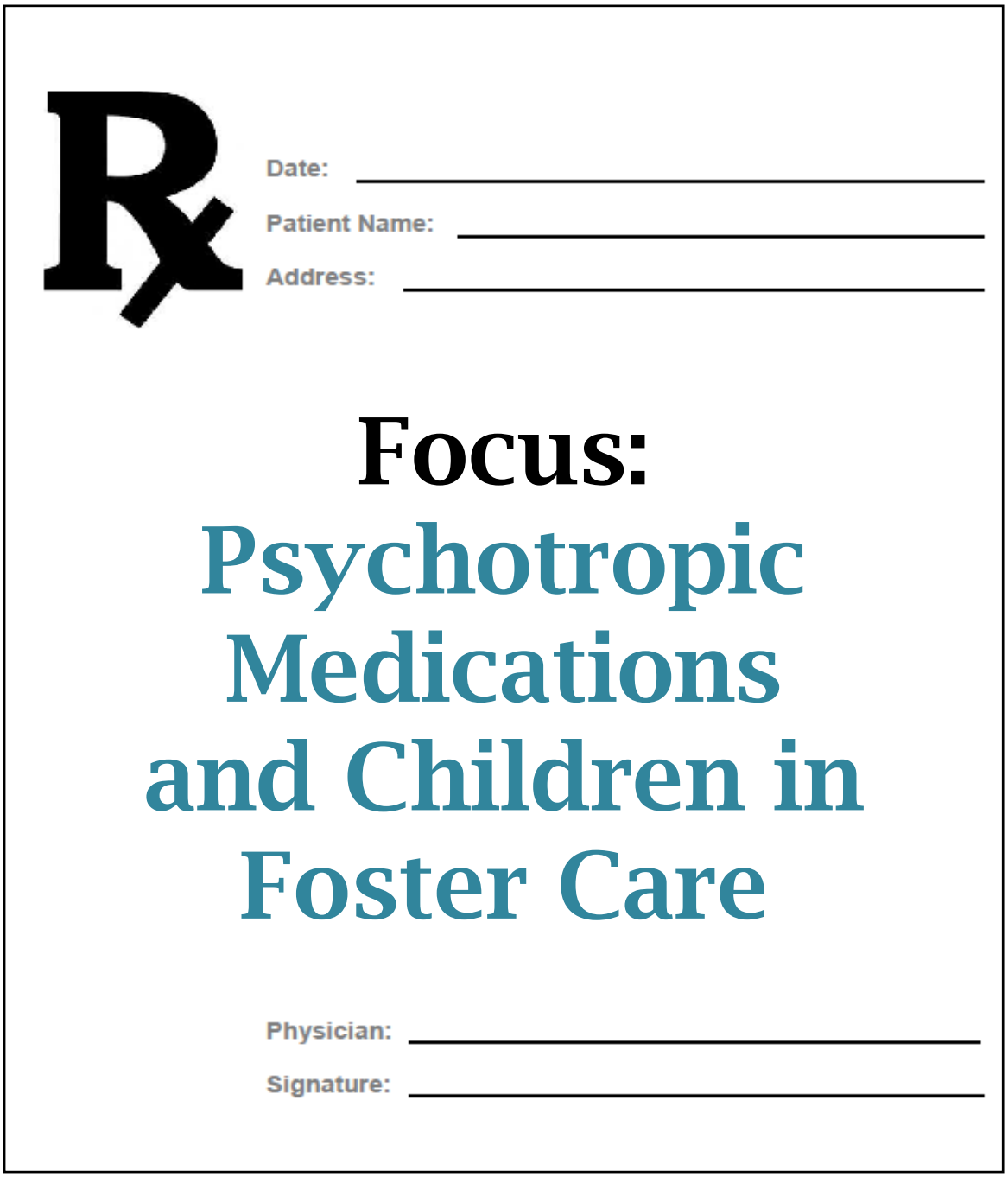
Michigan Supreme Court
State Court Administrative Office

Michigan Foster Care Review Board
2012 Annual Report



Mission Statement

The mission of the Foster Care Review Board is to utilize citizen volunteers to review and evaluate permanency planning processes and outcomes for children and families in the Michigan foster care system. Based on the data collected through case review, the Foster Care Review Board advocates for systemic improvements in areas of child safety, timely permanency, and family and child well-being.

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http://courts.michigan.gov (FCRB)

Vision Statement

The Foster Care Review Board will be viewed and valued by the courts, the Department of Human Services, private child-placing agencies, the Legislature, and the citizens of Michigan as a major source of credible data on the performance of the child welfare system. Additionally, citizens of the state will use the data to shape public policy and promote awareness regarding the child foster care system.

Program Description

The Foster Care Review Board (FCRB) provides independent third-party review of cases in the state child foster care system. The FCRB also hears appeals by foster parents who believe that children are being unnecessarily removed from their care. Established by the Michigan Legislature in 1984, the Foster Care Review Boards Act, MCL 722.131-140, helps ensure that children are safe and well cared for while in the state foster care system, and that their cases are being moved toward permanency in a timely and efficient manner.

The FCRB provides this support by reviewing randomly selected individual foster care cases from each county and providing case-specific recommendations to the family division of the local circuit court, to local offices of the Department of Human Services (DHS), and to contracted agencies. The review process also serves to identify systemic barriers to safety, timely permanency, and child well-being, and to monitor Michigan's compliance with important federal funding requirements.

The FCRB review boards are comprised of citizen volunteers from a variety of professions and backgrounds. FCRB program staff recruit, screen, and train the citizen volunteers on key aspects of the child welfare and foster care systems, including court policy and rules, federal funding requirements, DHS policy, and state statutes regarding child protection.

Citizen review remains a cost-efficient and effective means of assisting the courts, DHS, the Legislature, and other interested parties by providing an objective perspective on the foster care case management process. Citizen volunteers donated over 10,000 hours of their time to case review this past year. Their capacity and willingness to significantly increase that number is limited only by available staff support.

This annual report details the efforts of the FCRB during the past year and shares with Michigan's policymakers some of the systemic issues that our citizen volunteers have identified while reviewing foster care cases throughout the state.

Annual Report Requirements

Michigan law, MCL 722.139, requires the State Court Administrative Office to publish an annual report of the FCRB program that includes all of the following information:

- An evaluative summary, with applicable quantitative data, of the activities and functioning of each local review board.
- An evaluative summary, with applicable quantitative data, of the activities and functioning of the aggregate of all local review boards.
- An identification of problems that impede the timely placement of children in permanent placements, and recommendations for improving the timely placement of children in permanent placements.
- The statistics and findings regarding its reviews of permanent wards, and identification of any barriers to permanency.

Psychotropic Medications and Children in Foster Care

Safety, Well-Being, and Permanency

The 2012 Foster Care Review Board (FCRB) Annual Report focuses on the utilization of psychotropic medication with children in foster care who display emotional and behavioral disorders and the impact this may have on a child's safety, well-being, and achievement of timely permanency.

