**Blue Ribbon Commission to Study the Organization of and Service Delivery by the Department of Health and Human Services**

Resolve 2023, chapter 98
Wednesday, May 29, 10:00am
Room 209 (Health and Human Services Committee room)
Cross State Office Building, Augusta ME

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## AGENDA

- Welcome, *Chairs Senator Duson and Representative Craven*
- Commission member introductions
- Recap of last interim meetings and resolve; agenda; materials distributed (staff)
- Budget initiatives related to child welfare enacted in 2024 supplemental budget (staff)
- Department of Health and Human Services Presentations
  - Case study: "Family involved in the child welfare system engaging in reunification activities after children (>1 child) have been removed from the home. Children are placed in two different kinship settings and have concerns about the safety of the children if the family is reunified." Where do families involved in the child welfare system, foster families, individuals (children and parents) go for services across DHHS? How do the bridges work between offices within DHHS, individuals and courts? What are the options for review of actions taken in child welfare cases (who can people complain to; what does quality assurance look like)?
  - Update on DHHS child welfare initiatives
- Office of Program Evaluation and Governmental Accountability Presentation
  Peter Schleck, Director
  - Information Brief--Oversight of Maine's Child Protective Services (OPEGA)
  - Frontline Perspectives in Child Protection as Catalysts for Reform (GOC report)
- Child Welfare Ombudsman Presentation and response to questions
  Christine Alberi
- Recap of LD 779 (separate department) and 1788 (Office of Inspector General for child welfare) from last session in the HHS committee (staff)
- Commission discussions on child welfare
- Next steps

Future meeting dates: June 12, July 10, September 17, October 9, October 30.

LAW WITHOUT GOVERNOR'S SIGNATURE

JULY 19, 2023

CHAPTER 98

RESOLVES

## STATE OF MAINE

## IN THE YEAR OF OUR LORD

## TWO THOUSAND TWENTY-THREE

## H.P. 571 - L.D. 915

# Resolve, to Establish the Blue Ribbon Commission to Study the Organization of and Service Delivery by the Department of Health and Human Services

**Emergency preamble. Whereas,** acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

**Whereas,** this legislation establishes the Blue Ribbon Commission to Study the Organization of and Service Delivery by the Department of Health and Human Services; and

**Whereas,** this legislation must take effect before the expiration of the 90-day period so that the commission may timely meet and make its report to the Legislature; and

**Whereas,** in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

**Sec. 1. Commission established. Resolved:** That the Blue Ribbon Commission to Study the Organization of and Service Delivery by the Department of Health and Human Services, referred to in this resolve as "the commission," is established.

**Sec. 2. Commission membership. Resolved:** That, notwithstanding Joint Rule 353, the commission consists of 13 members as follows:

1. Three members of the Senate appointed by the President of the Senate, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature;

2. Three members of the House of Representatives appointed by the Speaker of the House of Representatives, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature;

3. Two members appointed by the President of the Senate, one of whom must have lived experience in caring for one of the following types of individuals and one who

represents the interests of at least 2 of the following types of individuals or providers of care to at least 2 of the following types of individuals:

A. Individuals with intellectual disabilities or autism;

B. Individuals with mental health disorders or substance use disorder;

C. Individuals experiencing poverty;

D. Elderly individuals;

E. Children receiving child welfare services; or

F. Children receiving early childhood services;

4. Two members appointed by the Speaker of the House of Representatives, one of whom must have lived experience in caring for one of the following types of individuals and one who represents the interests of at least 2 of the following types of individuals or providers of care to at least 2 of the following types of individuals:

A. Individuals with intellectual disabilities or autism;

B. Individuals with mental health disorders or substance use disorder;

C. Individuals experiencing poverty;

D. Elderly individuals;

E. Children receiving child welfare services; or

F. Children receiving early childhood services;

5. The Commissioner of Health and Human Services or the commissioner's designee; and

6. Two directors of offices within the Department of Health and Human Services chosen by the commissioner.

**Sec. 3. Chairs. Resolved:** That the first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the commission.

**Sec. 4. Appointments; convening of commission. Resolved:** That, notwithstanding Joint Rule 353, all appointments must be made no later than 30 days following the effective date of this resolve. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members, the chairs shall call and convene the first meeting of the commission. If 30 days or more after the effective date of this resolve a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the commission to meet and conduct its business.

**Sec. 5. Duties. Resolved:** That the commission shall examine the organizational structure of the Department of Health and Human Services and the services provided by the department. The commission shall examine:

1. The organizational structure of and service delivery by similar agencies in other states and in nongovernmental organizations;

2. The strengths and weaknesses in the services provided with state and federal funding;

3. Current proposals for improving the safety and well-being of children and strengthening families across all populations and geographical areas of the State;

4. Barriers to accessing services, as well as system failures and additional needed resources; and

5. Areas in which processes can be streamlined and efficiencies made within the department.

**Sec. 6. Staff assistance. Resolved:** That the Legislative Council shall provide necessary staffing services to the commission, except that Legislative Council staff support is not authorized when the Legislature is in regular or special session.

**Sec. 7. Report. Resolved:** That, no later than November 6, 2024, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, for presentation to the joint standing committee of the Legislature having jurisdiction over health and human services matters. The committee may submit legislation to the 132nd Legislature in 2025.

**Emergency clause.** In view of the emergency cited in the preamble, this legislation takes effect when approved.

# Blue Ribbon Commission to Study the Organization of and Service Delivery by the Department of Health and Human Services

**Resolve 2023, chapter 98**

**Membership List**

| Name | Representation |
|---|---|
| Senator Jill Duson – Chair | Member of the Senate, appointed by the President of the Senate |
| Representative Margaret Craven – Chair | Member of the House, appointed by the Speaker of the House of Representatives |
| Senator Joseph Baldacci | Member of the Senate, appointed by the President of the Senate |
| Senator Marianne Moore | Member of the Senate, appointed by the President of the Senate |
| Representative Daniel Shagoury | Member of the House, appointed by the Speaker of the House of Representatives |
| Representative Kathy Javner | Member of the House, appointed by the Speaker of the House of Representatives |
| Rob Moran | Member representing interests of those with intellectual disabilities, behavioral health disorders, poverty, elderly or children receiving child welfare services or early childhood services |
| Allina Diaz | Member representing interests of those with intellectual disabilities, behavioral health disorders, poverty, elderly or children receiving child welfare services or early childhood services |
| Nancy Cronin | Member representing interests of those with intellectual disabilities, behavioral health disorders, poverty, elderly or children receiving child welfare services or early childhood services |
| Dawud Ummah | Member representing interests of those with intellectual disabilities, behavioral health disorders, poverty, elderly or children receiving child welfare services or early childhood services |
| Beth Hamm | Deputy Commissioner, Department of Health & Human Services |
| Ian Yaffe | Director of an office within the Department of Health & Human Services |
| Bill Montejo | Director of an office within the Department of Health & Human Services |

Summary of LD 915 meetings October 24, 2023 and November 14, 2023

October 24, 2023:

1. The Commission received a presentation from Molly Bogart, Director of Governmental Affairs, Department of Health and Human Services, and a memo from Kristin Brawn, Research, Office of Policy and Legal Analysis, on the restructuring of the Department of Health and Human Services through time.
   Molly summarized this history, including the merger of the department in the early 2000s. The intent of the merger was "coordinated systems". Director Paul Saucier, was on the transition team in 1993. He noted that clarity of goals is critical; restructuring is to get to those goals. The King Administration had a goal of efficiency and productivity. Implementation was a multi-year process. The Baldacci Administration focused on the merger of the two departments and this was also a several year project. Accounting consolidation was the last step and was in a recent budget. The idea of a single department focused on a coordinated and responsive system with accountability; overlapping responsibilities such as children who come to the system with adults; eligibility is key and MaineCare is critical to almost all of it (e.g. most OADS services are financed by MaineCare).
2. Molly outlined the structures of the offices within DHHS, physical presence, headcount, eligibility for services, and metrics for success (including the dashboards on the DHHS website).
   https://legislature.maine.gov/doc/10389 (pp105-132 for Molly's presentation and pp 5-8 for Kristin's memo)
3. There was a brief discussion of the Government Evaluation Act and when the last audit of the department took place. The next GEA is due in 2025/26 in the 132nd Legislature. The last one took place in 2017/18. The prior full GEA review hasn't been located. Molly also mentioned there are various levels of audit that are required within the department for federal programs.
4. The Commission considered whether issues related to the Office of Child and Family Services would be better left until 2024 because of ongoing work by the Government Oversight Committee and the Health and Human Services Committee.
5. The Commission discussed options for future work, including ideas about states with initiatives to improve customer service, surveying national organizations, developing types of consumers, and current DHHS priorities.

