policy misinterpretations. As previously described, the Binsfeld provisions regarding the removal of subsequent children and the policies surrounding the placement of children with extended family were frequently misapplied.

***Attorneys have little or no accountability to parents, children, or courts.***

The Review collected significant evidence through focus group interviews that parents' attorneys were difficult to reach and that youth had no idea of the name or contact information for their attorneys. Many parents and youth experienced their attorneys as being aligned with the court and with DHS and not function as their advocates. No one interviewed understood that they had a right to ask for a new attorney if they felt they were inadequately represented.

Parents and youth interviewed in focus groups did not understand court proceedings or the standard of representation they could expect from their attorneys. From the QSR, it was apparent that the parents' attorneys did not explain the repercussions of voluntarily relinquishing their children on their ability to parent future children (Binsfeld law). *Vicky, Imani's mother, believed that she could voluntarily relinquish her two oldest children without that decision affecting her ability to reunify with Imani. She had contacted her attorney regarding the relinquishment and the attorney agreed to compile the needed paperwork. It was clear, however, from discussions with the Reviewers that Vicky did not realize the implications and that her social worker was already finding an adoptive home placement for Imani.*

In both counties, there is an explicit expectation that GALs visit with their clients. However, in Saginaw a significant number of attorneys did not visit their clients on the "East Side" where African American clients live because of apparent safety concerns. In Wayne County, attorneys were observed telephoning their young clients the day before the court proceeding rather than visiting with them. Judicial officers asked GALs if they had visited with their clients and the GALs admitted they had only communicated with the DHS worker. In these instances, the court proceeded with the case without meaningful input from the youth involved. In speaking with Judges, it was clear that they are aware of the limited interactions attorneys have with their clients, but they feel that due to limited resources (i.e., attorneys are paid so poorly and had high case loads), that there is little if anything they can do to hold attorneys accountable to quality representation of parents and youth coming into the system. A focus group with youth in Wayne County's juvenile detention center (some of whom had a history of child welfare involvement) revealed that most did not know the name or contact information of their guardians ad litem.

**Concluding Thoughts**

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The Review found a pervasive lack of awareness of racial disproportionality and disparity among individual caseworkers, attorneys, and judges interviewed. Many interviewed questioned the validity of the data on racial disproportionality and disparity. Some believed this data is solely related to the consequences of poverty and not to racial bias or inadequate methods of working with people from diverse cultural backgrounds. While viewing poverty as the sole cause for disproportionality is a common first reaction to this problem across the nation, few practitioners understood how the imposition of a singular way of working with families regardless of their cultural background and circumstances can lead to structural bias and poor outcomes for African American children and families. Some practitioners had great difficulty discussing race or reflecting on how the policies and practices that guide their work might negatively impact families of color (using such phrases as “color blind” or “everyone is the same to me”). Most interviewees attributed racism in the child welfare system to the “fault” of individuals as opposed to considering how racism is embedded in institutional structures. As a result, reviewers experienced significant defensiveness and there were few discussions about ways to systemically undo those practices.

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## RECOMMENDATIONS

The following recommendations are based on the findings in the Review. These recommendations are designed to be implemented together to create institutional change that will assure racial equity for children and families who come into contact with the child welfare system. At the request of DHS, these recommendations are as detailed as possible.

### **1. DHS must build the internal leadership capacity to ensure that the Department functions in an equitable, fair, and responsive manner.**

- Staff development
  - Top leadership and managers must be trained and retrained on the dynamics of race and child welfare using an anti racism approach, such as that used by participants in the Race Equity Review, as part of creating an environment which is amenable to addressing institutional racism.
  - DHS should develop a communication strategy that will provide top leadership with a consistent way of talking about this issue to the larger community and engaging the community in equity efforts.
  - DHS should work with consultants to develop and implement specialized training for supervisors on supervising for racial equity in child welfare.
  - New worker and supervisor training curricula must include an understanding of racial disproportionality and disparity in child welfare.
  - DHS should work with its partners to provide cross systems training on racial equity and child welfare (such as training leaders and workers in juvenile justice system, the mental health and health fields, and the courts).
- Internal leadership and management of change
  - DHS must develop an internal leadership group to provide strategic and tactical direction for the racial equity work and that involves various levels of the organization and is ethnically diverse.
  - The leadership team must be provided with necessary financial support and other resources to develop a strategic plan for racial equity.

### **2. DHS must use relevant and reliable data driven management for racial equity.**

- DHS central office must develop routine data reports that look at critical decision points in the child welfare system by race/ cultural groups.
- County offices managers, among other leaders, must also have this data capacity and be trained to use data to manage their organizational units and to problem solve based on the empirical findings.
- DHS should provide an annual report to the public of progress on remedying racial disproportionality and disparities. This report should track the changes in system performance as it relates to racial inequities and outcomes for children and families.

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**3. DHS must clearly articulate and implement a case practice model which translates DHS' philosophy into policies and practices and is informed by an understanding of racial inequities.**

- The philosophy must be operationalized to serve as a practice guide for frontline staff and external practitioners. This guide must recognize cultural differences of families and promote fairness and equity.
- Some systems structures will need to be amended to support the practices inherent in the philosophy. For example, for families to be actively included in TDM meetings and other decisions that affect them and their children and for children to have a voice in decisions that affect them, business hours will have to accommodate family members' school and/or work schedules. Efforts also must be made to ensure that providers can actively participate in meetings.
- Supervisors and workers must be regularly held accountable for implementing the case practice model. Personnel appraisal process should include assessments of the quality of their practice, their cultural competency, and outcomes for the parents and children on their caseload.
- DHS must build an internal quality assurance review that annually evaluates the quality of practice and examines racial differences in outcomes. Parents and youth with previous child protection experience should inform the review process.

**4. DHS must correct current policies and policy misinterpretations that disadvantage children and families of color. Further, DHS must build the capacity to identify and correct future policies.**

- The policies interpreting the Binsfeld legislation must be clarified so that all supervisors and workers understand the required assessment of the safety of children and the current capacity of parents to protect children. Clarification should be done through training, memos to the field, and other identified means.
- Kinship care requirements must be clarified and workers trained on these requirements and expectations.
  - DHS should consider a policy that provides a preference for relatives and requires, before placement in foster care, an affirmative ruling out of relatives who volunteer to care for the child/ children.
  - Training of staff should include:
    - information about the flexibility of the caretaker age requirement;
    - information reinforcing the use of waivers and expectation that workers ask for waivers when appropriate; and
    - skills to work with kinship care families and manage the tension between family members and resolve the permanency status of the child.
- Quality assurance mechanisms should be conducted regularly to evaluate that policies are being implemented as intended and are not disadvantaging families of

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color. Mechanisms can include qualitative case reviews and focus groups with parents, youth, and DHS staff.