Appropriate utilization of psychotropic medication can help ensure success in these three vital categories of a child's experience in foster care. However, failure to consider or utilize alternative treatment options that may prove as or more effective than medication, failure to adequately monitor a child's ongoing response to medication, and failure to coordinate a comprehensive treatment regimen for a child with emotional and behavioral disorders can have significant consequences to that child.

Failure to provide children with a treatment regimen that results in symptom reduction and facilitates healthy psychosocial development can result in multiple placement disruptions, impact school performance, interfere with social relationships, and delay and even prevent a child from achieving the optimal permanency goal of placement in a safe, stable, and permanent family home. As indicated in the section of this report regarding barriers to permanency, **ward behavior** (that typically indicates an unresolved emotional or behavioral disorder) **has consistently been one of the top three barriers to permanency for children with a goal of adoption**.

Observations and Concerns

The FCRB, in fulfilling its responsibility to monitor and report on individual child well-being during each review, looks at four key areas: physical health, mental health, education, and child and youth development.

In the specific area of mental health, we monitor if the child is displaying symptoms of or has been diagnosed with an identified mental health or behavioral disorder. If a diagnosis has been made, we monitor whether a treatment plan has been established to address the disorder, including psychosocial interventions (e.g., individual and/or group therapy, behavioral management plans, etc.) and whether psychotropic medication has been prescribed.

Because of the potential risks associated with utilization of psychotropic medication with children in foster care (this issue is addressed more specifically later in this report), as well as the fact that caring for these children and teens requires a solid understanding of the positive and negative aspects of medication use, we give significant attention to this area in our reviews.

In monitoring the use of psychotropic medications, we "try" to look at the following:

- The medication(s) the child is on;
- The number of medications the child is on;
- The purpose or benefit of the individual medications;
- If the child is, indeed, benefiting from the medication;
- Duration of time the child has been on the medication and what the indicators are for moving the child off the medication;

- Potential side effects of the medication and how those side effects are being monitored;
- The frequency of medication reviews and whether they are conducted by a child psychiatrist or primary care physician;
- If psychosocial interventions were attempted prior to placing the child on the medication and what interventions are presently occurring; and
- If there has been a process of informed consent prior to placing the child on the medication evidenced by a fully completed and signed DHS Form 1643 in the case file.

We emphasize the word "try" above because, many times, this information is neither available in the case file (despite DHS policy that requires it), nor through the parties present at the review, which always includes the caseworker and may include the parent, foster parents, youth, and/or lawyer-guardian ad litem.

This lack of information is concerning as a review of the literature and research indicates that it is critical for caretakers, caseworkers, and the children themselves to understand the purpose, risks, and benefits of medications prescribed to address a diagnosed behavioral or mental health disorder, as well as be able to identify whether the child is experiencing the desired benefits and/or possible side effects of the medication.

Shared or collaborative decision-making and monitoring is identified in the research as essential to producing positive outcomes for children and youth with mental and behavioral health disorders, particularly regarding the use of psychotropic medication. Related treatment plans should be developed collaboratively with the clinician, parent, foster parent, caseworker, and child or youth.

Currently, Michigan's MiTEAM model promotes the engagement of all interested parties in significant decisions regarding the care of the child. It is uncertain, however, how regularly the use of psychotropic medication is being addressed within the MiTEAM meetings.

Utilization and Monitoring of Psychotropic Medication

Research

Bringing a child into foster care—especially a young child—is in itself a traumatic event for any child and can result in the child experiencing related anxiety and depression, which may or may not be displayed behaviorally. Typically, if this is the only challenge the child has, it can be addressed and alleviated through brief counseling and/or through the structure and nurture of a safe, stable foster home with frequent, well-planned visitation with parents, siblings, and family.

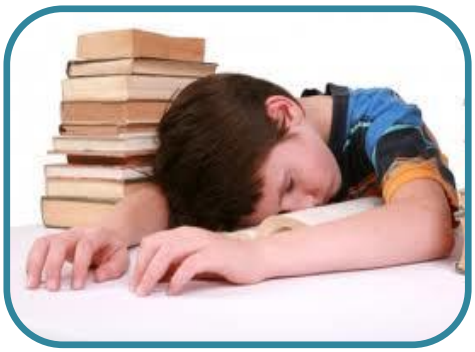
However, many children and youth who enter the foster care system often struggle with significant behavioral and serious mental health disorders that can be a result of genetics, previous maltreatment and trauma, or a combination of both. These disorders can then become exacerbated by the distress, anxiety, and confusion of being placed in an unfamiliar and uncertain living situation, separated from their parents, home, and school.

A 2011 U.S. Government Accounting Office (GAO) report advised that 57 percent of children in foster care are diagnosed with a mental or behavioral disorder, which was nearly 15 times that of non-foster children receiving Medicaid assistance. The most common diagnoses of

children in foster care include Oppositional Defiant Disorder (ODD), Conduct Disorder, Adjustment Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Major Depressive Episode, and Post-Traumatic Stress Disorder (PTSD).

Because children in foster care experience trauma and display behavioral problems at higher rates than other children, their use of behavioral and mental health services, including psychotropic medications, occurs at a higher rate. The alarming finding in the GAO report, as well as other related studies, is that children in foster care who are diagnosed with mental and behavioral disorders are treated with psychotropic medication at significantly higher rates than children diagnosed with mental and behavioral disorders in the general population. The GAO reports that in the five states surveyed (Michigan being one of them), children in foster care were 2.7 to 4.5 times more likely to be medicated as children who are not in foster care.

Psychotropic medications generally include mood stabilizers, antipsychotics, antianxiety medications, depressants, and stimulants. They are designed to help alleviate or manage troublesome and sometimes dangerous symptoms that interfere with a child's psychosocial development, and their ability to function in the home school and community. They are used primarily to help regulate mood and emotions, reduce impulsive aggression, improve focus and concentration, and organize disordered thought processes.



However, the literature and research indicate quite clearly that the risks these drugs pose, specifically to children, are not well researched or understood, and that their utilization may come with potential side effects or other interferences in the child's mind, body, and relationships. Some antidepressants can reduce the child's ability to experience emotions, even pleasurable emotions. Behavior management medications can cause drowsiness and withdrawn behavior, as well as significant weight gain, which can then cause additional problems for youth who are image conscious. A few extra pounds can profoundly impact a developing child's self-esteem, performance, and relationships. Additional unneeded weight gain places children and teens at risk for diabetes, heart disease, eating disorders, and can lead to a lack of compliance with treatment recommendations. Furthermore, rapid weight gain can also decrease the motivation to exercise, the desire to socialize, and the ability to engage in typical physical activities of youth and childhood.

Attention disorder medications can interfere with appetite or sleep and create additional physical problems for a child. Certain psychotropic medications cause tics, nightmares, and even some of the same symptoms they aim to help, such as hearing voices. Various medications used to treat thought disorders can cause lifelong side effects that do not go away, even when the medication is stopped.