November 14, 2023:

1. Chair Duson gave an update from the Government Oversight Committee. At the time, the GOC was working on a report that was expecting to be completed by the end of 2023. In addition, a report was also developed by the "Walk a Mile in Their Shoes" foundation. The Commission decided that OCFS issues would wait until after the 131st Legislature 2nd regular session.
2. Molly Bogart gave a presentation on DHHS's identification of areas in need of improvement and current work. The department has been working on a number of large projects including: the "unwinding" of Medicaid coverage required by the pandemic which has also had impacts on the call centers, improving the behavioral health system, MaineCare rate reform, developing and implementing a lifespan waiver for the IDD

population (Secs. 21 and 29 and transition services), aging in place plans, and needs of Maine families including the Child Safety and Family Wellbeing Plan and Family First services. Molly also outlined the constituent services system and timeliness of department responses to those inquiries.
https://legislature.maine.gov/doc/10428 (pp. 30-39)

3. The Commission decided to solicit examples for types of consumers for DHHS to develop models of where consumers go to receive what types of services, and national organizations to solicit for best practices and cost-effectiveness, from Commission members after the meeting.

Consumer case studies for 2024 meetings:
These are the case studies that were sent to the department with intended dates for presentation:

1. Family involved in the child welfare system engaging in reunification activities after children (>1 child) have been removed from the home. Children are placed in two different kinship settings and have concerns about the safety of the children if the family is reunified. (May 29)
2. Child with medical diagnoses, receiving IDEA Part C. Needs SLP, PT, OT, neurologist, intensive early intervention treatment. Also need for child care. (June 12)
3. Low income family, facing homelessness, with two children with special needs. Teenager with ADHD and medication management. Younger child with autism and Sec. 28 services (understaffed). (June 12)
4. Young family with a parent with SUD using TANF/ASPIRE for training to improve circumstances. (July 10)
5. An elderly person, with an income of 275% FPL, qualifies for in-home services under section 63, is food insecure, and lacks transportation. The person wants to age in place. (July 10)

The other meeting dates will be Sept 17, Oct 9 and Oct 30.

## Summary of Child Welfare Initiatives in 131st Legislative Session
## In Biennial or Supplemental Budgets

**Through 1st Special Session**
**PL 2023 c.412**

| | Short Description | Sum of SFY 2024 | Sum of SFY 2025 |
|---|---|---|---|
| (1) | 1 new position to serve as an out-of-home investigator | $ 95,050 | $ 99,880 |
| (2) | 1 position recalassified | $ 3,833 | $ 4,195 |
| (3) | 2 new Hearing Specialists | $ 210,939 | $ 222,043 |
| (4) | 53 positions reorganized within the child welfare programs | $ 221,175 | $ 217,516 |
| | **Grand Total** | **$ 530,997** | **$ 543,634** |

**Through 2nd Regular Session**
**PL 2023 c.643**

| | Short Description | Sum of SFY 2024 | Sum of SFY 2025 |
|---|---|---|---|
| (1) | 1 new Child Protective Services Assistant Program Administrator | $ - | $ 120,832 |
| (2) | 3 new positions to handle Legal paperwork | $ - | $ 275,357 |
| (3) | 5 positions reorganized within the child welfare programs | $ - | $ 20,241 |
| (4) | 8 new positions to handle onboarding and training and to mentor new caseworkers - 1 per District | $ - | $ 1,026,834 |
| (5) | Increases pay range for 545 positions as caseworkers and supervisors | $ - | $ 3,955,675 |
| (6) | One-time funding for incentives to Behavioral Health Providers to provide serves to families in the child welfare system in rural areas | $ - | $ 500,000 |
| | **Grand Total** | **$ -** | **$ 5,898,939** |

**Prepared by OFPR - 05-28-24**

# Maine Department of Health and Human Services

**Jeanne M. Lambrew, Commissioner** **www.maine.gov/dhhs**

**April 30, 2024**

**FOR MORE INFORMATION, PLEASE CONTACT:**
Lindsay Hammes, Maine Department of Health and Human Services
Lindsay.Hammes@Maine.gov

# NEWS RELEASE

## Maine Office of Child and Family Services Joins National Partnership for Child Safety

*Partnership advances Safety Science implementation and plan to keep children safe by keeping families strong*

**AUGUSTA**— The Maine Department of Health and Human Services' (DHHS) Office of Child and Family Services (OCFS) announced today that it has joined the National Partnership for Child Safety (NPCS), a quality improvement collaborative with a mission to improve child safety and prevent child maltreatment fatalities.

NPCS shares with its members efforts to support families and promote Safety Science, a model to improve child welfare practices that OCFS has adopted and continues to fully implement. Maine joins 38 state, county and tribal child and family-serving child welfare jurisdictions who are part of NPCS and assessing and applying Safety Science principles in their agencies, representing nearly 70 percent of families involved with the child welfare system nationally.

"As we recognize this final day of child abuse prevention month in April, we're pleased to announce Maine's partnership with the National Partnership for Child Safety," **said Bobbi Johnson, Director of OCFS.** "It offers an opportunity to expand our work with Collaborative Safety to develop and implement Maine's Safety Science Model. We look forward to the opportunity to work across child welfare jurisdictions nationwide to build on the gold standard of evidence-based, quality improvement efforts to reduce child maltreatment and improve outcomes for children and families involved with child welfare."

As part of joining the NPCS, OCFS will participate in the Partnership's data warehouse, the National Center for Fatality Review and Prevention's (NCFRP) Case Reporting System. This system for child fatality reporting will allow for enhanced collection and storage of data, improving Maine's ability to identify trends and major risk factors so OCFS can develop plans for policy and practice improvements. Joining the NFR-CRS has been a recommendation of several partners over the last year and Maine will join the majority of the country's other child welfare jurisdictions in participating.

"On behalf of Maine's Child Death and Serious Injury Review Panel, I applaud OCFS' decision to join the National Center for Fatality Review and Prevention's Case Reporting System," **said Mark Moran, chair of**

**Broome, Anna**

| | |
|---|---|
| **From:** | Bogart, Molly <Molly.Bogart@maine.gov> |
| **Sent:** | Tuesday, April 30, 2024 10:37 AM |
| **To:** | Baldacci, Joe; Craven, Margaret; Fredericks, Ann; Graham, Anne; Griffin, Abigail; Ingwersen, Henry; Javner, Kathy; Lemelin, Michael; Madigan, Colleen; Meyer, Michele; Moore, Marianne; Shagoury, Dan; Zager, Sam |
| **Cc:** | Broome, Anna; Lazure, Luke; Senft, Samuel |
| **Subject:** | FW: NEWS RELEASE: Maine Office of Child and Family Services Joins National Partnership for Child Safety |

**This message originates from outside the Maine Legislature.**

Good morning, HHS Committee members –

I wanted to be sure that you saw this announcement from the Department that we will be joining the National Partnership for Child Safety. While this brings many important connections, a particularly important aspect is that the Department will participate in the Partnership's data warehouse, the National Center for Fatality Review and Prevention's (NCFRP) Case Reporting System.

You may remember hearing about this from Mark Moran as a recommendation on behalf of the Child Death and Serious Injury Review Panel. In the panel's presentation last Fall, they recommended that "Maine should participate in the National Fatality Review Case Reporting System to allow for more consistent, complete data collection that would make data driven policy and practice decisions possible." Director Johnson and her team have been working to make this happen and we're glad to be making this change.

Take care,
molly

Molly Bogart, Director of Government Relations
Department of Health and Human Services
Phone: (207) 592-4361 (call/text)
Email: molly.bogart@maine.gov
Pronouns: she/her

Who we serve. What we do. Who we are.