**5. The risk assessment tool must be further examined and its implementation improved.**

- The risk assessment tool
  - The risk assessment tool and protocol need to be rigorously evaluated to ensure that the weighting/scoring system does not inappropriately disadvantage families of color.
- The implementation of the risk assessment tool
  - Supervisors must be trained and supported in making sure that the protocol is implemented as intended, that is, it is used to facilitate decision making rather than to justify decisions.
  - The quality case reviews described above must also examine the implementation of the risk assessment protocol and provide feedback to staff on any implementation issues.
  - The tool itself must be recalibrated regularly -- at least within the guidelines of the Children's Research Center.

**6. Resource providers that contract with DHS must provide fair and equitable services.**

- DHS offices must ensure that an array of contracted agencies provides relevant, needed services in all geographic areas of a community; and that these agencies fairly and sufficiently serve and are accessible to the African American communities from which children are most likely to be removed.
- DHS must assure that the contracting process includes an assessment of the ability of providers to meet the needs of discrete racial, cultural, and linguistic populations.
- Providers should be routinely evaluated based on:
  - the quality of service;
  - the outcomes for all families and children, and for different racial and cultural groups;
  - consumer feedback on satisfaction and effectiveness; and
  - the ability of providers to locate in the communities from which children come and/or the access to public transportation to the sites.

**7. DHS must build external partnerships in working for equity.**

- Steps to build this partnership include:
  - Reconvening the Taskforce on Racial Equity, sharing the findings of the report and engaging this group in the development of the strategic plan, monitoring progress, reporting to the public, and advocating for the changes necessary to better respond to the needs of families and children of color.

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- Working with the Taskforce to educate professionals and community members about racial disproportionality and disparity in the child welfare system.
  - Beginning a dialogue with the residents, including civic and religious leaders, of the geographic areas from which children are most likely to be reported in a discussion about the data for the neighborhood, the need for community engagement, and the need to promote community based strategies for keeping children safe.
  - DHS should work with this partnership to invest in a prevention system for families.
    - A sufficient array of community-based supportive resources for families must be identified and supported.
    - A set of DHS workers should be redeployed as prevention workers in public schools with the highest referrals to child protective services. These workers will be tasked with providing information and referrals to appropriate community-based prevention services for families in need.
    - DHS should work with mandated reporters in the communities from which children come to identify community-based prevention and early intervention resources that can be used to divert families from the child welfare system.
    - The partnership should also work together to address the lack of housing, transportation, and other resources for families in their communities.

#### **8. DHS should collaborate with the courts to improve the quality of legal decisions.**

- Using the resources of Michigan State Court Improvement project and the National Council of Juvenile and Family Court Judges' Court Catalyzing Change Initiative, cross training for judges and child welfare administrators must be developed that will provide information on racial disparities and disproportionality in child welfare and juvenile justice systems. Such training will also strengthen the courts oversight of racial disparities and disproportionality.
- When available, DHS should provide the judiciary with the tools being developed by the National Council of Juvenile and Family Court Judges to provide guidance to judicial officers on the issue of race equity.
- Courts should track their overall performance on child welfare and juvenile justice cases, and should specifically trace the status of different racial/cultural groups on measures such as:
  - Length of time to disposition,
  - Length of time to permanency,
  - Continuances, and
  - Coordinated child welfare and juvenile justice proceedings.
- Judges should exercise their oversight role actively to assure that families and children of color are being adequately served (by culturally appropriate resources--formal and informal) and that the decisions being made are not unnecessarily intrusive.

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- DHS and the Courts and the Legislature should aggressively work together to improve access to quality representation for children, youth and the parents of children who are, or have been, removed from their families.
  - DHS and the courts should work with the CASA program to ensure equitable distribution of their services.
  - Additional advocacy efforts, such as the Parent Partner program, should be evaluated for effectiveness and expanded.

**9. Michigan’s child welfare and juvenile justice system leaders must work collaboratively to explore policies and practices which meet the specific needs of dual ward youth.**

- Accurate data on dual wards need to be available for planning and service purposes.
- Joint case planning conferences for dual ward youth should be implemented immediately. These conferences need to be held, involving representation from the child protective and juvenile justice agencies, the youth, parent or caretaker, to develop a coordinated plan and clarify assessment and case planning responsibility.
- Law enforcement protocols for bringing youth into custody need to be modified to be age appropriate and to minimize trauma to the youth.
- Further qualitative study needs to be done of dual ward youth to identify the policies and practices that contribute to the problems in serving these children. Among the issues to be examined are:
  - Coordination of service;
  - Coordination of the legal proceeding;
  - Management of psychotropic medication;
  - Policy clarity and training;
  - Improvement of legal and social services so that youth are engaged in decisions made about their lives and in the services they receive; and
  - Unnecessary criminalization of youth behavior, particularly “running away” from foster care placements.



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## APPENDIX A

### Michigan Race Equity Review:

*Avenues for future inquiry into policies and procedures affecting children involved in the both the child protective and juvenile justice systems*

As part of a broader effort to examine racial disproportionality and disparity in the child protective system, the state of Michigan's Department of Human Services (DHS) asked a team of national experts, state and local leaders, and state and community stakeholders to assess the impacts of its policies and protocols. This team, led by the Center for the Study of Social Policy (CSSP), designed and implemented a qualitative Race Equity Review (Review) to assess the *institutional* features of Michigan's child protective system that directly produce or contribute to racial disproportionality and disparity. Methodology and findings of the Review are discussed in depth in the full report, *Race Equity Review: Findings from a Qualitative Analysis of Racial Disproportionality and Disparity for African American Children and Families in Michigan's Child Welfare System*. The Review primarily focuses on the experiences of African American children and their families in Saginaw and Wayne Counties' child welfare systems.

In a parallel process, Public Policy Associates, inc. (PPA) entered into a contract with DHS' Bureau of Juvenile Justice (BJJ) to help identify and describe the treatment of dual wards – youth simultaneously under the jurisdiction of Michigan's juvenile justice and child protective systems. As part of this contract, PPA undertook to identify policies, programs, decisions, and procedures that put children, youth, and families of color at a disadvantage in Michigan's child welfare system. In an effort to look at the systemic factors that contribute to youth involved in the child protective system subsequently becoming involved in the juvenile justice system, PPA formed a partnership with CSSP and joined the Race Equity Review already underway in Wayne County in the spring of 2007.

As part of the Review, the team conducted a qualitative assessment of the experiences of youth who were dual wards in Wayne County. Further, a specialized team with juvenile justice expertise was directed to examine how child welfare policies and protocols interacted with juvenile justice policies and protocols. Specifically, the study looked at how the county's juvenile justice and child protective systems interacted in coordinated case planning, service delivery, and treatment for dual wards. Although this aspect of the Review included only a very limited case sample and only looked at experiences in Wayne County, the Review team uncovered practices and policies that suggest problematic treatment of dual wards. Further examination is necessary to determine the prevalence of these issues and the potential statewide implications. Additionally, the sample size was too limited to make conclusive findings regarding the effects of racial disproportionality and disparity on the dual ward population.