A multistate study on psychotropic medication oversight in foster care conducted and published in 2010 by Tufts University Clinical and Translational Science Institute found that the use of psychotropic medication for the treatment of behavioral and mental health disorders of children in foster care can range anywhere from 13 to 52 percent, depending on geographic location, while use of medication for children with similar disorders in the general population was 4 percent.

Although neither the GAO or Tufts University study necessarily found a pattern of inappropriate prescribing practices, they did point out that because of foster children's greater mental health needs, exposure to acute and long-term traumatic experiences, and the

fact that some of the drugs utilized do not have approved dosage levels for children, states must have access to the latest research and guidelines regarding the use of psychotropic medications among children, as well as systemic structures in place to meet the significant challenges in assuring that any treatment provided matches the child's behavioral health needs and that their care is well monitored and coordinated.

Frequent use of psychotropic medications for children and youth in foster care was only one of the concerns noted in the research and literature. Others include the use of multiple psychotropic medications simultaneously, the use of such medications in young children between 3-6 years of age, and the failure to consider or provide prevenient or simultaneous evidence-based psychosocial treatments as a means of addressing the child's mental or behavioral health needs.

Treatment Options and Considerations

For children and youth in foster care who struggle with behavioral and mental health disorders, the goal is to help them heal and be able to function in an age-appropriate manner at home, school, and in the community. First and foremost, they need to be safe. Depression or suicidal thinking must be addressed. Self-abusive behaviors must be contained and risk-taking behaviors reduced. Medication can be part of a successful intervention and treatment plan in these instances.

Children also need to be able to organize their thinking so that they can begin to understand what has happened to them and how that is impacting their lives. Medication can be a temporary aide to this process. However, they also need to be able to experience their emotions and work through them, learn how to manage them in age-appropriate ways, and communicate effectively with those who care for them, advocate for them, and make decisions on their behalf. At times this can be hindered by medications, especially if there is not adequate explanation to the child regarding what the medications are for and effects they may experience from them.

Thus, even though medication use can be helpful and is often instrumental in treating mental health issues in children and teens, the concerns lie in what type of medications are being used; if they are the right ones for the child or youth based on symptoms, age, functional ability, and history; if they are being well monitored, both for benefits and side effects; and if psychosocial interventions that can treat symptoms as well as, or better than, medication have been considered.

The latter concern is significant because we, as a society and a foster care system, all too often look for quick fixes to complex behavioral and mental health disorders. Treatment options can sometimes be significantly influenced by foster parents and school personnel, who want to immediately decrease behavioral issues, and by the fact that Medicaid will typically pay for medication, but will not always cover evidence-based psychosocial interventions.

The Center for Health Care Strategies, Inc., which works with state community health and child welfare agencies, health care plans (including Medicaid), and community organizations, conducted a 26-state study and identified multiple issues related to the potential over-reliance on psychotropic medication. These included lack of psychosocial therapies and specialists or individuals trained to deliver psychosocial therapies, as well as a lack of clear strategies within the states to increase the availability of alternatives to psychotropic

interventions, including addressing limitations on behavioral health financing, the adoption of evidence-based practices and evidence-informed approaches, and the provision of trauma-informed assessments.

Evaluation of all aspects of the child's life, as well as attention to trauma the child may have experienced, is essential to the judicious and thoughtful consideration of all treatment options and establishment of a treatment plan that will produce the optimal outcome for that child.

The literature and research regarding the treatment of mental health and behavior disorders is very clear in its recognition that the use of psychotropic medications should occur only as a result of a thorough bio-psycho-social evaluation.

Bio, short for biological, refers to the physical, chemical, and genetic factors that may be contributing to the disorder. Psycho, short for psychological, refers to the affective and cognitive aspects of a disorder. Finally, social refers to the environmental/relational factors that may be contributing to the disordered behavior.

Psycho-social interventions in place of or in collaboration with medication should be clearly targeted to the alleviation of specific symptoms or development of new skills. Children often need only to learn skills such as anger management or problem solving to help them interact with others more successfully. Some children need to talk about their trauma or their grief to make sense of and resolve it. Specific types of interventions or therapies that should be considered, with or without medication, include play therapy, social skills group, parent-child interactive therapy (PCIT), dialectic behavioral therapy (DBT), cognitive behavioral therapy (CBT), child-parent psychotherapy, parent coaching, and anger management groups.

Applicable Federal Law

Creating and implementing integrated oversight and monitoring protocols that ensure appropriate use of psychotropic medication for children in foster care requires thoughtful and intentional collaboration across complex systems, e.g., child welfare, mental health, court, and education.

The federal government has promoted such protocols through various mandates. States that receive funding through Title IV-B, subpart 1, of the Social Security Act, are required to address, through policy and practice, some of the most pressing issues related to oversight and monitoring of psychotropic medication use for children in foster care. These mandates recognize that the mental and behavioral health disorders of children in foster care present a number of unique problems that require a well-coordinated system of care and collaborative team effort by <u>all</u> parties involved in ensuring a child's well-being.

The Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) requires state and tribal agencies to develop a plan for ongoing oversight and coordination of health care services for children in foster care. This is to be done in coordination with the state Title XIX (Medicaid) agency, pediatricians, and other experts and providers of health care services. The plan must describe how the state will ensure a coordinated strategy to identify and respond to physical and mental health needs; provide continuity of health care services that are monitored by a medical home or single source entity; and ultimately ensure children receive high quality, coordinated health care services and appropriate oversight and monitoring of psychotropic medication.

The Child and Family Services Improvement and Innovation Act of 2011 (Public Law 112-34) provides guidance and direction concerning the care and treatment of the social, emotional,

and mental health needs of children who have experienced maltreatment. It requires that each state, as part of their Health Care Coordination and Oversight Plan, develop a plan for the oversight of prescription medicines that includes protocols for the appropriate use and monitoring of psychotropic medications with children and youth in foster fare. The plan must provide for informed and shared decision making and provide methods for ongoing communication between the prescriber, the child, caretakers and parents, child welfare workers, and other key stakeholders.

State Child and Family Services Plans (five-year strategic plans that set forth the vision and goals to be accomplished to strengthen the states' child welfare systems) must now include details about how emotional trauma associated with maltreatment and removal is addressed, as well as a description of how the use of psychotropic medications is monitored.

The Child and Family Services Act of 2011 also reauthorized the Promoting Safe and Stable Families Program, with the requirement that state child welfare agencies address the issue of trauma when developing a plan for meeting the health and mental health needs of youth in foster care. Recent studies and research indicate that trauma-informed assessment and related psycho-social interventions could reduce the need to control mood and behavior with psychotropic medication. These studies indicate that trauma-related behavioral disorders are often misdiagnosed as mental illnesses and treated with psychotropic medication, which may not only be unnecessary, but could make matters worse for some children.