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**From:** Hammes, Lindsay <Lindsay.Hammes@maine.gov>
**Sent:** Tuesday, April 30, 2024 9:55 AM
**Subject:** NEWS RELEASE: Maine Office of Child and Family Services Joins National Partnership for Child Safety

**the panel.** "The Panel has formally and informally advocated for this move over the past several years and sees it as another potential tool to enhance our collective understanding of the factors that contribute to and the causes that underlie children's serious injuries and deaths. Cases in which kids are seriously injured or die unexpectedly are most often incredibly complex, as is child welfare work in general. Enhancing our capacity to analyze data, review trends and themes, and choose interventions that are evidence-informed will only benefit the children we all seek to protect from serious harm. We are hopeful that Maine's ongoing efforts to prevent such harm to our kids will be bolstered by this partnership with the NCFRP and the Panel is grateful for Director Johnson's leadership on this issue."

The partnership is part of OCFS' ongoing work to seek resources to strengthen Maine families and promote better short and long-term outcomes for Maine's children. OCFS' work to strengthen the child welfare system includes reducing caseworker vacancies, which have dropped 25 percent since January 2024, to 55 as of April 22, 2024.

Governor Mills proposed and the Legislature approved significant investments in child welfare in the recently passed supplemental budget, including:

- Increased pay for child welfare staff in recognition of the difficulty of their work;
- Additional staff support for legal administrative tasks with three new Legal Secretary positions so there is one in every District Office;
- Establishment of new onboarding and training coordination positions in each District to mentor new caseworkers and support ongoing training;
- Establishment of an additional leadership position to support the Lewiston District Office; and
- Dedicated funding to increase the availability of services for children and families living in rural areas who are involved with the child welfare system, among other investments in children's behavioral health services.

These actions to support child welfare staff are expected to further reduce caseworker vacancies and help give teams led by caseworkers the time and expertise for investigations, reunification, and support for children and families. They add to the recruitment and retention payments for child welfare caseworkers the Department announced in February.

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**SENATE**

**JOSEPH M. BALDACCI,** DISTRICT 9, CHAIR
**HENRY L. INGWERSEN,** DISTRICT 32
**MARIANNE MOORE,** DISTRICT 6

**SAMUEL SENFT,** LEGISLATIVE ANALYST
**ANNA BROOME,** PRINCIPAL LEGISLATIVE ANALYST
**JACKSON NICHOLS,** COMMITTEE CLERK

**HOUSE**

**MICHELE MEYER,** ELIOT, CHAIR
**COLLEEN M. MADIGAN,** WATERVILLE
**MARGARET CRAVEN,** LEWISTON
**SAMUEL LEWIS ZAGER,** PORTLAND
**DANIEL JOSEPH SHAGOURY,** HALLOWELL
**ANNE P. GRAHAM,** NORTH YARMOUTH
**KATHY IRENE JAVNER,** CHESTER
**ABIGAIL W. GRIFFIN,** LEVANT
**MICHAEL H. LEMELIN,** CHELSEA
**ANN FREDERICKS,** SANFORD

**STATE OF MAINE**
**ONE HUNDRED AND THIRTY-FIRST LEGISLATURE**
**COMMITTEE ON HEALTH AND HUMAN SERVICES**

TO: Senator Jill C. Duson, Senate Chair
Representative Margaret Craven, House Chair
Members, Blue Ribbon Commission to Study the Organization of and Service Delivery by the Department of Health and Human Services

FROM: Senator Joseph M. Baldacci, Senate Chair JMB
Representative Michele Meyer, House Chair MM
Joint Standing Committee on Health and Human Services

DATE: April 9, 2024

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The Health and Human Services Committee recently considered LD 1788, An Act to Establish the Office of the Inspector General of Child Protection. The original draft of LD 1788 was modeled on the Nebraska law. After the bill was printed, new language based on the New Hampshire Office of the Child Advocate was proposed by the sponsor, Senator Baldacci. The Committee voted Ought Not to Pass on LD 1788 as there were too many unresolved issues to make a policy decision, including particular concerns about confidentiality of records and interfering with criminal investigations. Every member of the committee is committed to improving the lives of children and families who are involved in the child protective system.

We are requesting that the Blue Ribbon Commission includes the issue of oversight of the child protective system as a specific topic as part of your discussions in the 2024 interim. There are current oversight requirements in federal and state statute and the question is whether additional oversight is necessary and, if so, what form that additional oversight should take. Additional oversight might take the form of a separate office or organization along the lines of that in Nebraska and New Hampshire, or it might take the form of additional functions and authority granted to the existing Child Welfare Ombudsman.

In addition, there are issues around the confidentiality of information and records as well as the timing of criminal investigations that were brought to our attention by the Office of the Attorney General that would need to be resolved as part of any statutory action. We have also asked Attorney General Frey to assemble a stakeholder group to discuss this topic. Please note that Senator Baldacci, a member of the Blue Ribbon Commission is the sponsor of the bill and the Senate Chair of our committee. He is also expected to be involved in the stakeholder group convened by the Attorney General.

We look forward to your report on the organization and services of the Department of Health and Human Services at the end of this year. We urge you to include this topic in your discussions. Thank you for your willingness to service on the Blue Ribbon Commission.

cc: Christine Alberi, Child Welfare Ombudsman
Aaron Frey, Attorney General

SENATE

JOSEPH M. BALDACCI, DISTRICT 9, CHAIR
HENRY L. INGWERSEN, DISTRICT 32
MARIANNE MOORE, DISTRICT 6

SAMUEL SENFT, LEGISLATIVE ANALYST
ANNA BROOME, PRINCIPAL LEGISLATIVE ANALYST
JACKSON NICHOLS, COMMITTEE CLERK

HOUSE

MICHELE MEYER, ELIOT, CHAIR
COLLEEN M. MADIGAN, WATERVILLE
MARGARET CRAVEN, LEWISTON
SAMUEL LEWIS ZAGER, PORTLAND
DANIEL JOSEPH SHAGOURY, HALLOWELL
ANNE P. GRAHAM, NORTH YARMOUTH
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ANN FREDERICKS, SANFORD

**STATE OF MAINE**
**ONE HUNDRED AND THIRTY-FIRST LEGISLATURE**
**COMMITTEE ON HEALTH AND HUMAN SERVICES**

TO: Senator Jill C. Duson, Senate Chair
Representative Margaret Craven, House Chair
Members, Blue Ribbon Commission to Study the Organization of and Service Delivery by the Department of Health and Human Services

FROM: Senator Joseph M. Baldacci, Senate Chair JB
Representative Michele Meyer, House Chair MM
Joint Standing Committee on Health and Human Services

DATE: May 13, 2024

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The Health and Human Services Committee recently considered LD 779, An Act to Create a Separate Department of Child and Family Services. The majority of the Committee voted Ought Not to Pass on LD 779 and the minority voted Ought To Pass as Amended (updating dates to reflect the bill was carried over from the First Special Session and adding a fiscal note). The vote in Committee was 11-2. The OTP-A motion was supported in the Senate but the bill was not taken up in the House prior to adjournment.

The majority of the Committee were concerned that establishing a new department centered on child and family services would create duplicative managerial positions rather than programmatic improvements to services. However, each member of the committee is committed to improving the lives of children and families who are involved in the child protective system regardless of their vote on the bill. In that light, we are requesting that the Blue Ribbon Commission might choose to include in your discussions this interim, the possibility of whether splitting up the department into two might be beneficial to clients of the department, including children and families involved in the child protective system.

Please note that Senator Baldacci, a member of the Blue Ribbon Commission supported the passage of LD 779 and is the Senate Chair of our Committee.

We look forward to your report on the organization and services of the Department of Health and Human Services at the end of this year. Thank you for your willingness to serve on the Blue Ribbon Commission.

**OPLA RESEARCH REQUEST MEMO**

To: Anna Broome, Senior Analyst, HHS Committee
From: Kristin Brawn, Legislative Researcher
Date: March 13, 2024
RE: Other State Child Welfare Offices of Inspector General (LD 1788)

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Hi Anna,

You asked me to look into other states that have established independent offices of investigation to oversee the states' child welfare programs, similar to the Office of Inspector General of Child Protection proposed in LD 1788. I looked at similar offices in Illinois, Nebraska and New Hampshire. Please see the findings of my research below.

**Illinois – Office of the Inspector General for the Department of Children and Family Services** (20 ILCS §505/35.5, 35.6 and 35.7)

The Office of Inspector General (OIG) for the Illinois Department of Children and Family Services (DCFS) was established by the General Assembly in 1993 to reform and strengthen the state's child welfare system. According to the OIG's first annual report in 1995, prior to the establishment of the OIG, complaints from biological, foster and adoptive families "received a bureaucratic response to their concerns that ignored the root of the issue, the child involved." The OIG operates independently within DCFS, and the Inspector General is appointed by the Governor and confirmed by the Senate for a term of four years. The law charges the OIG with conducting investigations into allegations of or incidents of possible misconduct, misfeasance, malfeasance, or violations of rules, procedures or laws by any DCFS employee, or any foster parent or private agency with which DCFS contracts. The law also grants OIG the power to subpoena witnesses and compel the production of books and papers pertinent to an investigation.