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## Background on “dual wards” in Michigan

For the purpose of this discussion, “dual wards” are youth who are determined by the court to come under the jurisdiction of both the child protective and juvenile justice systems simultaneously. In Michigan, there are several processes through which young people become involved with both of these systems. Typically, youth come to the attention of the child protection system first. Once a youth is in the custody of the child protective system, and s/he is subsequently found guilty of committing a delinquent act, the case will move forward in one of two ways: (1) The juvenile justice system assumes full jurisdiction over the youth and the child protection case is closed or (2) both systems maintain jurisdiction and/or custody, and the youth becomes a “dual ward”. There are some instances where youth are placed in a detention or another juvenile justice out-of-home setting first, and their parents or legal guardians subsequently refuse or are unable to care for them once they are free to return home. In these cases, the child may simultaneously be declared a dependent because of “abandonment” or the “lack of parental supervision.”

In Wayne County in FY2007, approximately one in four committed juveniles had an abuse-neglect placement history. This was significantly more prevalent among females than males.<sup>1</sup>

- 23.8% of committed juveniles were verified as previously placed out-of-home, prior to delinquency adjudication.
- 35.6% of female committed juveniles were verified as previously placed out-of-home prior to delinquency adjudication.
- 20.6% of male committed juveniles were verified as previously placed out-of-home prior to delinquency adjudication.

Unfortunately, these data include both dual wards and youth that have previously experienced out-of-home placement due to neglect and/or abuse but are now under the sole jurisdiction of the juvenile justice system. In Wayne County, the data system utilized by the Juvenile Assessment Center (JAC) is not designed to report specifically on dual wards.<sup>2</sup> This data system is problematic, and makes it impossible to readily know how many dual wards there are in Wayne County.

According to snapshot data from May 2007, there were 153 dual wards in Michigan (Table 1). These data include youth placed in Wayne County for treatment by the state system, but do not include youth under the jurisdiction of Wayne County, which operates its own juvenile justice

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<sup>1</sup> Comprehensive Statistical Report through Fiscal Year 2007 Juvenile Justice Services: Wayne County Care Management System.

<sup>2</sup> Since agency-specific data systems are rarely integrated, it is difficult to determine the national prevalence of crossover youth (young people that have started in one system and moved to the other) and dual ward youth (young people under the jurisdiction of both systems at the same time). However, it is clear that this population is sizable (see Herz, Denise and Joseph Ryan (2007). “Building Multisystem Approaches in Child Welfare and Juvenile Justice”. Washington, DC: Center for Juvenile Justice Reform, Georgetown University).

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interventions (through the JAC). Data for youth under Wayne County’s jurisdiction are not easily produced and were not available from the state in time for this report.

As described above, dual wards are under the jurisdiction of both child welfare and the juvenile justice systems. Each of these systems has their own mandates, authority, policies, and structures. To meet the needs of dual wards and address issues of disproportionality and disparity, it is necessary to examine the experiences of these youth and the extent to which each system responds, both individually and collaboratively, to their needs. This paper discusses the Review approach and sets forth some preliminary observations that require further study.

### **Methodology: Quality Service Review and Institutional Analysis**

The Michigan Race Review operates on the assumption that institutions organize workers to think and act in specified ways. This specific Review analyzed the policies, procedures, and protocols that control service delivery and decision-making for children who were reported for child neglect and how these factors contribute to racial disproportionality and disparity in the child protection system. The Review also illuminated problematic policies and practices of other intervening systems such as the court system, mental health system, and juvenile justice system.

The following research question guided Michigan’s Review:

*“How does it come about that, after a substantiation of child neglect, African American children are more likely to be removed from their homes?”*

A part of this Review looked in a limited way at the experiences of four youth involved in both the child protection and juvenile justice systems in Wayne County. For these youth, the review team sought to identify how policies, procedures, and decisions in the child welfare system contribute to juveniles moving from the child welfare system to the juvenile justice system.

The Review analyzed substantiations of child neglect and subsequent decision-making regarding removal of a child from his/her home. Data from Michigan, similar to those of other states, also show that a substantiation of child neglect (rather than a substantiation of physical or sexual abuse) is more likely in investigations involving African American and Native American children. It is noteworthy that neglect, unlike physical abuse and sexual abuse, is often ill defined and subjectively assessed.

The Review team collected qualitative data using two well-tested tools—the Quality Service Review (QSR) and the Institutional Analysis (IA). The QSR provided an in-depth examination of the current state of case practice through a detailed review of a selected number of cases. Information from the QSR used to inform to the IA process, which provided a broader examination of policies and administrative practices of the child welfare system and its partners.

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The QSR is a case-based assessment of the effectiveness and quality of human services interventions with children and their families. A lead reviewer and a shadow (often a DHS staff member or community leader) used a QSR protocol for conducting a guided professional appraisal of the:

- Status of a child receiving services,
- Status of the parent/caregiver, and
- The connection between the family's needs, the assessment, service plan and implementation and the results.

In Wayne County, reviewers conducted a total of sixteen QSRs – four of these youth were dual wards (two were Caucasian and two were African American). All of the dual ward youth were initially involved in the child protection system (either a report had been made or jurisdiction over the child granted) and all subsequently became involved in the juvenile justice system for a variety of reasons. For these youth, data was collected from the following sources: DHS caseworkers, probation officers, court referees, therapists, psychiatrists, community-based service providers, mentors to youth, lawyers-guardians ad litem, school social workers, parents, foster parents, and youth themselves.

The Institutional Analysis (IA) is a process that uncovers how the design and implementation of case processing structures produce unfair, ineffective, and often unintended outcomes for children and families. The tool was adapted to examine the policy and practice issues that may contribute to disproportionality and disparate outcomes for families and children of color. An Investigation team conducted the IA. In Wayne County, the team was comprised of child welfare administrators, advocates for parents/children, child welfare data managers, child protective workers, community based providers, parents and foster parents who have experienced the child protection system, and consultants from CSSP, PPA and other national organizations. The team broke into smaller working groups charged with collecting qualitative information through interviews, focus groups, observations, and document analysis. The smaller working groups reconvened, presented their data, and synthesized information so that broader themes could be determined. For a more in-depth discussion of both qualitative tools and methodology, please see the full Michigan report.

Although this Review primarily focused on the disparate experiences of children and youth of color who are involved in the child protective system, the Wayne County examination of four dual wards identified areas of concern, raising questions about the ability of both the child protective and juvenile justice systems to meet the needs of these children. Due to the small sample size, the following identified areas cannot be generalized county-wide or statewide, but rather require further inquiry to document the areas where remediation is needed.