In addition to these mandates, the U.S. Department of Health and Human Services Administration for Children and Families issued an "information memorandum" dated April 11, 2012, addressing the need for substantive oversight of psychotropic drugs due to elevated levels of use for children in foster care compared with children in the general population. It called for better state oversight of psychotropic medication for children in foster care, better coordination of mental health care across child welfare services sectors, better access to non-pharmacological psycho-social interventions for behavioral disorders, and increased use of evidence-based mental health assessment and treatment.

Michigan's Policy and Practice

Michigan, in addition to responding to the federal mandates noted above, has also been required to give significant attention to the mental health needs of children in foster care as a result of findings in the 2010 Child and Family Services Review Final Report, which found Michigan in need of improvement in this area, as well as in response to the Modified Settlement Agreement (MSA), *Dwayne B. v Rick Snyder, et al.,* which requires Michigan to monitor the provision of healthcare services for appropriate quality and to ensure they are having the intended effect.

The Michigan Department of Human Services (DHS) has addressed these requirements in its Health Oversight and Coordination Plan. This plan appears very detailed in regard to utilization of psychotropic medication. The plan calls for a state child welfare health advisory board and health liaison officers (HLOs), who will serve as point persons in each county to assist in the delivery of health care services to children. One role of an HLO is to ensure documentation is in the case file for psychotropic medication approvals and uses for children in foster care.

DHS has also addressed the federal requirements in its five-year Child and Family Services Plan. Related DHS policy is also quite detailed and comprehensive with documentation requirements for the prescribing, monitoring, and managing of psychotropic medication clearly spelled out:

> A Medical Passport (DHS Form-221) must include the child's diagnosis; name of prescribed psychotropic medication(s), dosage, and prescribing clinician's name and medical specialty; medication monitoring appointments with the prescribing physician; ongoing testing/lab work specific for the prescribed medication; any related side effects to the medication; all non-pharmacological treatment services (therapy, behavioral supports/monitoring, other interventions, etc.).

DHS policy requires that all items above must be incorporated into the medical section of the case service plan, which must also include the child's reaction to the medication, including the child's comments and/or concerns regarding the medication; caregivers' observations and comments regarding the effect of the medication; feedback regarding the medication's effect on the child from birth parent(s), therapists, daycare providers, teachers and/or other persons as applicable; all feedback (oral and written) from the prescribing clinician and a signed and completed DHS-1643, Psychotropic Medication Informed Consent.

As we have noted in previous FCRB annual reports, good DHS policy is not always implemented in practice. In the course of our reviews, board members rarely see Medical Passports completed as required in regard to psychotropic medication, nor do we find case service plans that provide anywhere close to the information required by policy. We do at times find this information in other documents for children in residential treatment or who are receiving services through the Severely Emotionally Disturbed (SED) Waiver Pilot.

Since the FCRB began tracking DHS Form 1643 in July 2012, we have found that a majority of files for children prescribed medication do contain the form. However, a number of the forms are not completed and lack the signature of the consenting party.

DHS training of new caseworkers includes a unit on mental health and psychotropic medication, but there is no requirement for ongoing, continued training in this very important and key aspect of a child's experience in foster care. State foster parent support organizations report foster parents receive little or no required training regarding psychotropic medications and the monitoring and reporting of a child's response to the medication, including side effects. Foster parents who are designated "treatment foster homes" or who care for children who receive services through the SED waiver reportedly do receive this training, though.

Challenges

One of the great challenges to successful utilization, management, and monitoring of psychotropic medication for children in foster care is the reality that these children do not always have a consistent caregiver who can be a knowledgeable and reliable historian for what a child has experienced or what kinds of symptoms they are dealing with. Parents may not have been around their children enough to provide accurate information. Parents who are in conflict with their child or who have neglected their child may exaggerate symptoms or blame the child when they themselves are really at the root of the presenting issues. Parents and foster caregivers can sometimes become so frustrated by a child's behaviors that they exaggerate the child's symptoms to gain added support and sympathy or, in the case of foster parents, an increased per diem. Consequently, when there is no reliable caregiver who can objectively describe the child's symptoms, struggles, and progress, the information collected can be biased and incomplete.

Furthermore, if caregivers and caseworkers are not adequately trained and educated in caring for a child with significant emotional and psychological needs, medications can often be given to the child just to control their behaviors, rather than to truly treat the child's disorder; side effects can go undetected, and benefits of the medications missed or misrepresented.

Another challenge is that children in foster care, especially those with significant behavioral disorders, can experience frequent placement moves and changes in mental health providers, which hinders continuity and coordination of care. This reality emphasizes the need for a highly coordinated system of care, with a clearly designated person to monitor the child's mental and behavioral health care, as well as caretakers and caseworkers who have knowledge of both the benefits and side effects of psychotropic medications the children are prescribed.

A third challenge is the development of highly coordinated and collaborative system of care across complex systems, e.g., child welfare, mental health, court, and education. The DHS Health Advisory and Resource Team (HeART), which is made up of representatives from these systems, has been working on related issues, and their work should continue with the utmost support from leaders of the systems involved.

Conclusions

Responding to the unique needs of children in foster care who have experienced maltreatment and are exhibiting symptoms of emotional or behavioral disorders requires a multifaceted - yet targeted - treatment approach, of which the prescribing of psychotropic medication may be one component. These prescriptions must be driven by true need, careful and thoughtful diagnosis, and full consideration of nonchemical interventions. If, instead, they are driven by money, expediency, or simple frustration with an inadequate system of care, then their use is inconsistent with a child's right to receive proper medical care and to live without the numbing or dangerous side effects of psychotropic drugs.

PSYCHOTROPIC MEDICATIONS		
	Total Count	**% of Total on Meds (275)**
Children on psych meds	275	
Percentage of all 978 children (cases) reviewed in 2012		28 %
Children on 2 or more meds	209	76 %
Children benefitting	219	80 %
Medication reviews: frequency		
30 days	165	60 %
60 days	16	6 %
90 days	68	25 %
Medication reviews: reviewer		
Psychiatrist	221	80 %
Primary care physician/other	54	20 %

The effective oversight of the utilization, benefits, and side effects of psychotropic medication is essential to a child's safety and well-being, and can even impact timely permanency. It is ultimately the role and responsibility of mental and behavioral health clinicians to make appropriate assessments of a child's treatment needs and to propose, implement, and monitor an appropriate plan of intervention. However, all parties responsible for the child's well-being while in the foster care system (caseworkers, judges/attorneys, foster parents, therapists) must understand the proper role of psychotropic medications so they can help ensure the child is receiving treatment most appropriate to his or her needs and effectively advocate and provide input into treatment decisions.

As we strive to strengthen our child welfare system's ability to safely and appropriately utilize and manage psychotropic medication in the treatment of mental and behavioral disorders in our children, and provide them the very best possible treatment for the trauma they have

experienced and the disorders impacting their lives, it will be necessary to recognize the corresponding need to enhance system capacity to implement effective, non-pharmaceutical interventions to treat the social-emotional, behavioral, and mental health issues common among children who have been maltreated.