The office responds to and investigates complaints filed by the state and local judiciary Department and Child Welfare Contributing Agency (CWCA) employees, foster parents, biological parents, the public, referrals from the Office of Executive Inspector General (OEIG), and referrals pertaining to Child Welfare Employee Licensure (CWEL), and investigates deaths of all Illinois children with whom DCFS has had prior involvement. At the request of the DCFS Director or when the OIG has noticed a particularly high level of complaints in a specific division of DCFS, the OIG will conduct a systemic review of that division. Investigations may yield case-specific recommendations, including disciplinary recommendations, and/or recommendations for systemic changes within the child welfare system. The OIG monitors compliance with all recommendations. The OIG is required to submit an annual report to the Governor and the General Assembly regarding reports and investigations made for the prior fiscal year, including recommendations for administrative actions and matters for consideration by the General Assembly.

According to the OIG's 2024 Annual Report, in FY 2023, the OIG received 612 requests for investigation, 103 OEIG referrals, and 53 CWEL referrals totaling 768 complaints, a 16% increase from FY 2022. From these complaints, the OIG opened 768 general investigations and 160 investigations of child deaths, and conducted 7,276 searches for criminal background information.

**Nebraska – Office of Inspector General of Nebraska Child Welfare**
(Nebr. Rev. Stat. §§43-4301, 43-4302, 43-4317, 43-4318, 43-4319, 43-4321, 43-4323, 43-4324, and 43-4331)

The Office of Inspector General of Nebraska Child Welfare (OIG) was created by the Legislature in 2012, following a significant crisis in the state's child welfare system after a failed attempt at privatization that resulted in multiple problems, including upheaval in the workforce, increasing the risk to children and the families being served and the loss of many critical private providers needed to serve children in the system, according to the OIG's 2022-2023 Annual Report. The OIG was established at the recommendation of a report published by the Legislature's Health and Human Services Committee regarding the committee's review, investigation and assessment of the effects of child welfare reform which the Nebraska Department of Health and Human Services began implementing in July of 2009.

The OIG is established within the Legislature's Office of Public Counsel for the purpose of conducting investigations, audits, inspections and other reviews of the Nebraska child welfare system. The Inspector General is appointed by the Public Counsel for a term of five years, with approval from the chairperson of the Executive Board of the Legislative Council and the chairperson of the Health and Human Services Committee of the Legislature. The law requires the OIG to investigate allegations or incidents of:

1. Misconduct, misfeasance, malfeasance or violations of the statutes or rules and regulations of the Department of Health and Human Services (DHHS), Juvenile Probation, the Crime Commission, or juvenile detention facilities by employees or persons under contract with those agencies and facilities; and
2. Deaths and serious injuries of youth (a) in homes, facilities, and programs licensed or under contract with DHHS or Juvenile Probation; (b) in cases in which services were being provided to a child or family by DHHS or Juvenile Probation; or (c) in cases that have had an open investigation for child abuse and neglect in the last 12 months, if, after review, the OIG determines the death or serious injury did not occur by chance.

The law also requires the OIG to receive and assess complaints from members of the public and authorizes the OIG to open an investigation based on those complaints if certain requirements in the law are met. The law authorizes the OIG to conduct full investigations and retrieve relevant records or compel persons to testify through subpoena, request or voluntary production, review all relevant records, and interview all relevant persons. The office may request or subpoena any record necessary for an investigation from DHHS, the juvenile services division as permitted by law, the Nebraska Commission on Law Enforcement and Criminal Justice, a foster parent, a licensed child care facility, a juvenile detention facility, a staff secure juvenile facility or a private agency that is pertinent to an investigation.

The law also requires the Inspector General to provide to the Health and Human Services Committee, the Judiciary Committee, the Supreme Court, and the Governor an annual summary of reports and investigations made for the preceding year, including recommendations and the status of implementation of the recommendations and recommendations to the committees regarding issues discovered through investigation, audits, inspections and reviews by the OIG that will increase accountability and legislative oversight of the Nebraska child welfare system, improve operations of DHHS, the juvenile services division, the Nebraska Commission on Law Enforcement and Criminal Justice and the Nebraska child welfare system, or deter and identify fraud, abuse and illegal acts.

In regard to effectiveness of the OIG since its creation, the 2022-23 Annual Report states that the creation of the OIG has resulted in over 11 years of accountability and increased transparency in the child welfare system. In 11 years, the OIG has received and reviewed over 5,000 intakes including

incident reports, complaints and grievances. It has issued 44 reports of investigation which incorporated case reviews of over one hundred individual children. The OIG has made 115 recommendations for system improvement to DHHS, two private providers contracted with DHHS's Division of Children and Family Services and the Administrative Office of Probation, Juvenile Services Division. Eighty-four of those recommendations have been accepted by those agencies and providers. The OIG's work has informed senators on key issues as they drafted legislation related to child welfare, including but not limited to, Sudden Unexpected Infant Death education, sexual abuse of state wards, oversight of Nebraska's Youth Rehabilitation and Treatment Centers and the privatization of case management in the state's child welfare system.

**New Hampshire – Office of the Child Advocate**
(RSA, Chapter 21-V)

The Office of the Child Advocate (OCA) was established by the Legislature in 2017. According to the OCA's 2018 Annual Report, the deaths of two young girls in 2014 and 2015 whose families were known to the New Hampshire Division of Children, Youth and Families (DCYF) and a call from a grieving grandmother constituent prompted Senator David Boutin to sponsor legislation in 2015 to form the Commission to Review Child Abuse Fatalities (SB 244). Early commission hearings unearthed two prevailing themes: a lack of transparency in child welfare and a lack of public trust in DCYF. These findings prompted Senator Boutin to create a subcommittee to explore the idea of an independent children's ombudsman. The subcommittee met throughout 2015-2016, examining the response to the child deaths, which led to the subcommittee's recommendation of independent oversight of DYCF through an Office of the Child Advocate and enactment of legislation to establish the OCA.

The OCA is established as an independent agency that operates with full independence from any state official, department or agency in the performance of its duties. The law charges the OCA with the following duties:

- Provide independent oversight of executive agencies to:
  - Ensure that children involved with an agency, and in particular, children served by the child welfare or juvenile justice systems, receive timely, safe, and effective services and that their best interests are being protected;
  - Strengthen the state by working in collaboration with agencies and other necessary parties on cases under review;
  - Ensure that children placed in the care of the state or receiving services under the supervision of an agency in any public or private facility, receive humane and dignified treatment at all times, with full respect for the child's personal dignity, right to privacy, and right to adequate and appropriate healthcare in accordance with state and federal law;
  - Examine, on a system-wide basis, the care and services that agencies provide children, and provide recommendations to improve the quality of those services in order to provide each child the opportunity to live a full and productive life;
  - Advise the public, governor, commissioners, speaker of the house of representatives, senate president, and oversight commission about how the state may improve its services to and for children and their families; and
  - Periodically review and investigate any aspect of an agency's policies, procedures, and practices and work collaboratively with the agency to improve policies, procedures, practices, and programs affecting children.

- Upon its own initiative or upon receipt of a complaint, review and if deemed necessary:
    - Investigate the actions of any agency and make appropriate referrals; provided that department of health and human services specific complaints shall be handled by the ombudsman;
    - Investigate those complaints in which the child advocate determines that a child or family may need assistance from the office or a systemic issue in the state's provision of services is raised by the complaint; and
    - Provide assistance to a child or family whom the child advocate determines is in need of assistance, including seeking resolution of complaints, which may include, but not be limited to, referring a complaint to the appropriate agency or entity, making a recommendation to such agency or entity for action related to the complaint, and sharing information in any proceeding before any court or agency in the state in which matters related to the division's child protection and juvenile justice services are at issue.

- Regularly consult with executive agencies and the oversight commission;
- Provide information and referral services to the public regarding all child-serving state services, particularly child protection and juvenile justice services;
- Perform educational outreach and advocacy initiatives in furtherance of the mission and responsibilities of the office; and
- Periodically review the facilities and procedures of any and all institutions or residences, public or private, where a child has been placed by an agency.