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## **Problematic policies and practices that may contribute to racial disproportionality and disparity for “dual wards”**

Amendments to the Juvenile Justice and Delinquency Prevention Act (JJJPA, P.L. 107-273) recognized research confirming the link between child abuse and neglect and juvenile delinquency. As a result, JJJPA now requires states to coordinate the efforts of child welfare and juvenile justice systems. More funding was also made available for prevention programs that target victims of child abuse and neglect. Examples of required mandates in P.L. 107-273 include:

- Juvenile courts should now have access to public child welfare records related to juveniles before the court;
- The establishment of policies and systems that incorporate CPS records into juvenile justice records when creating treatment plans; and
- Assurances that juveniles whose placements are funded by Title IV-E Foster Care receive the specified protections, including a case plan and case plan review.

The Investigation team found that these mandates were not regularly incorporated into the policies and practices of the child welfare and juvenile justice systems.

### ***1. Lack of policy to guide coordination between the child protection system and the juvenile justice system results in conflicting practice with youth***

During the Wayne County Review, interviews with various stakeholders who have encountered dual ward cases revealed that no one was able to identify a specific policy that addresses how to work with this population or how to work collaboratively across systems. Observations and further interviews confirmed that this policy void has resulted in inconsistent practice in both systems. For example, workers could explain how a youth under the jurisdiction of child protection could legally be declared a “dual ward” or solely a “delinquent ward”, but they did not know the factors that determined each outcome. Furthermore, according to workers, if a youth becomes solely a delinquent ward, the foster care worker is to provide the Juvenile Assessment Center (JAC) with all the youth’s case information to be included in the JAC’s initial assessment. However, interviewees were uncertain as to whether this actually happens consistently. The procedures they identified are outlined in a Memorandum of Understanding (MOU) between Wayne County DHS and JAC, but this MOU was not readily known nor easily accessible to workers interviewed.

Due to the lack of policies relating to treatment of dual wards, both agencies engage in practices that can conflict and /or interfere with the appropriate treatment of youth in their care. According to several juvenile justice workers, foster care workers for dual wards have limited information regarding what is occurring with the youth. The two management information systems are unable to exchange information. A foster care worker cannot readily access information the delinquent case and vice versa. When youth are moved by the juvenile justice

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system (or if they are missing), the foster care workers often do not receive notification. In the cases reviewed, this lack of communication resulted in conflicting case plans, unclear roles, and undefined responsibilities.

## ***2. Lack of engagement of dual wards by those responsible for their care***

Investigation team members heard from youth through focus groups and interviews that few knew of the plans being made for them by caseworkers, juvenile judges, and probation officers. Youth reported that they were not visited in detention facilities by their DHS workers. This was particularly troubling for youth whose parents' rights had been terminated. These youth were only authorized to call DHS workers or their lawyers; no family members could be contacted. However, it seems that these same youth were nearly abandoned by the state – reporting that they had neither knowledge of, nor spoken with, the lawyer- guardian ad litem (L-GAL) and caseworkers now responsible for their care. Each youth is assigned an L-GAL to advocate for his/her “best interests”. With such limited presence observed, it calls into question how effectively L-GALs fill this important role. Youth also reported not understanding what would happen to them after entering the Juvenile Detention Facility. They did not know how long they would have to stay at the detention facility, what their long-term case plan would be, or where they would be placed next. This raises major concerns about the quality of representation from all parties assigned to the case.

## ***3. Uncoordinated approach to psychotropic medications potentially creating significant risk for youth***

Upon entering the detention facility, these youth were taken off all psychotropic medications. This policy purportedly exists so that a youth would have a “clean system” for a psychological/psychiatric evaluation, which occurs seven days after detention placement. However, child protection case plans requiring counseling and medication compliance often were not considered when youth entered detention. In one of the cases reviewed, a youth on medication for depression and attention deficit hyperactivity disorder (ADHD) was removed from her medication. After only five days at the detention facility, she was released back to her home -- before receiving a psychological/psychiatric assessment. Thus, she was off her mood stabilizing medications for nearly a week by the time she returned home – essentially she was setup for failure. As result, she had an altercation with her family several days later and returned to state custody. And once again, she was taken off all her medication. This policy has dangerous and potentially destructive ramifications.

## ***4. Decision making by the courts for dual wards***

Several different stakeholders identified concerns with how the court system in Wayne County deals with dual ward cases. Advocates indicated that despite a Michigan statute (MCL 600-1011), calling for one family-one judge, youth often have several different judges simultaneously. In the cases reviewed, dual wards were seen by one judge for their child protection case, and another judge for the juvenile delinquency matter. Advocates also

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reported that judges and referees tend to “make kids delinquent” because they perceive that the juvenile justice system has more appropriate services for them. Interviews with judicial officers also revealed that they believed that youth would be more amenable to treatment if they were “locked up” in a juvenile justice placement. Further research is necessary to determine whether there are in fact additional services available to delinquent youth that cannot be provided for youth in the child protection system.

*5. Punitively responding to youth in foster care when behavior is “normal” or when therapeutic interventions are required*

Youth, police officers, and lawyer-guardians ad litem identified the issue of punitive treatment for youth in foster care. Youth who leave a court-ordered placement without permission are often placed directly into detention. Police officers reported that the vast majority of youth who go AWOL are running home to immediate or extended family. Rather than examining the reason for their running, the appropriateness of the previous placement, or the suitability of the setting the children are absconding to, youth who “run away” are treated criminally. When police apprehend these youth, the practice is to handcuff and transport them in the backseat of police cars. These situations are exacerbated by the fact that the WEB Unit (police officers who conduct removals of children) has no specialized training in interacting with this population.

Youth who require specialized treatment settings are sometimes inappropriately placed in group homes. These youth subsequently “act out” or get into physical confrontations with other youth or staff. Reportedly, group home practice has been to call the police, who then take the youth to detention.

By way of example, one Quality Service Review case involved an eleven year old girl who was picked up by the police and placed in detention for fighting with her grandmother. However, upon interviewing all parties, it was clear that the grandmother had threatened to have the girl’s father “beat” her, something which had happened repeatedly in the past. This girl spent almost a week in detention and had a domestic violence charge pending. The past abuse by her father was not examined by the juvenile justice system because her grandmother was the legal guardian.

## **Conclusion and Next Steps**

Child protection and juvenile justice systems in jurisdictions around the country share many of the same young people, and struggle to treat these youth appropriately. Despite federal mandates, these systems maintain distinct philosophies and policies and practices and narrow the role of their workers. This results in failure to collaborate on placement and treatment of vulnerable children and youth. The child protection and juvenile justice agencies in Michigan face many of the same challenges. Due to a lack of policies pertaining to dual wards, these young people are often left in the dark about their own case planning, their legal status, and their relationship with their birth families. The court system has the potential to provide

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consistent oversight in these cases, but in reality youth are often seen by several judges who do not understand their involvement in each system. Moreover, youth involved with the child protection system may be at a greater risk of criminal charges for status offenses that are generally not criminalized for youth in stable family situations.