Recommendations

1. We recommend that DHS establish supervisory and continuous quality improvement protocols to help ensure that requirements of the Health Oversight and Coordination Plan and related policy regarding prescribing and monitoring of psychotropic medication are implemented consistently throughout the foster care system.
2. We recommend that DHS establish training requirements regarding psychotropic medication for foster care caseworkers and licensed foster parents that will provide them with the information they need to effectively monitor and advocate for a child's needs in this area.
3. We recommend that DHS continue to work diligently with the Department of Community Health and the state Legislature to promote and fund the utilization of evidence-based practices in the treatment of emotional and behavioral disorders of children in foster care.
4. We recommend that DHS collaborate in the development of a broad range of trauma-informed, developmentally and culturally appropriate programs that help improve the standard of care for foster children with emotional and behavioral disorders.
5. We recommend that the State Court Administrative Office (SCAO) provide ongoing training opportunities for jurists and lawyer-guardians ad litem to effectively determine if a foster child's psychotropic medication is being properly prescribed and managed.
6. We recommend that the DHS ensure that court reports include information on psychotropic medication the child is prescribed, the reason for the medication and if and how the child is benefitting from the medication.

Update: 2011 Recommendations

The Foster Care Review Board's 2011 Annual Report, which addressed the issue of parent-child visitation, contained the recommendations noted below. That report is available at the Michigan Courts website: click here

The FCRB recommended that the Michigan Department of Human Services, the State Court Administrative Office, and local courts implement recommendations that were to be presented in a statewide Parent-Child Visitation Task Force report, which was required as part of the federal Child and Family Services Review, Program Improvement Plan. That report has been completed; however, it had not yet been distributed within the foster care system at the time.

We also recommend that any potential legislative action required to implement the recommendations be pursued through the state Permanency Options Workgroup.

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Program Highlights:

Annual Child Welfare Awards

These awards are presented at our annual conference to formally recognize outstanding work by child welfare professionals.

2012 Winners:

Foster Parents of the Year
John and Judy Wright
Ennis Center for Children

Foster Care Caseworker of the Year
Matt Miller
Michigan DHS, Emmet County

Parent Attorney of the Year
John Ceci
Livingston County

Lawyer-Guardian Ad Litem of the Year
Ginny Mikita
Kent County

Jurist of the Year
Honorable Susan Dobrich
Cass County Probate Court

From left: Bob Kruse , Ginny Mikita, Andy Wright, Judge Susan Dobrich, Judy Wright, Justice Mary Beth Kelly, John Ceci, Matt Miller

Press Release re: 2012 Child Welfare Award Winners:
http://courts.mi.gov/News-Events/press_releases/Documents/FCRBAwards2012.pdf

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2013 Nominations:

The Foster Care Review Board is pleased to announce that we are accepting nominations for the 2013 awards through September 6. Complete information about submitting a nomination can be found at:

http://courts.mi.gov/Administration/SCAO/OfficesPrograms/fcrbp/Pages/Child-Welfare-Awards.aspx

Program Highlights:
Annual Training Conference

The 2012 FCRB Annual Training Conference was held in Lansing, with all first-day sessions conducted collaboratively with the State Court Administrative Office's Court Improvement Program. The conference, titled **"Keeping Them Connected,"** addressed the important role of parent-child visitation in promoting child well-being and achieving timely permanency.

National experts on this subject, Dr. Katharine Leslie and Rose Wentz, presented on how frequent, well-planned, purposeful, and progressive involvement of parents with their children while in foster care eases the anxiety and reduces the trauma children experience as a result of being forcibly separated from their parents, while at the same time improving the children's overall well-being while in care. Practical ways of increasing and improving visitation were presented. A panel consisting of foster parents, biological parents, and caseworkers addressed the need for close collaboration among these parties to help maintain and establish healthy connections between the parent and child while in foster care.

On the second day of the training conference, we were privileged to have Fay Givens and Dr. Kay McGowan present on the history and development of the federal Indian Child Welfare Act. Included in their presentation was a viewing of their coproduced, award-winning documentary, "Indian School: A Survivor's Story."

Program Performance

1. Percentage of foster parent appeals investigated within seven days, as required by MCL 712A.13b(3):
   - 2010: 86 percent
   - 2011: 90 percent
   - **2012: 91 percent** ⬆

2. Percentage of cases reviewed by local boards consecutively every six months, as required by MCL 722.137(1)(b):
   - 2010: 56 percent
   - 2011: data unavailable due to data entry inconsistencies
   - **2012: 60 percent** ⬆

3. Percentage of reports distributed to interested parties within 30 days of the review, or prior to the next court hearing, as required by MCL 722.137(1)(b):
   - 2010: 80 percent
   - 2011: 71 percent
   - **2012: 80 percent** ⬆

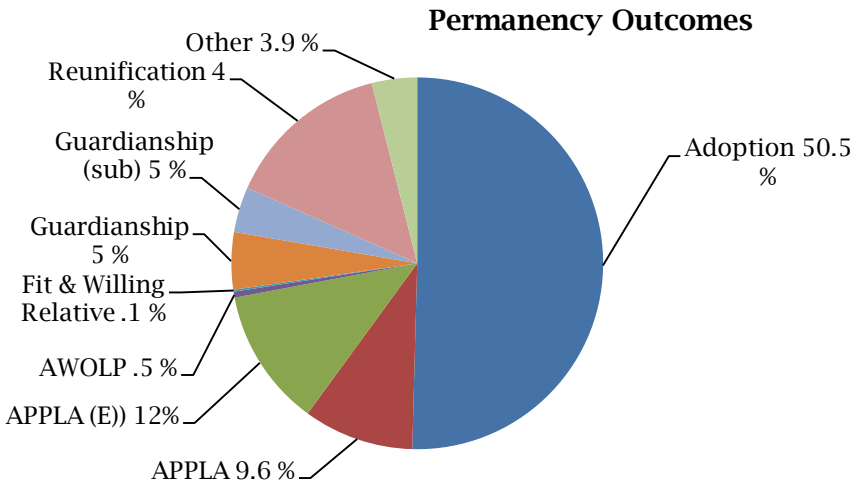
Program Data

Pursuant to our legislative mandate and mission statement, the Foster Care Review Board collects and evaluates data through case review and appeal hearings. This data then allows the program to advocate for systemic improvements related to child safety, timely permanency, and family and child well-being.

Data collected is centered on the following categories:

- Permanency outcomes
- Barriers to permanency
- Appeal information
- County review data

Highlights from the data information collected in 2012 are provided below, and complete data is found on the following pages:



Total Review Hearings in 2012:
637
(Involving 978 children)

Total Appeal Hearings in 2012:
58
(Involving 89 children)

Top Barriers to Permanency
Reunification Parents unwilling to participate in or utilize services offered
Adoption Ward behavior
Guardianship Required documentation not completed and approved by the DHS Bureau of Child Welfare
Placement With Fit and Willing Relative Relative lacks financial resources to care for children and cannot be licensed
APPLA Ward behavior

Barriers to Permanency

The chart below identifies the most common barriers to timely achievement of each permanency outcome and the applicable number of cases for each, as identified in the course of our reviews.