In 2020, the Legislature also established the Oversight Commission on Children's Services to provide oversight to the OCA, and tasked the Commission with the following duties:

- Recommend candidates to the Governor for appointment to the position of child advocate;
- Provide oversight to the OCA in its effort to support an effective, comprehensive, and coordinated system of services and programs for children, youth, and families;
- Review with the OCA the efficacy of selected programs and services of executive agencies;
- Collaborate with the office to identify and implement best practices on behalf of children and families; and
- Monitor and review implementation of the memorandum of understanding entered into by the department of health and human services and the department of justice regarding the collaboration between the agencies in the investigation and prosecution of abuse and neglect cases.

The Child Advocate is appointed by the governor and executive council, upon the recommendation of the Oversight Commission on Children's Services. The Child Advocate serves a term of four years. The law grants the OCA the authority to subpoena witnesses, records, documents, reports, reviews, recommendations, correspondence, data and other evidence that the OCA reasonably believes is relevant. The law requires the Child Advocate to submit an annual report of the activities and findings of the OCA, and present his or her recommendations to the Oversight Commission. The report must also be provided to the commissioner of any executive agency that is the subject of a report prepared by the OCA, the Governor, the Speaker of the House of Representatives, the Senate President, and the state library.

# Office of Child and Family Services

Blue Ribbon Commission to Study the Organization of and Service Delivery by DHHS

May 29, 2024

Director Bobbi Johnson

# Commission Questions

**What is OCFS currently most focused on with respect to the child welfare system?**

- Ensuring child safety through improving quality and consistency in practice
- Strengthening management structure and office culture
- Staffing

**What changes have been made?**

- Completed management audit and redefining roles within child welfare
- Joining the National Partnership for Child Safety
- Hired significant number of staff

**What is still to come?**

- Increased work with Collaborative Safety
- Implementation of Alia Innovations
- Expanded efforts to address substance use

**How will OCFS use new positions and recruitment?**

- Integrating new support positions into teams
- Targeted recruitment of support staff

# Commission Questions

**How is the Department working to address issues with access to counsel?**

- OCFS does not have any direct role in recruiting counsel
- Maine Commission on Public Defense Services

**How is the Department working to address accessibility of services for children and families?**

- Multiple initiatives to improve services from many perspectives
- *See Resources slide for additional information/links*

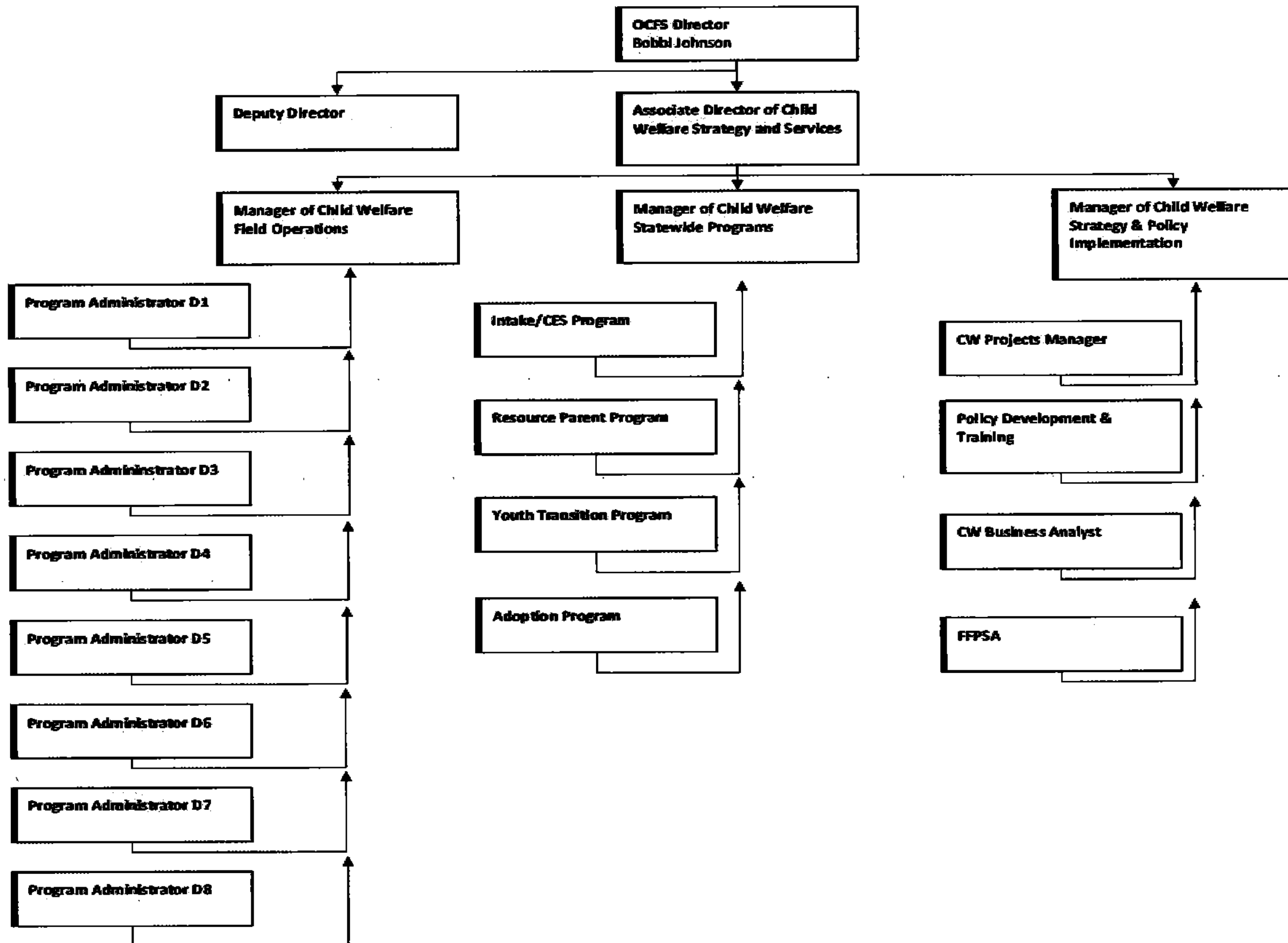
**What are the options for a review of actions taken by child welfare?**

- Escalate to senior staff at OCFS
- Court oversight
- Child Welfare Ombudsman

**What does quality assurance look like from a systems perspective?**

- 2022 Report by OPEGA: Oversight of Maine's Child Protective Services
- Internal QA & Citizen Review Panels
- Federal Government review and oversight