These issues are in dire need of further investigation. Wayne County has a unique privatized juvenile justice system with a single point of entry. Because this is different from all other counties in Michigan and the sample of cases in this Review was so small, the experience of children in Wayne County and several other jurisdictions should be researched to determine whether they share these same struggles. A few counties that contain a high prevalence of dual wards such as Genesee County, Oakland County, and St. Clair County are good candidates for future review. In addition, Wayne County should be examined more thoroughly, and JAC should focus on creating a data report that specifically identifies dual wards. DHS and BJJ should also collaborate and support ongoing qualitative research in order to capture full information about the policies and practices that pertain to dual ward youth throughout the state. In addition, further studies have the potential to understand the institutional features that contribute to racial disproportionality and disparity in Michigan's dual ward population.

Table One: 2007 Dual Ward Snapshot Data from the SWSS System<sup>3</sup>

County Name	Race of Youth				Grand Total
	Black	Native Am.	Other	White	
ALLEGAN				2	2
ANTRIM				2	2
ARENAC				2	2
BARAGA		1			1
BARRY				1	1
BAY				1	1
BERRIEN	2				2
CALHOUN	2				2
CASS	1			1	2
CHARLEVOIX	2			1	3
CHEBOYGAN				2	2
CHIPPEWA				1	1
CRAWFORD				2	2
DELTA				1	1
EATON				4	4
EMMET	1			1	2
GENESEE	3			7	10
GOGEBIC				1	1
GRAND TRAVERSE				2	2
GRATIOT				3	3
HURON	1			3	4
INGHAM	4			1	5
IONIA	1				1
ISABELLA	1			1	2
JACKSON				3	3
KALAMAZOO	1			1	2
KALKASKA				1	1
KENT	1		1	4	6
LAKE				1	1
LENAWEE	1			2	3
LIVINGSTON			1	2	3
MACOMB				3	3
MASON				1	1
MENOMINEE		2			2
MIDLAND				1	1
MONROE				1	1
MONTCALM				1	1
MONTMORENCY				1	1
MUSKEGON	1			2	3
NEWAYGO				2	2
OAKLAND	7			5	12
OGEMAW				2	2
ONTONAGON				1	1
PRESQUE ISLE				2	2
SAGINAW	3			1	4
SCHOOLCRAFT				1	1
SHIAWASSEE				1	1
ST CLAIR	4	1		15	20
ST JOSEPH				1	1
VAN BUREN	1			2	3
WASHTENAW	1			1	2
WAYNE	10				10
WEXFORD				2	2
Grand Total	48	4	2	99	153

<sup>3</sup> Youth under the jurisdiction of Wayne County (JAC) are not included in this sample

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## APPENDIX B

### Designing and Implementing the Michigan Race Equity Review

In late 2006 a team of professionals with representation from the Center for the Study of Social Policy (CSSP), Ellen Pence and Associates, Michigan Department of Human Services (DHS), University of Pennsylvania School of Social Policy and Practice, Casey Family Programs, and the Annie E. Casey Foundation (hereafter referred to as the *Design Team*) was formed to design and coordinate a Race Equity Review in Michigan (Review). This team frequently consulted with a formal group composed of Michigan DHS leadership and external stakeholders (hereafter referred to as *Michigan Home Team*). The Design Team was responsible for:

- Designing the external Review;
- Refining existing qualitative analysis tools;
- Narrowing the scope of the Review;
- Selecting Review sites;
- Orienting local staff to the processes;
- Training reviewers;
- Reporting findings to the Michigan Home Team and the Michigan Advisory Committee on the Overrepresentation of Children of Color in Child Welfare; and
- Further synthesizing and analyzing data.

The Design Team selected two qualitative review methods for adaptation and implementation: the Quality Service Review (QSR) and the Institutional Analysis (IA). These QSR and IA are well-tested, qualitative analyses which complement each other. The QSR allows for analysis of practice and system capacity from a case perspective. The IA allows for an understanding of the structural features of a system and how the structure produces certain outcomes on the case level. The Team believed that the combined implementation of these two methods would result in both a snapshot of current practices and outcomes and an understanding of the system structure which orient practitioners.

#### *Refining the QSR Protocol*

The Design Team consulted with Human Systems and Outcomes, Inc.(HSO) to refine a basic QSR protocol to focus specifically on the quality of child protective investigations and decision-making. Design Team members worked with HSO to add an indicator “Critical Discernment.” This indicator assesses how evidence is gathered, filtered and applied during a child protective investigation when making strategic decisions about children and families. Design Team members believed that high quality critical discernment skill would aid in protecting against racially inequitable decisions. See Appendix D for summaries of specific child states and system performance questions which guided QSR reviewers as they assess individual cases.

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### ***Refining the Institutional Analysis***

The development of the IA for use in a Race Equity Analysis emerged from a two-year collaboration between CSSP and Ellen Pence of Praxis International to modify Praxis' well-developed and tested *Safety and Accountability Audit* protocol. The original *Safety and Accountability Audit* protocol focuses on enhancing safety for women and children and ensuring system accountability to these women and children in cases where there is domestic violence. The modified tool now focuses on reviewing how the institutional features of child welfare and related legal practices produce racial disproportionality and disparity.

### ***Narrowing the scope of the Review***

The IA qualitatively examines the institutional features that produce a particular outcome. During the IA, quantitative data inform areas of inquiry, however, the IA itself does not produce quantifiable documentation of a problem. Rather, it seeks to answer the question, "How does this problematic outcome come about?" In planning an IA, it is important to *ask the investigation question from the standpoint of those individuals who are being managed as cases in the system*. After reviewing Michigan's demographic data on child protection referrals, investigations, and cases, the Design team narrowed the Review to focus on "***how does it come about that after substantiation, African American children are more likely to be removed from their homes.***" Because the decision to remove a child from their home was the first point of significant disproportionality within the child protection system, the team felt this was a critical decision-making point to investigate for institutional racism.

After deciding on the scope of the Review, Design Team members focused on identifying the sequence of institutional actions that take place in the course of intervening with children and families—from answering the telephone at the hotline to closing a CPS investigation. This sequence of actions or decisions is then "mapped." Through the mapping process the Design Team pinpointed each critical step in case processing; key actors (workers, psychologists, judges, etc...) at each step; and key policies, regulations, and guiding practices. Additionally, the mapping process defined the purpose and function of each step. The Design Team relied on this map in planning the investigation schedule—specifically, identifying people to interview, processes to observe, policy and administrative documents to analyze, and case files to review. Ultimately, the mapping process provided a framework for organizing the IA.

### ***Selecting Review sites***

The Design Team selected two Review sites. Selection criteria included: strong local leadership, significant overrepresentation of African American children, a willingness to participate in the Review, and dedicated local staff to help coordinate and participate in the Review. The team, in consultation with the Michigan Home Team, selected Saginaw County as the first demonstration site and Wayne County, which encompasses the city of Detroit, as the second site for Review.

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### ***Orienting Staff, Preparing and Training Review Partners***

In preparation for the Review, several sessions were conducted by Design Team in each site to both inform staff and gain their interest in participating in the Review as either a member of the investigation team or as an informant in the process.