Category/Definition		No. of Cases	Counties Most Affected
Reunification			
	Parents unwilling to participate in or utilize services offered	96	Wayne, Berrien, Washtenaw, Kalamazoo, Oceana
	Parenting time is not sufficient to support reunification	83	Wayne, Ingham, Oakland, Midland
	Parents are not participating in parenting time	52	Wayne, Macomb, Gratiot, Jackson
	Parents utilizing but not benefitting from services offered	52	Wayne, Shiawassee, Menominee, Kalamazoo
	Parental incarceration	29	Mackinac, Jackson
	Affordable/suitable housing not available	23	Wayne, Berrien
Adoption			
	Ward behavior	90	Wayne, Van Buren
	Lack of appropriate adoptive home	63	Wayne, Berrien
	Parental appeal of termination decision	32	Multiple counties
	Competing parties (wishing to adopt)	25	Wayne, Mecosta,
	Administrative delay-Completion of required studies	16	Wayne, Berrien
	Administrative delay-Subsidy	16	Multiple counties
Guardianship			
	Required documentation not completed and approved by the DHS Bureau of Child Welfare	10	Wayne, Kalamazoo
	Ward behavior	10	Gogebic, Wayne
	Subsidy process delays	4	Wexford
Placement With Fit and Willing Relative			
	Relative lacks financial resources to care for children and cannot be licensed	7	Allegan, Genesee
	Required documentation to approve as permanency plan not completed	3	Monroe
Another Planned Permanent Living Arrangement (APPLA)			
	Ward behavior	59	Wayne, Livingston, Oakland, St. Clair
	Ward does not have adequate independent living skills	39	Wayne, Genesee, Macomb, Missaukee
	Specific living arrangement not identified	24	Muskegon, Alpena
	Required documentation not completed and approved by DHS Bureau of Child Welfare	19	Wayne, Kent
	Specific living arrangement not established	10	Alpena

Permanency Outcomes – Closed Cases

These figures represent cases reviewed by the FCRB and closed during 2012 due to the permanency goal being achieved or due to other circumstances in which the child was terminated from court jurisdiction.

Permanency Outcome	Total		Percent of Total		Average Days in Care		Average Number of Placements	
	2012	2011	**2012**	2011	**2012**	2011	**2012**	2011
Adoption	**294**	162	**50.5 %**	41.8 %	**1260**	835	**2.7**	7.2
APPLA*	**56**	14	**9.6 %**	3.6 %	**1584**	1858	**6.8**	7.2
APPLA (Emancipation)	**70**	27	**12 %**	7.0 %	**2391**	2249	**6.6**	8.3
AWOLP***	**3**	1	**.5 %**	.3 %	**2280**	n/a	**15.0**	n/a
Fit & Willing Relative	**1**	7	**.1 %**	1.8 %	**6546**	807	**4.0**	2.9
Guardianship	**52**	44	**9 %**	11.3 %	**2979**	2064	**9.6**	5.0
Reunification	**84**	70	**14.4 %**	18 %	**594**	1888	**2.6**	3.3
Other	**23**	63	**3.9 %**	16.2 %	**2107**	2317	**7.8**	8.4
Totals	**583**	388	**100 %**	100 %	**1725**	1717	**5.7**	6.0

* APPLA – Another Planned Permanent Living Arrangement
** APPLA(E) - Another Planned Permanent Living Arrangement-Emancipation
*** AWOLP – Absent Without Legal Permission

Appeals

Pursuant to 1997 PA 163, foster parents may appeal the removal of a ward from their home. Eligible appeals are heard by local foster care review boards, which then either agree or disagree with the child's removal. If the review board **agrees** with the foster parents and determines that the removal was **not** in the child's best interests, the matter is then heard by the court or reviewed by the Michigan Children's Institute (MCI) superintendent (if the child is an MCI ward).

APPEAL TOTALS		
	2012	2011
Appeals held: cases/wards	**89**	130
Appeals held: hearings	**58**	75
Hearings held timely	**53**	68
Percentage held timely	**91 %** ↑	90 %
Hearings held untimely: total	**5**	7
Percentage held untimely:	**9 %**	10 %
Appeal intakes	**117**	114
Ineligible for appeal	**59**	28
Hearings cancelled	**15**	11

In 2012, the Foster Care Review Board Program received **117 intake calls** from foster parents who inquired about appealing a removal decision. Local review boards conducted **58 appeal hearings** (some involving several wards), agreeing with the foster parents **38** times (43 percent) and with the agencies **51** times (57 percent). We are hopeful that the significant reduction in appeals this year is indicative of greater placement stability for children system wide.

County Data

County	Case Reviews		Appeal Hearings	
	Total Reviews- Sibling Groups	Total Children Reviewed	Total Appeals – Sibling Groups	Total Appeals – Children/Wards
ALCONA	3	5		
ALGER	2	2		
ALLEGAN	9	12		
ALPENA	4	6		
ANTRIM	2	2		
ARENAC	2	6		
BARAGA	2	2		
BARRY	1	1		
BAY	6	12		
BENZIE	2	4		
BERRIEN	18	28		
BRANCH	5	5		
CALHOUN	9	18	1	1
CASS	7	14		
CENTRAL OFFICE *	94	146	7	10
CHARLEVOIX	2	2	1	2
CHEBOYGAN	2	2		
CHIPPEWA	4	5		
CLARE	1	1		
CLINTON	1	1		
CRAWFORD	2	4		
DELTA	2	2		
DICKINSON	4	5		
EATON	3	7	1	1
EMMET	2	5		
GENESEE	13	16		
GLADWIN	4	6		
GOGEBIC	4	7		
GRAND TRAVERSE	3	3	3	5
GRATIOT	3	6		
HILLSDALE	1	1	1	1
HOUGHTON	1	1		
HURON	4	5		
INGHAM	19	28	2	4
IONIA	1	2		
IOSCO	2	4		
IRON	1	4		
ISABELLA	4	4	1	1
JACKSON	8	16	1	3
KALAMAZOO	18	34	1	2

** County changes to "central office" with case status of adoptive supervision, adoption subsidy, or OTI adoption.*

(Continued on next page)