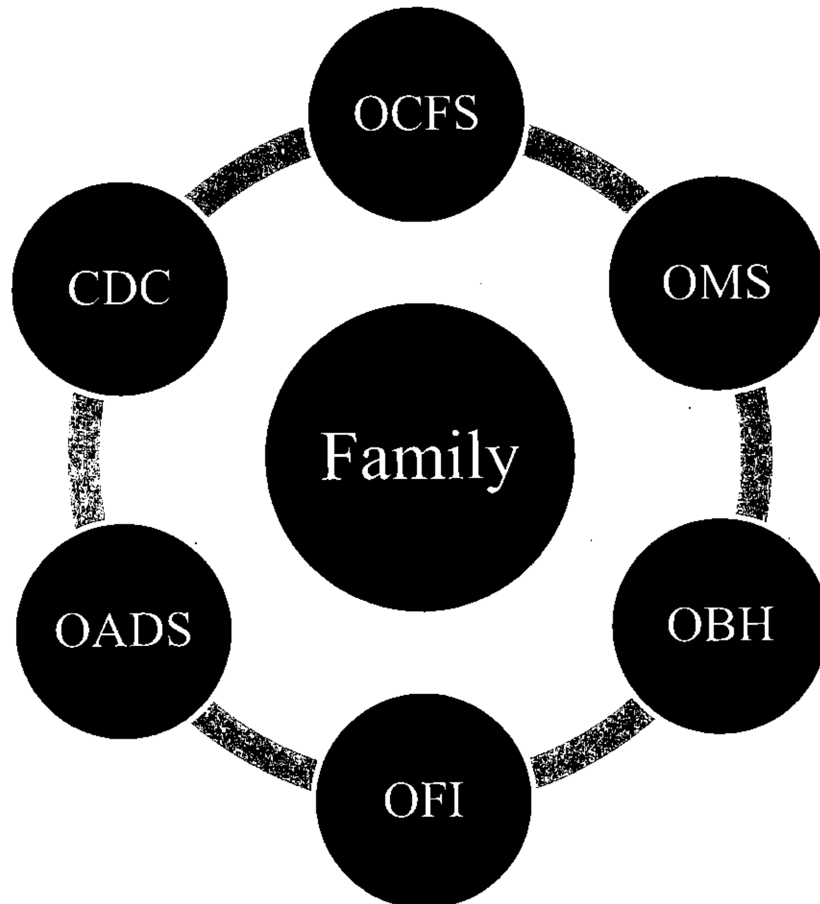
# Reorganization



# Resources

- Governor Mills directed recruitment and retention payments for child welfare staff in her State of the State address which began in February. Between January and May 24, 2024:
  - Casework vacancies dropped from 84 to 46 (-45%)
  - Case aide vacancies dropped from 13 to 7 (-46%)
- The Office has joined the National Partnership for Child Safety, a quality improvement collaborative with a mission to improve child safety and prevent child maltreatment fatalities.
- The Department posed a review of work during the 131st Legislature: Maine Takes Further Action to Improve Child Welfare System
- Blog posts about efforts to expand the availability and accessibility of services include:
  - April 2024: Supplemental Budget Summary
  - January 2024: DHHS Reorganizes Behavioral Health to Better Serve Children and Families
  - January 2024: MaineCare Implements Cost of Living Adjustments as Part of Rate Rerform
  - July 2023: Major Policy Advances for Maine Children and Youth
  - July 2023: Biennial Budget Summary

# DHHS Collaboration

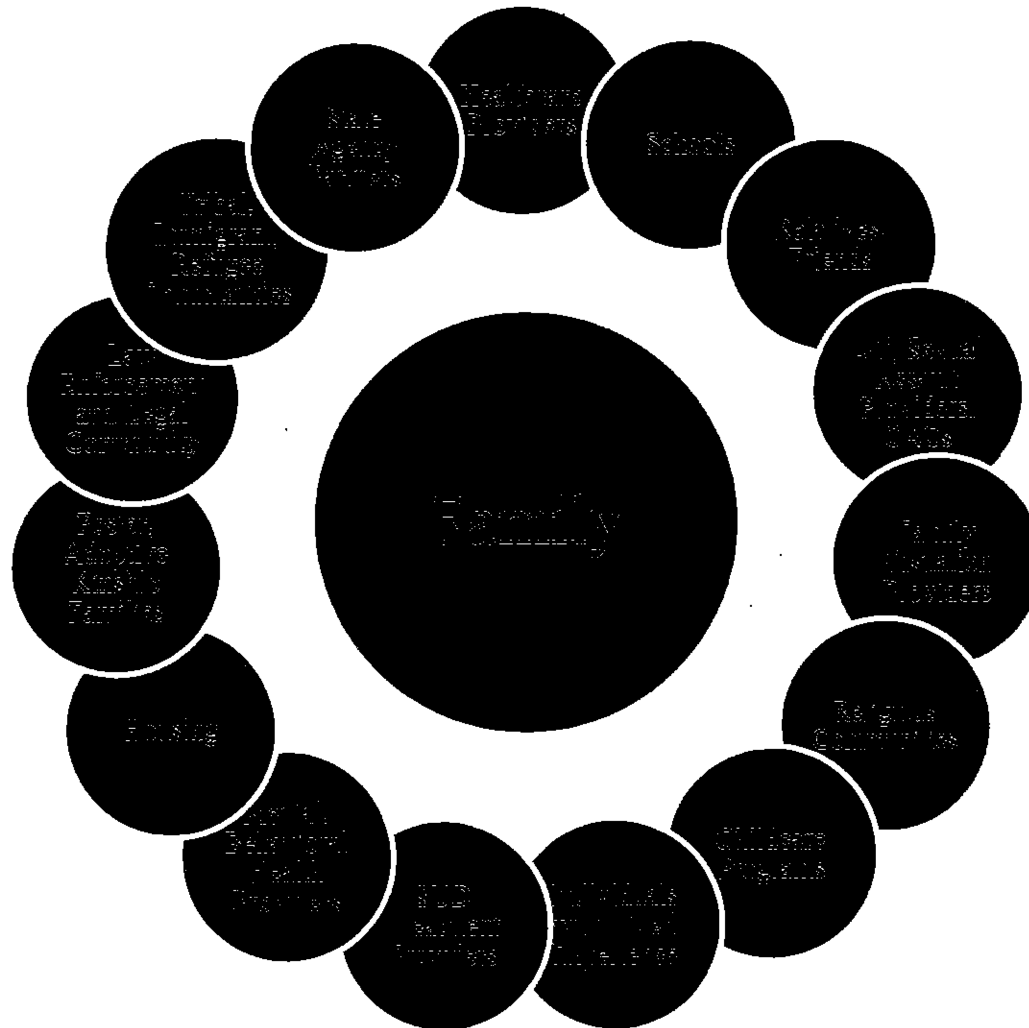



**Examples:**

- Concrete supports from OMS and OFI (WIC, TANF, SNAP, Support Enforcement, child care)
- MaineMOM program in collaboration with MaineCare
- Peer Recovery Coaches pilot in conjunction with OBH
- Partnership with OADS on youth transitioning from children's to adult services
- Partnership with CDC on furthering the work of the Pediatric Mental Health Access project and federal renewal grant.
- Work with OMS to ensure ongoing MaineCare coverage for parents with children in care – the first state in the nation to get approval for this demonstration

# System Collaboration

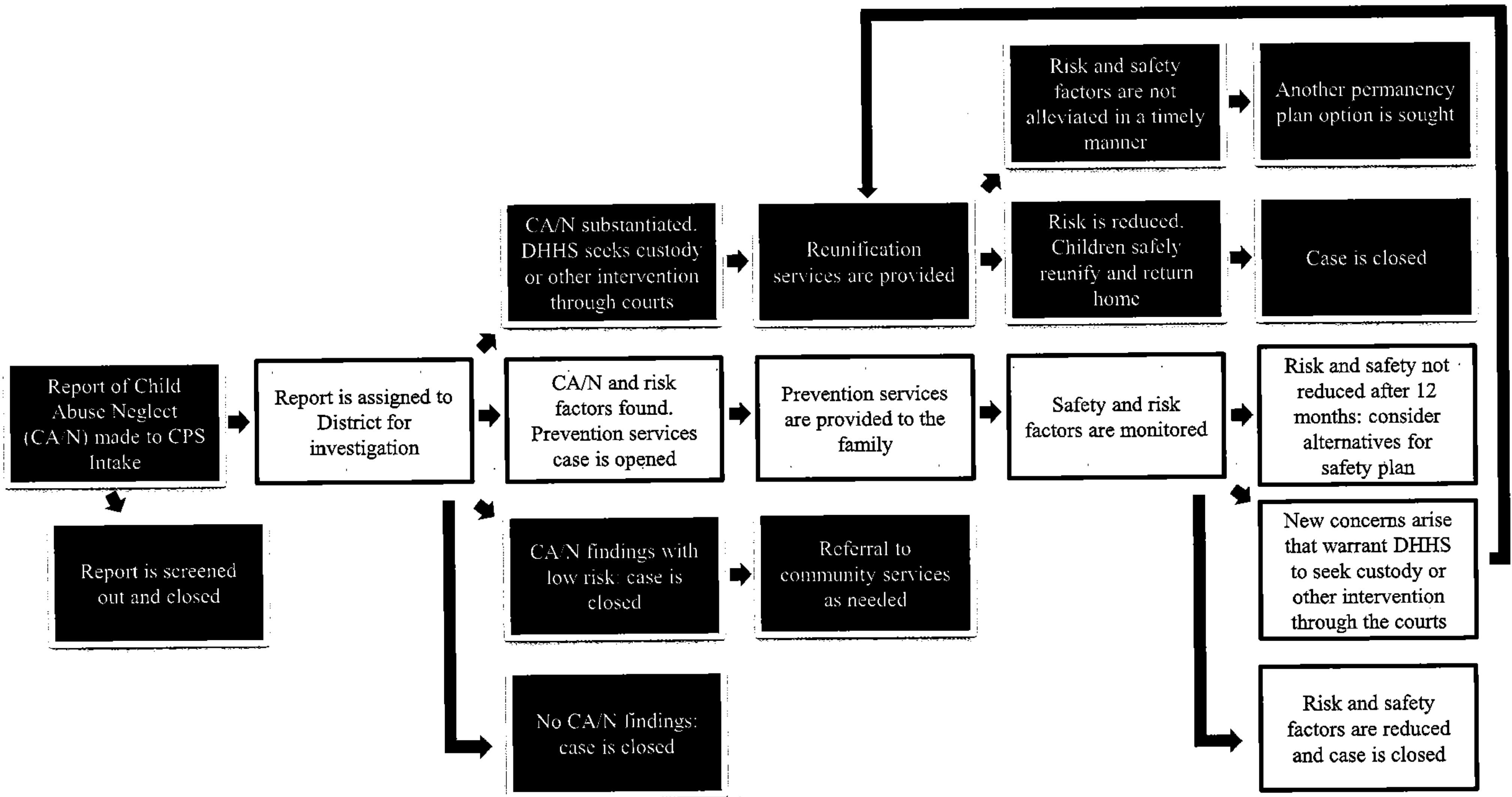
Collaborations within OCFS and across state and community partners is critical.