The Design Team worked with local leadership and DHS central office staff to select a diverse group of individuals willing to commit to the Review trainings and process. These individuals comprised the “investigation team.” In addition to Design Team representation, Investigation team members were child protection supervisors and frontline workers, DHS central office staff, community based providers, assistant attorney general, parents and foster parents. Qualities looked for in team members included:

- respect for individuals of diverse backgrounds,
- the ability to focus on institutional features that produce disproportionality and disparity,
- the ability to uncover and analyze problematic practices without becoming defensive,
- flexible schedule during the Review process, and
- a sense of humor.

The People’s Institute for Survival and Beyond conducted *Undoing Racism* trainings for all members of the Investigation team as well as leadership and stakeholders from both sites.<sup>4</sup> The Design Team worked with the People’s Institute to ensure their training provided participants with a common understanding of institutional racism and highlighted issues of racial disproportionality and disparity in the child welfare system. As part of this training, Dr. Carol Spigner of the University of Pennsylvania, School of Social Policy and Practice and chairperson of the Design Team, provided participants with a history of the involvement of children of color in public child welfare systems in the United States.

Further, members of the Design Team conducted an IA training session for all participants in the IA protocol to provide a basic understanding of the data collection process and bolstered interviewing, observation, and analysis skills.

### ***Conducting the QSR***

A lead reviewer who is trained and experienced in conducting QSRs in other states is assigned two cases to assess from Monday – Thursday of a week. Home, office or community-based interviews all take place in either one day or two consecutive days. Interviewees include parents, caretakers, other relevant family members, and as many as possible of the parties involved in a recent CPS investigation and decision-making about whether to substantiate the allegations and remove a child. Each lead reviewer was assigned a “Shadow” or partner with whom to conduct the Review. The Saginaw county QSR was conducted March 19-23, 2007. The Wayne county QSR was conducted September 24-28, 2007.

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<sup>4</sup> Visit <http://www.pisab.org/about-us> for more information about the People’s Institute and Undoing Racism.

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### ***Conducting the IA***

From April 23 - 27, 2007, an Investigation Team of approximately 25 local and national consultants were divided into four groups, with each group responsible for gathering data through conducting interviews, focus groups, case record reviews, and observations of practitioners such as hotline and investigation staff and judges at work. Each Group was led by someone familiar with the IA process. In addition to investigation case files, the groups examined the following:

- Group 1 - intake and investigation of child abuse and neglect cases, including examining the Structured Decision Making® tools
- Group 2 - the decision making process around removal, family team meetings, and how placement occurs
- Group 3 - the court process, including the legal representation of parents and children
- Group 4 - community based providers contracted by DHS to provide services to families and children

This process was repeated in Wayne County from October 15-19, 2007 with a 5<sup>th</sup> Group added to focus on youth involved in both the child protection and juvenile justice systems.

### ***Reporting findings to Michigan's Home Team and Advisory Committee.***

In addition to reporting preliminary findings to DHS leadership in each county at the end of the week of the respective QSR and IA, the Design Team also presented preliminary findings to the Michigan Home Team and Advisory Committee at the completion of each on-site Review.

### ***Further synthesizing and analyzing data***

After the Review process, the Design Team met several times to refine the massive volume of data collected. Specifically, the team analyzed the data ensuring that there were multiple data sources to raise an initial concern to the level of a finding. Although labor intensive, the team worked with the data to determine what information was reflective of a generally poorly functioning child welfare system and what was reflective of institutional racism—in some instances the data was reflective of both. The synthesized findings presented in this report focus expressly on problematic practices that produced racial disproportionality and disparity.

This document is part of the reporting commitment CSSP made to the state of Michigan and local and national funders. Additional technical assistance from CSSP to Michigan local accountability groups will be provided per a negotiated contract with Michigan.

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## APPENDIX C

### The Institutional Analysis

The *core standardizing methods* used by public agencies to direct, influence, and control how workers act on cases:



- **Administrative procedures and protocols**, such as forms, screening tools, report-writing formats, matrices and assessments tools;
- **Rules and regulations**, laws, policies, and policy manuals;
- Organized **linkages** that connect a worker operating at a given point of intervention to other practitioners with prior or subsequent involvement in the case. For example, an investigative worker's actions are in part determined by information received by the hotline worker, and information required by the worker responsible for filing the petition, the judge, and the subsequent case worker;
- The allocation (or absence) of **resources**, such as parenting classes, visits from workers, emergency funds, child care, substance abuse evaluation and treatment, and staff time (case loads);
- **Education, training, and skill development** in the form of educational training for workers and supervisors, educational requirements, exposure to professional discourses, mentoring opportunities, and participation in local, state, and/or national forums;

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- ***Concepts and theories*** that are embedded in the discourse of the field as well as in policy and administrative régimes. Policies and administrative practices are connected to broader assumptions, theories, values, and concepts regardless of the individual values of the practitioner who will carry them out.
  - ***Job descriptions, agency missions***, and specifically ***assigned tasks*** at various points of intervention that inform a worker of his or her role and duties and set a boundary around what a worker is and is not expected to do on a case;
  - ***Systems of accountability*** to clients, to other practitioners, other intervening agencies, to the intent of policies and directives, and to the goals of intervention. Examples include supervisory approval of case plans, quality control of guardian ad litem procedures and reports, integrity of case documents, family involvement in case planning, court review of placements and permanency plans, the use of lawsuits, and grievance procedures;
  - Other methods may be particular to a specific location and will be discovered by the IA investigation team. For example, in jurisdictions where a particularly egregious or fatal case of child abuse or neglect occurs, the political atmosphere may pressure workers to remove children from their families when risk of future harm is questionable (rather than directing workers to provide more intensive in-home supports to families). Or a jurisdiction may be in the midst of civil litigation and the unique features of the lawsuit (or settlement agreement) directs attention, interventions and resources to particular types of cases of abuse and neglect.

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## APPENDIX D

### Quality Service Review Questions to be Answered

#### QUESTIONS CONCERNING THE STATUS OF THE CHILD

Presented below are a set of common sense questions used to determine the current status of the child and family. Persons using this list of questions are directed to the **Quality Service Review Protocol (QSR)** for further explanation of these questions and matters to consider when applying these questions to a child and family receiving supports and services. Training on review concepts, methods, and uses is recommended for anyone wishing to apply these questions to the children and caregivers in a family receiving services.

#### SAFETY

1. **SAFETY & RISK:** • Is the child free of abuse, neglect, and exploitation by others in his/her place of residence and other daily settings? • Is the child free from injury caused by others in his/her daily home, school, and community settings? • Do parents and caregivers provide the attention, actions, and supports necessary to protect the child from known risks of harm in the home?
2. **BEHAVIORAL RISK:** • To what degree is the child/youth consistently avoiding self-endangerment situations and refraining from using behaviors that may put him/herself or others at risk of harm?