	Case Reviews		Appeal Hearings	
	Total Reviews-Sibling Groups	Total Children Reviewed	Total Appeals – Sibling Groups	Total Appeals – Children/Wards
KALKASKA	4	5		
KENT	20	25	3	3
LAKE	4	5		
LAPEER	3	4	1	1
LEELANAU	2	4	1	3
LENAWEE	4	4	1	3
LIVINGSTON	5	10	2	3
LUCE	1	1		
MACKINAC	3	9		
MACOMB	17	28	1	1
MANISTEE	3	6	1	2
MARQUETTE	3	8	1	3
MASON	3	3		
MECOSTA	5	7		
MENOMINEE	4	5		
MIDLAND	5	7	1	3
MISSAUKEE	1	2		
MONROE	6	9	1	1
MONTCALM	3	4	1	2
MONTMORENCY	3	4		
MUSKEGON	19	28	1	1
NEWAYGO	3	6	1	1
OAKLAND	13	26	3	4
OCEANA	3	6		
OGEMAW	2	2		
OSCEOLA	1	1		
OSCODA	3	7		
OTSEGO	5	6	1	1
OTTAWA	5	8		
PRESQUE ISLE	1	1		
ROSCOMMON	2	4	1	2
SAGINAW	15	20	1	2
SANILAC	3	3		
SCHOOLCRAFT	2	3		
SHIAWASSEE	4	9	1	
ST CLAIR	4	4	2	4
ST JOSEPH	4	6		
TUSCOLA	5	8		
VAN BUREN	7	13	2	2
WASHTENAW	11	12	3	4
WAYNE	143	231	13	15
WEXFORD	2	4		
TOTALS	**637**	**978**	**61**	**90**

2012 FCRB Board Members

List is representative of committee members as of 12/31/12.

Alcona County	Genesee County	Kalamazoo County	Muskegon County	Wayne County
Tamara Quick	Gordon Sherman	Mary Roberts	Patricia Roof	Denise Carr
Carline Bendig	Dawana Taylor	Carlos Daniels	Carolyn Smith-Gerdes	Johnette Connors
Alger County	Quincy Dobbs	Cheryl Nebedum	Janice Hilleary	Janice Cowan
Rose Wilbur	Agnes Greene	Lisa Rodriguez	Linda Knapp	Paula Cunningham
Allegan County	Toyonna Robbins	Kent County	Sharon Mazade	Tonie Dance
Vivien Vandenberg	Shuntai Beaugard	Vernon Laninga	Newaygo County	Tara DeFoe
Chris Seidel	Shawn Bryson	Daniel Groce	Larry Feikema	Lynda DeFrain
Antrim County	Sheila Powell	Jan Fotsch-Foxen	Oakland County	Marvin Dick
Susan Gielda	Grand Traverse Co	Jacqueline Rudolph	Carol Borich	Katrina Dixon
Arenac County	Diana Zapalski	Carol Bennett	Barbara Allen	Doncella Floyd-Jones
Tifanie Tremble	Hillsdale County	Lake County	Darnita Stein	Brenda Godfrey
Barry County	Martha Crow	Frances Arquette	Charles Ludwig	Mary Hammons
Ronald Heilman	Diane Langan	Lenawee County	Cassandra Chandler	Warren Harrison
Carol Stanton	Huron County	Jonathan Hale	Clara Dawkins	Felisha Taylor
Benzie County	Janice Holz	Livingston County	Janet Evans-Covington	Loretta Horton
Lynda Jamison	Jon Fruytier	Gabrielle Hancock	Kay Norton	Kathie House
Rebecca Garland	Ingham County	Cynthia Salfate	Gary Shripka	David L. Hunt
Berrien County	Kristina Marshall	Luce County	Osceola County	Joy Inniss-Johnson
Kenneth Orlich	Cheryl Mask	Ronald Ford	Janice Booher	Yvette Jenkins
Joan Smith	Kimber Thompson	Macomb County	Ottawa County	Ethel Knight
Bridgette Williams (Is	Stephanie Williams	Angie Greenslade	Dennis Schaaf	Darryl Lewis
Mary Spessard	Julie Loveless	Eugene Groesbeck	Susan Thorpe	Theresa Mattison
Lenore Becker	Laura Peiffer	Lynda Steele	Sanilac County	Judy Mock
Branch County	Charles Foster	Elayne Gray	Linda Bombard	Ronald Moore
Jerry Yoder	Raymond Buch	Jack Pittman	St. Clair County	Jacqueline Moss
Lucinda Wakeman	Susan Refior	Rosemary Sear	Kathryn Bruer	Daphne Nedd
Michael Ronzone	David Shorter	Edna Chang	Robert Goldenbogen	Don Novak
Calhoun County	Iosco County	Helen Springer	Brendon Aspenson	Elizabeth Oliver
Arlen Facey	Renee Keller	Mecosta County	Deborah Ziegler	Anitta Orr
Cass County	Alan Gould	Jill Gernert	St. Joseph County	Rita Ross-Price
James Rutten	Vera Middleton	Midland County	Betty Taylor	Wain Saeger
Jill Ernest	Iron County	Stephen Ignatowski	Washtenaw County	Nancy Silveri
Cheboygan County	Bobbi Bonetti	James Kubiak	Lisa Ruby	Janine Sladewski
Marilyn Kapp	Jackson County	Colin Buell	Gayle Stewart	Rita Smythe
Chippewa County	Edwina Divins	Michael Love	Marion Hoey	Willie Stanley
Doris Posey	Selena Harris	Al Myatt	Cathy Ann Haynes	Ellen Stephens
Clare County	Susan Sharkey	Monroe County	Sonja Felton	Irene Stringer
Donald Murray	Diana Liechty	Frederick Corser, Jr.	Wayne County	Kimberly Sutherland
Clinton County	Harold White	Thomas Perry	Patrick Arella	Carol Terpak
Michael Kessler	Pamela Fitzgerald	Montmorency County	Nancy Arnold	Robert Thomas
Emmet County	Jamie Lynn Hornin	Mary Jo Guest	Angela Asteriou	Theresa Thomas
Kenda Deschermeier	Kalamazoo County	David Smith	Beatrice Bikali	Sara Tyranski
Jean Frentz	Sally Putney	Muskegon County	Brenda Boyd	Pamela Travis
Genesee County	Helayne Smith	Edward Holovka	Brooke Brantley-Gilber	Claudia Yates
Stephanie Young	Shirley Topp	Melba White Newsom	Willie Cambell	
Lauretta Montini	Linda Dunn	Willie German		