Program initiatives are designed to support and strengthen systems and families.

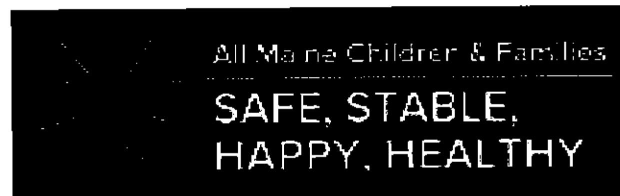
Knowledge of and support for these initiatives is important in order to collectively move forward.

# Child Welfare Case Flow



# Questions

Director Bobbi L. Johnson, LMSW
Office of Child and Family Services



Christine Alberi, Child Welfare Ombudsman
Blue Ribbon Commission to Study the Organization and Service Delivery by the Department of Health and Human Services
May 29, 2024

Good morning, Senator Duson, Representative Craven, and members of the Blue Ribbon Commission. Thank you for having me here today. My name is Christine Alberi, and I am the Child Welfare Ombudsman for Maine.

The Ombudsman's office has spent some time recently looking into the history of child welfare in Maine over the past 25 years to try to understand why systemic issues in child welfare ebb and flow in such a frustrating way. In 2001, Logan Marr, a child in state custody, died at the hands of her foster parent, who was also a child welfare caseworker. At the time there were over 3000 children in state custody. This outsized number of children in state custody was due to another horrific child death at the hands of the mother's boyfriend in 1984, which caused the conventional wisdom to become: when in doubt, remove the child. Additionally in 2001, very few children were placed in kinship homes. As we have seen, highly publicized child deaths can create a spotlight on child welfare practice, and this is just what happened in 2001. Logan's death also began a series of intensive and successful child welfare reforms, including the creation of the Child Welfare Ombudsman.

In May 2004 the Office of Child and Family Services was created which included a single system of care for Children's Behavioral Health. A new director was appointed and with several years of previous study of issues, with the help of outside consultants, and support from state government, child welfare reform started to take effect. Between 2004 and 2009 kinship placements increased from 16% to 38.9%. By 2008 the number of children in state custody dropped to less than 2000. As we all remember, in 2008 there was also a national economic crash which squeezed state budgets. Nevertheless, by 2011, Maine Child Welfare was held up as a national model by the Annie E. Casey Foundation, and Harvard's Kennedy School of Government named Maine as a finalist for the Innovations in American Government Award in 2009 due to the child welfare reforms. Child welfare professionals and legislators from Virginia, Louisiana, Maryland, and Indiana had visited Maine to observe Maine's system.

I share this to say that despite all of the problems we have now, there is no reason we cannot get back to a place where we can again be a national model. However, things are more complicated now. The opioid crisis caught most state's child welfare systems unprepared. Frontline staff will report that cases are far more challenging now than they were 15 years ago, and the risk to staff in the field is higher. Our challenges are very different than they were in 2001.

The Ombudsman's office as it exists now is a unique model in New England. We spend our time and resources on two primary areas. The first is to complete information and referral calls. Anyone is welcome to call us and set up an appointment to speak with us. We then talk through the case with the individual who calls and provide information on laws, policies, procedures, and give practical advice on how to proceed. For a small percentage of those who call, we can then

open a case specific review based on their initial contact or contacts with us. We review cases based on the caller's complaints in an effort to resolve their issues, but we review cases from a neutral perspective. These case specific reviews are surveyed and are the basis of our annual report.

Protecting children from child abuse and neglect is extremely difficult work with limited windows of opportunity to intervene. Ideally, enough services and resources would be available to families so that children are never unsafe. Unfortunately, we must continually face the reality that there are children that are or will be unsafe in their parents' care and the state is responsible for protecting those children. When we have those opportunities to intervene to protect children it is crucial that we act based on the facts available. Our 2023 Annual Report is not meant as a call to take more children into state custody or reunify fewer children with parents, but to improve child welfare practice so that in each case and for each child the correct decisions can be made.

Out of the 82 cases surveyed this year, 49 had substantial issues. Cases with substantial issues are defined as cases where there was a deviation from best practices, adherence to policy, or both that had a material effect on the safety and best interests of the children, or rights of the parents. Out of these 49 cases, 27 primarily involved investigations and 18 primarily involved reunification. The remaining 4 cases had varying issues.

As has been true in previous annual reports, this year shows continued struggles with decision-making around child safety. Primarily, the Department has had difficulty in two areas: 1) during initial investigations into child safety and decision-making around whether a child is safe during an investigation, and 2) during reunification when making safety decisions about whether to send a child home.

Much of the public focus in child welfare has been on child deaths that continue to be reported in the news. These children who have died deserve our full attention and respect. It is equally important to remember that there are many children who are harmed repeatedly in the care of their parents, but never appear in the news. Children are living in difficult and traumatic circumstances all over the state every day. We have the responsibility, as a state, to protect those children. While there are many interlocking pieces to our child welfare system, including the courts, providers, relatives, and government entities--the Office of Child and Family Services social workers are the first responders to calls about unsafe children, and the first line of defense for those children.

We have recommended that the Department continue to fully support the use of Safety Science in order to effect positive systemic change; that there be continued support and funding for an increase in the availability of services that are necessary for the well-being of children and families, prevention of child welfare maltreatment, and for the successful reunification of children with parents; that the Department should explore all possible methods to provide increased transparency to the legislature and the public; and that the Department consider the opinions of outside stakeholders in both assessing and naming the primary issues in child welfare, and in providing solutions to those issues. And finally, it is crucial that frontline staff's

experiences and opinions are given the utmost consideration and their recommendations are implemented when possible.

Finally, I would like to highlight one of the positive findings found on page 14 of our Annual Report: When the parents were in jail the caseworkers made many efforts to keep both parents engaged. The caseworker understood the parent's previous history of substance use and previous attempts at treatment and slowed down the case to accommodate this. The caseworker toured the parent's sober living facility and met the other residents prior to allowing overnight visits. The caseworker transported the children to the first overnight visit. Regular family team meetings were held throughout the case and were well attended by providers. The children were successfully reunified with the parent.

Thank you again for having me here today, and I am happy to answer any questions.

Christine Alberi
Child Welfare Ombudsman
ombudsman@cwombudsman.org
207-215-9591

OPEGA INFORMATION BRIEF

February 2024

# INFORMATION BRIEF

## Child Protective Services Reunification

February 2024

prepared for the
**Government Oversight Committee**
by the
**Office of Program Evaluation & Government Accountability of the Maine State Legislature**

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# OPEGA Information Brief: Child Protective Services Reunification

## About Reunification

Reunification in child welfare is a system of parallel processes in the District Courts and the Department of Health and Human Services (DHHS) Office of Child and Family Services (OCFS) designed to find permanent homes for children in state custody, with a preference for returning children to their biological parent(s). Federal law prioritizes reunifying families as the best outcome, if the circumstances that jeopardize the child's health or welfare can be alleviated. The courts—through the work of judges, attorneys for parents and for OCFS, and child representatives—ultimately decide what parents need to do to reunify with their child and whether to restore parental custody or find another form of permanency like adoption. With respect to reunification, OCFS arranges foster placements for the child, supports resource families and kinship placements that provide foster care, provides social work to help children recover from maltreatment and prepare to return to their biological parent, and identifies needs and arranges services to help the parent alleviate the conditions that led to the child's removal. OCFS also has responsibilities for achieving other methods of permanency for the child when reunification is no longer an option.