#### STABILITY

1. **STABILITY:** To what degree are: • The child's daily living, learning, and work arrangements stable and free from risk of disruption? • The child's daily settings, routines, and relationships consistent? • Known risks being managed to achieve stability and reduce the probability of future disruption?

*[Timeframe: past 12 months and next 6 months]*

#### QUESTIONS CONCERNING THE STATUS OF THE PARENT/CAREGIVER

1. **PARENTING CAPACITIES:** To what degree: • Does the parent/caregiver demonstrate adequate parenting capacities on a reliable daily basis commensurate with that required to provide the child(ren) with appropriate nurturance, guidance, protection, care and supervision? • If the child(ren) has special medical, emotional, behavioral, and/or developmental needs, does the caregiver have and use any special knowledge, skills, and supports that may be required to meet the needs of the child(ren)?

Excerpt from: Racial Disparity in Child Welfare Systems: Uncovering Its Sources Using the Institutional Analysis (10-01/07).

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## Quality Service Review

### Questions to be Answered

#### QUESTIONS CONCERNING THE STATUS OF THE PARENT/CAREGIVER, cont'd.

2. **CAREGIVING CAPACITIES:** To what degree are the child's/youth's primary caregivers in the group home or facility supporting the education, development, and independence of the child/youth adequately on a consistent basis [as appropriate to age and need]?
3. **PARENTING CHALLENGES: To what degree:** • Do parents, with whom the child is currently residing or has a goal of reunification, present or experience a pattern of significant, ongoing challenges that limit or adversely affect the parent's capacity to function successfully as an adequate caregiver for this child? • Does the family have any special life challenges that interfere with or prevent them from living together safely and functioning successfully?
4. **BASIC NECESSITIES:** To what degree: • Are the family's earned income and/or economic supports adequate to cover the family's basic living requirements (i.e., shelter, food, clothing, transportation, health care/medicine, child care)? • Is the parent accessing, receiving, and adequately managing the economic supports to which he/she is eligible? • Does the parent have economic security and skills sufficient for meeting the family's basic needs and maintaining a stable living arrangement for the children? • Does the current living arrangement provide the family with adequate space and living conditions?
5. **INFORMAL SUPPORTS:** To what degree: • Is the family with an informal support system that assists them with essential caregiving responsibilities? • Do families having special needs children, recovery/relapse prevention plans and/or family safety plans have adequate levels of informal support provided by family, friends, neighbors, or other supporters involved who will help them manage adequately on an enduring basis? • When a family has a child with special needs (physical, developmental, emotional, behavioral), do parents/caregivers have opportunities to exchange experiences, strategies, and successes with parents of similar circumstances?

#### QUESTIONS CONCERNING SYSTEM PERFORMANCE INDICATORS

##### ENGAGING

- 1a. **ENGAGING:** To what degree: • Are those interveners involved with the family using out-reach and engagement strategies, including special accommodations with any difficult-to-reach family members, to increase family engagement and participation in the service process? • Are interveners building a trust-based working relationship with the child, family and/or others to support ongoing assessment, understanding, and service decisions? • Are interveners relying on a mutually beneficial partnership with the child, family, and/others that is sustaining their interest in and commitment to a change process?

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## Quality Service Review

### Questions to be Answered

#### QUESTIONS CONCERNING SYSTEM PERFORMANCE INDICATORS, cont'd.

**1b. ROLE & VOICE:** To what degree are family members with whom the child is living and/or will be reunited, active ongoing participants (e.g., having a significant role, voice, influence) in decisions made about child/family change strategies, services, and results? [*Role and voice in recent meetings*]

#### TEAMING

**2. TEAM INFORMATION:** To what degree: (1) Did the people who provide support and services for this child and family form a working team to meet, talk, and plan together? (2) Did the team have the skills, family knowledge, and abilities necessary to organize effective services for a child and family of this complexity and cultural background? • TEAM FUNCTIONING: To what degree (1) Did members of the team collectively function as a unified team in planning for safety and reducing risk? (2) Did actions of the family team reflect effective teamwork and collaborative problem solving that benefited the child and family?

#### ASSESSING

**3. ASSESSING & UNDERSTANDING:** To what degree: • Is there a shared, big picture understanding of the child and family's strengths, protective capacities, hopes, needs, safety risks, and underlying issues that must change for the child to live safely and permanently with the family of origin or adoptive family without agency supervision? • Are these understandings reflected in the family change process used for helping the family achieve safety, permanency, and well-being (as defined in stated conditions for safe case closure)? • Is ongoing situational awareness of the child and family being maintained throughout the child and family change process?

**4. CRITICAL DISCERNMENT:** To what degree has the decision agent (i.e., individual worker or team) used critical discernment in strategic decisions (e.g., substantiation, diversion, removal, return, parent replacement, safe case closure) in the life of the case as evidence by: • 1) EVIDENCE: Assembling a fact base and interpreting accurate, sufficient, relevant meanings to inform the strategic decision? • 2) DECISION: Applying relevant criteria to focus and guide selection of the most appropriate near-term safety protections and most beneficial long-term outcome path for the child and family with respect to safety, risk, well0being, and permanency? • 3) ERROR AVOIDANCE: Detecting and avoiding possible sources or error in fact or reasoning that could yield false positive and/or false negative errors at strategic decision points?

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## Quality Service Review Questions to be Answered

### QUESTIONS CONCERNING SYSTEM PERFORMANCE INDICATORS, cont'd.

#### PLANNING

**5. PLANNING STRATEGIES FOR SAFETY AND RISK PRODUCTION:** To what degree was a well-reasoned, strategy planning process used for: A. SAFETY. • Controlling and managing threats of harm while building and sustaining protective capacities of the parents? B. RISK REDUCTION. Collaboratively, with the family and their supports, identifying family and child circumstances and internal and external stressors that contribute to increasing risks of harm to the child? • Identifying family strengths to build upon to manage risk? • Intervening to address challenges which increase risk?

**6. COURT PROCESS:** • To what degree does the family participate in the court process? • Are petitions and motions filed in a timely manner with hearings conducted on schedule? • Are the parent and child receiving adequate legal representation? • Is the judge holding all parties accountable for following orders? • Has the judge achieved a reasonable balance flexibility and enforcing actions to permanency of children? • Are court orders clear to all, with parties receiving copies in a timely manner?

Excerpt from: Quality Service Review Protocol for use by Certified Reviewers. Prepared for and licensed to the Center for the Study of Social Policy. Human Systems and Outcomes, Inc: March 2007.