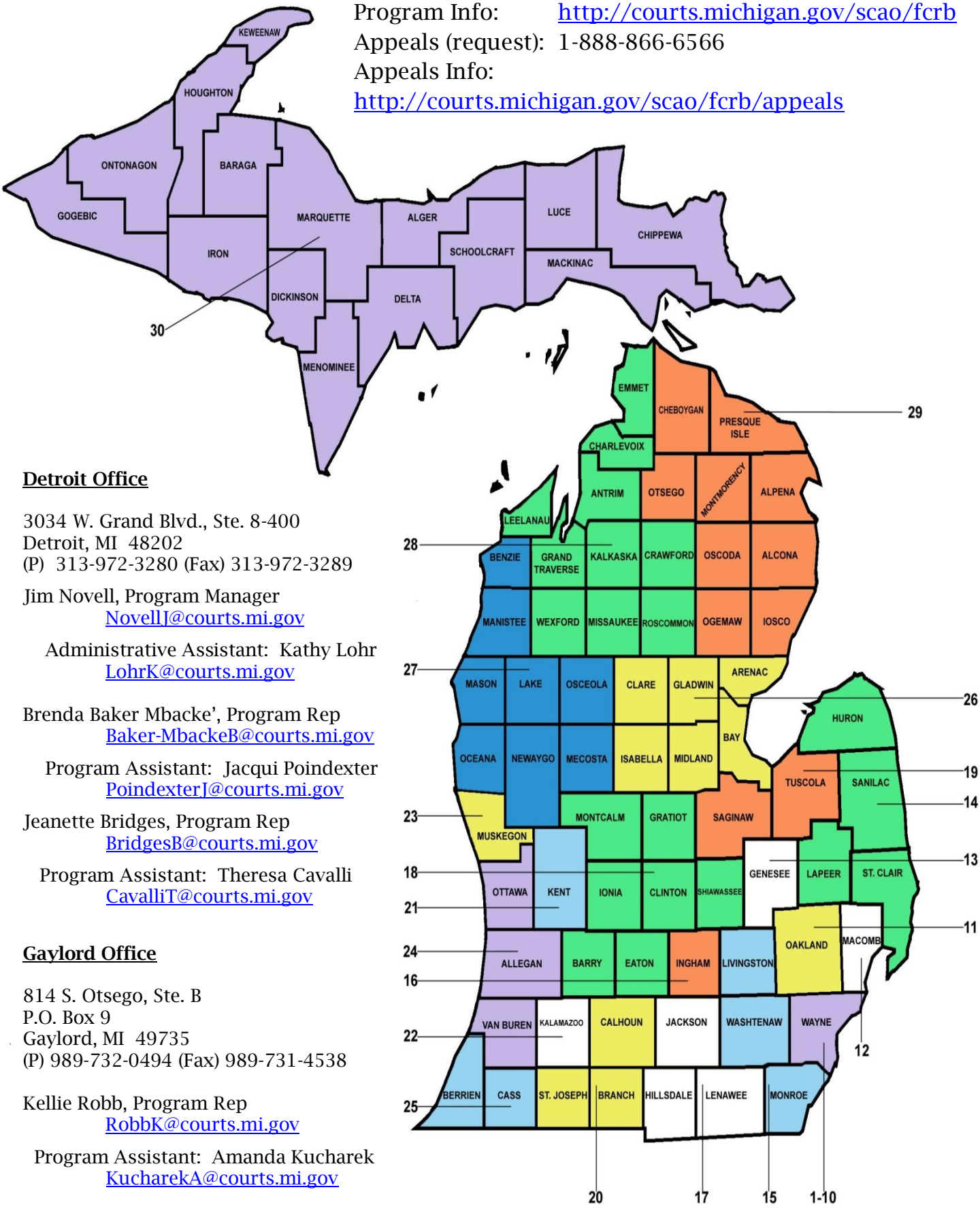
2012 FCRB Advisory Committee Members

***Bold** denotes 2012 FCRB Executive Committee members.*
List is representative of committee members as of 12/31/12.

Name	Title		Name	Title
Barbara Allen	FCRB Board 11, Wayne County		Terri Henrizi	Education Coordinator, ACMH
Casey Anbender	CWS Management Analyst		Jonas Hill, Sr.	FCRB Board 8, Wayne County
Michael Anderegg	Chief Judge, Marquette County Probate Court (retired)		Edward Holovka	FCRB Board 23, Muskegon County
Nancy Arnold	FCRB Board 8, Wayne County		Kelly Howard	Director, Child Welfare Services
Brenda Baker-Mbacke'	FCRB Program Representative		Marilee Johnson	FCRB Board 27, Manistee County
Carol Bennett	FCRB Board 21, Kent County		Vernon Laninga	FCRB Board 21, Kent County
Candee Bobalek	MAFAK Legislative Chair, PRIDE Trainer		Courtney Maher	Seita Scholar, Western Michigan University
Linda Bombard	FCRB Board 14, Ingham County		Cheryl Mask-Nealy	FCRB Board 16, Ingham County
Dana Booker	FCRB Intern, Wayne State University		Rubina Mustafa	Attorney, Detroit Ctr. for Family Advocacy
Jeanette Bridges	FCRB Program Representative		Roy Myatt	FCRB Board 26, Midland County
Jennifer Carpio-Zeller	FCRB Board 24, Van Buren County		Shirley Norman	FCRB Board 19, Tuscola County
Paula Cunningham	FCRB Board 4, Wayne County		**James Novell**	FCRB Program Manager
Clara Dawkins	FCRB Board 7, Wayne County		Kathryne O'Grady	System of Care Director, 3rd Jud. Circuit Court
Kenda Deschermeier	FCRB Board 28, Emmet County		Seth Persky	Interim Director, Office of the Family Advocate
Marvin Dick	FCRB Board 1, Wayne County		Jack Pittman	FCRB Board 12, Macomb County
Quincy Dobbs	FCRB Board 13, Genesee County		**Kellie Robb**	FCRB Program Representative
Jacob Drenovsky	FCRB Board 18, Shiawassee County		Nancy Rostoni	Foster Care Manager, Dept. of Human Services
Linda Dunn	FCRB Board 18, Bay County		Lisa Ruby	FCRB Board 15, Washtenaw County
George Eason	FCRB Board 5, Wayne County		Verlie Ruffin	Director, Office of the Children's Ombudsman
Michael Eberth	FCRB Board 9, Wayne County		Helayne Smith	FCRB Board 22, Kalamazoo County
Ryan Fewins-Bliss	Board President, CASA of Michigan		Leslie Kim Smith	Judge, 3rd Jud. Circuit Court, Fam. Div.
Ronald Ford	FCRB Board 30, Luce County		Janet Reynolds Snyder	Exec. Director, MI Federation for Children
Jeanne Fowler	President, Big Family of Michigan		Mary Spessard	FCRB Board 25, Berrien County
Alan Gould	FCRB Board 29, Iosco County		Carol Stanton	FCRB Board 18, Barry County
Elayne Gray	FCRB Board 12, Macomb County		Suzanne Stiles-Burke	Director, DHS Bureau of Child Welfare
Jonathan Hale	FCRB Board 17, Lenawee		**Lucinda Wakeman**	FCRB Board 20, Branch County
Marcia Haney	MAFAK Bylaws Chair, Pride Trainer		Addie Williams	Exec. Director, Spaulding for Children
Warren Harrison	FCRB Board 8, Wayne County			

MICHIGAN'S FOSTER CARE REVIEW BOARDS

Program Info: http://courts.michigan.gov/scao/fcrb
Appeals (request): 1-888-866-6566
Appeals Info:
http://courts.michigan.gov/scao/fcrb/appeals



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