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## ENDNOTES

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- <sup>2</sup> Annie E. Casey Foundation. (n.d.). *Race matters: Unequal opportunity within the child welfare system*. Retrieved from [http://www.aecf.org/upload/PublicationFiles/fact\\_sheet11.pdf](http://www.aecf.org/upload/PublicationFiles/fact_sheet11.pdf)
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- Jones, E. F. (2006). *Public policies and practices in child welfare services that affect life options for children of color*. Washington, DC: The Joint Center for Political and Economic Studies.
- <sup>4</sup> Child Protection/Protective System is referred to as the system or agency responsible for investigating reports of suspected child maltreatment, providing protective supervision of families with children who have been found to have been maltreated or providing protective custody to those children when they cannot safely remain with their parents.
- <sup>5</sup>Dunbar, K., & Barth, R. (2007). *Racial disproportionality, race disparity, and other race-related findings in published works derived from the national survey of child and adolescent well-being*. Retrieved from <http://www.f2f.ca.gov/res/pdf/RDDOtherRelated.pdf>
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- <sup>6</sup> Hill, R. (2006). *Synthesis of research on disproportionality in child welfare: An update*. Casey-CSSP Alliance for Racial Equity in Child Welfare.
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- <sup>8</sup> Hill, R. (2006). *Synthesis of research on disproportionality in child welfare: An update*. Casey-CSSP Alliance for Racial Equity.
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- <sup>12</sup> Original sources quoted in Equity report are: Children's Services Management Info System, CY-093, and Kids Count analysis of 2003 Census population estimates. More recent data was not available from Michigan at the time of the review.
- <sup>13</sup> *Equity report*, p. 9.
- <sup>14</sup> *Equity Report*, p. 3.
- <sup>15</sup> Grant-Thomas, A. & Powell, J. (2006, November/December). Toward a structural racism framework. *Poverty & Race* [Newsletter], 15(6), 3-6.
- <sup>16</sup> *Equity Report*, p. 10
- <sup>17</sup> Pence, E. and Sadusky, J., *The Praxis Safety and Accountability Audit Tool Kit*, Praxis International, Inc. (February 2005).
- <sup>18</sup> Ibid.
- <sup>19</sup> In addition to the 50 states, the CFSR assessed the child welfare systems of the U.S. Virgin Islands and Puerto Rico.
- <sup>20</sup> Some Reviewers had previously participated in an Undoing Racism workshop and did not do so again as part of this Review.
- <sup>21</sup> DHS reports that a June 2008 statutory amendment allows for court discretion to continue visitation.

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<sup>22</sup> This fundamental lack of resources was revealed particularly by the focus groups conducted with parents, youth, foster parents and case workers. Interviews and case records supported the finding that families lack basic necessities particularly food, clothing, housing, transportation, heating and the ability to prepare meals.

<sup>23</sup> Michigan DHS reports that for fiscal year 2007 only 55% of complaints received statewide were assigned for investigation.

[http://michigan.gov/documents/dhs/DHS-Legislative-Sec514-PA131-2007-CPS\\_227770\\_7.pdf](http://michigan.gov/documents/dhs/DHS-Legislative-Sec514-PA131-2007-CPS_227770_7.pdf)

<sup>24</sup> This refers to the fiscal year 2007. Michigan DHS Child Protective Services Trends Report Summary.

[http://michigan.gov/documents/dhs/DHS-Legislative-Sec514-PA131-2007-CPS\\_227770\\_7.pdf](http://michigan.gov/documents/dhs/DHS-Legislative-Sec514-PA131-2007-CPS_227770_7.pdf)

<sup>25</sup> This finding is qualitative. We recommend that a more thorough quantitative analysis of the state's hotline system be conducted.

<sup>26</sup> See *Equity Report* and Lemon, K., D'Andrade, A., & Austin, M. (2005). *Understanding and addressing disproportionality in the front end of the child welfare system*. Berkeley, CA: University of California at Berkeley School of Social Work.

<sup>27</sup> The National Center on Crime and Delinquency and the Children's Research Center. (n.d.). *CPS component: Risk assessment*.

Retrieved from [http://www.nccd-crc.org/crc/c\\_sdm\\_risk.html](http://www.nccd-crc.org/crc/c_sdm_risk.html)

<sup>28</sup> Michigan uses the term 'preponderance of evidence' for cps investigation findings of child abuse or neglect..

<sup>29</sup>Ibid

<sup>30</sup> See KIDSCOUNT census data for Michigan at [www.kidscount.org](http://www.kidscount.org)

<sup>31</sup> See *Equity Report* and Lemon, K., D'Andrade, A., & Austin, M. (2005). *Understanding and addressing disproportionality in the front end of the child welfare system*. Berkeley, CA: University of California at Berkeley School of Social Work.

<sup>32</sup> CRC recommends validation of the tools every 5-7 years and states that Michigan's Structured Decision Making® Family Risk Assessment tool should be validated in the near future. According to CRC the Risk Assessment tool referred to in this Review was validated in 1995. CRC re-validated the Risk Assessment tool in 2003 but it was not available for use by workers until late 2007.

<sup>33</sup> More information about *Family to Family* can be found on the Annie E. Casey website.

<http://www.aecf.org/MajorInitiatives/Family%20to%20Family.aspx>

<sup>34</sup> The Review only saw this practice with mothers. Data did not reflect a similar, consistent search for a termination of parental rights of the father.

<sup>35</sup> Although this was beyond the original scope of the research question, this information is relevant and worth further examination.

<sup>36</sup> See [http://www.michigan.gov/documents/DHS-Child-Welfare-Philosophy\\_167533\\_7.pdf](http://www.michigan.gov/documents/DHS-Child-Welfare-Philosophy_167533_7.pdf)

<sup>37</sup> In fact, a reviewer's car was broken into and ransacked the second day of the Institutional Analysis.

<sup>38</sup> The National Association of Counsel for Children recommends that individual attorney caseload be no more than 100 cases for an attorney concentrating in child welfare practice. See [www.NACCchildlaw.org](http://www.NACCchildlaw.org) for more information.

<sup>39</sup> Wayne County, however, had just entered into contracts with lawyers to provide legal representation to children exclusively.

<sup>40</sup> Although they felt that such training would be helpful to attorneys for parents and children, there was a feeling of powerlessness to require such training given the low reimbursement rates in their contracts. The attorneys for the DHS in Wayne County reportedly do receive significant training on issues faced by children and families.

<sup>41</sup> Law enforcement leadership, interviewed about safety concerns on the East Side, insisted that there was no more violence on the East Side than on the West Side in Saginaw. It also should be noted that the DHS director for Saginaw County took immediate action to address this inequitable distribution of resources.

<sup>42</sup> Although beyond the initial research question, the Review found several examples of foster care licensing workers refusing to work in particular neighborhoods, possibly having an impact on the availability of neighborhood based foster homes and kinship caregiver options. It is recommended that this be explored further.

<sup>43</sup> "Reasonable efforts" determination refers to the federal mandate that requires the dependency judicial officer (judge/commissioner, etc...) to specify information about the problem faced by a family whose child is removed from their home, to consider efforts made to maintain the child at home and alleviate the identified problems, and to determine whether those efforts were *reasonable*. Further, the officer must assess the reasons why the efforts were unsuccessfully or legally were not required.