## Our Approach

For this report, OPEGA: (1) examined relevant Maine statutes, federal law, agency rules, and OCFS policies; (2) conducted a total of 58 interviews with OCFS staff members, stakeholders in the court process, biological and resource parent representatives, and others; and (3) assessed OCFS reunification work by analyzing existing quality assurance data. OPEGA examined the 235 case reviews conducted from April 2017 to March 2023 that had reunification as the child's permanency goal.

OPEGA identified four cross-cutting challenges that are prevalent in reunification casework.

1. Caseworker practices concerns
   - Assessment of parent's substance use: Many cases did not meet the federal standard for regularly assessing parents' substance use. OCFS staff named caseworker inexperience and issues with drug screening as challenges contributing to this concern.
   - Caseworker engagement with family: Casework tended to fall short of expectations on assessments of caseworker conversations with parents about their needs and case planning goals, as well as facilitation of family team meetings. Staff said that inadequate training and job shadowing contribute to this deficiency.

2. High workloads impacting safety, permanency, and well-being outcomes
   - Permanency caseworker vacancies: OCFS has struggled with high staff turnover and inability to fill vacant positions, with some district offices experiencing especially high vacancy rates. This causes high workloads and means that staff are relatively inexperienced, which contribute to many of the identified challenges.

- Lack of support staff: Frontline staff reported that inadequate support with administrative and legal tasks exacerbates the challenge of high workloads and has a negative impact on casework quality.
- Lack of visitation supervisors and transportation for families: OCFS contracts with agencies to provide supervision for parent and child visits, as well as transportation for families. Staff and parent representatives reported high demand and lack of availability of these crucial services.

3. Waitlists for evaluations and treatment: Case reviews and staff interviews suggest that progress toward reunification is often hindered by long waitlists for parents' required mental health evaluations, mental health treatment, and for substance use disorder treatment.

4. Timeliness of termination of parental filings and other legal concerns: Case reviews identified challenges with timeliness of filing termination of parental rights, leading to delays in permanency for children. Several factors may contribute to delays, including caseworker workload and the backlog of cases in the judicial system delaying hearings necessary for timely reunification.


## Acknowledgements

OPEGA would like to thank the staff of Maine's Office of Child and Family Services for their cooperation and assistance in developing this Information Brief to the Government Oversight Committee. Many OCFS staff members provided data and participated in interviews; this review would not have been possible without their contributions. OPEGA also thanks the Office of the Attorney General and the Maine Judicial Branch for their contributions. Thank you to other stakeholders who were interviewed for sharing their time and expertise.

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# Acronyms Used in This Report

| | |
|---|---|
| AAG | assistant attorney general |
| CASA | court appointed special advocate |
| CFSR | Child and Family Services Review |
| CMC | case management conference |
| CODE | court ordered diagnostic evaluation |
| CPS | Child Protective Services |
| DHHS | Department of Health and Human Services |
| FTM | family team meeting |
| GAL | guardian ad litem |
| GOC | Government Oversight Committee |
| ICPC | Interstate Compact on the Placement of Children |
| ICWA | Indian Child Welfare Act |
| MCILS | Maine Commission on Indigent Legal Services |
| OAG | Office of the Attorney General |
| OCFS | Office of Child and Family Services |
| OPEGA | Office of Program Evaluation and Government Accountability |
| OPPLA | Other Planned Permanent Living Arrangement |
| OSRI | Onsite Review Instrument and Instructions |
| PPO | preliminary protection order |
| QA | quality assurance |
| R&R | rehabilitation and reunification |
| SDM | Structured Decision Making |
| TPR | termination of parental rights |

# Introduction

In August 2021, the Government Oversight Committee (GOC) approved an OPEGA review of Child Protective Services (CPS). The project included three components: 1) Oversight of CPS; 2) CPS Investigations; and 3) CPS Reunification. The first two were completed in the first quarter of 2022, and OPEGA began preliminary research on CPS Reunification in April 2022. The project was paused by the GOC in September 2022 for a new project: CPS Case File Reviews on safety decisions and actions taken on a series of high-profile child deaths in Maine. OPEGA resumed work on CPS Reunification in March 2023, alongside the prioritized CPS Case File Reviews.

This report is an OPEGA Information Brief that describes the reunification process, the primary challenges within that process, and some of the factors contributing to those challenges. We have chosen to provide an information brief due to the desire of the GOC for accelerated action in their efforts to reform the child protective system and the short duration of the second legislative session. The Brief is in two parts. Part 1 describes the process of reunification and the roles of the Department of Health and Human Services (DHHS) and the Maine Judiciary. Part 2 examines data on Office of Child and Family Services (OCFS) performance against federal performance standards to further define the challenges to be met and provides information on the varied perspectives of Department personnel as well as parents and their representatives.

# Part 1: The Process of Reunification

The Due Process Clause of the U.S. Constitution grants parents the fundamental rights of care, custody, and control of their children, and the Supreme Court has affirmed this right so long as a parent adequately cares for their children. Alongside this constitutional foundation, one of the widely accepted principles of child welfare policy and practice has been that for children removed from the care and custody of their parents, the best outcome is to be reunified with their parents—but only if safe to do so. This particular principle is reinforced throughout federal law[1] and is reflected in each state's relevant child welfare laws. Maine's Child and Family Services Child Protection Act (22 M.R.S. §§ 4001 to 4099-P)[2] establishes the statutory framework for child protective services provided by the state through the DHHS and the OCFS. The Act specifically requires that "reasonable efforts be made to rehabilitate and reunify families as a means of protecting the welfare of children, but prevent needless delay for permanency plans for children when rehabilitation and reunification is not possible (§ 4003(3))."

[1] References emphasizing reunification can be found in the Adoption Assistance and Child Welfare Act (1980) Public Law 96-272, the Adoption and Safe Families Act (1997) Public Law 105-89, and the Families First Prevention and Services Act (2018) Public Law 115-123.

[2] https://legislature.maine.gov/legis/statutes/22/title22ch1071sec0.html (last visited Feb. 12, 2024).

Reunification is a complex process in which a child's needs for safety, well-being, and permanency are continually assessed. The process involves case planning, the identification of services to address the conditions that led to the removal of the child from the home, the availability and provision of those services, parental engagement in the process and services, regular parental visitation with the child, the caseworker's ongoing assessment of the family's progress, and concurrent planning if reunification efforts are unsuccessful—all of which is overseen through an established court process in which parents are entitled to counsel to represent their interests, the state's interests are represented by an Assistant Attorney General (AAG), and the child's interests are represented by a guardian ad litem (GAL). The ultimate goal is for a child to achieve permanency: a legally permanent, nurturing family in the form of reunification with a parent or other relative, to a legally finalized adoption, or to a legal guardian.

In the following sections, we provide a basic overview of the general reunification process when reunification is warranted, the various parties to the process, the parties' roles and responsibilities, and the various considerations that are made throughout the process.

## Initial State Actions

During a child protective investigation, if the Department believes a child is in circumstances of jeopardy[3] to their health or welfare, they will file a petition for a child protection order with the court (also known as a jeopardy petition).[4] The petition will contain the allegations necessitating court action and a request for specific court action. These requests may include ordering the parents to participate in services deemed necessary to address child safety concerns or ordering the child into state custody. Once the petition is filed, the court will schedule a case management conference during which the parties will plan for the jeopardy hearing which is held within 120 days of the petition being filed. During this time, the child remains in the care and custody of their parents.

**Jeopardy** is defined in Maine statute as serious abuse or neglect, as evidenced by:

- Serious harm or threat of serious harm;
- Deprivation of adequate food, clothing, shelter, supervision, or care;
- Deprivation of necessary health care when the deprivation places the child in danger of serious harm;
- Truancy;
- Abandonment of the child or absence of any person responsible for the child, which creates a threat of serious harm; or
- End of voluntary placement, when the imminent return of the child causes a threat of serious harm

However, if the Department believes that there are one or more safety threats that indicate the child is at immediate risk of serious harm, they will also file a request for a preliminary protection order (PPO) when they file the petition for a child protection order. More often than not, the Department requests custody of the child in a PPO. The Department may also request, among other dispositions, that a perpetrator of violence leave the home or that the family engage in specific services identified to mitigate

[3] Defined in 22 M.R.S. §4002(6)

[4] See OPEGA's March 2022 *Child Protective Services Investigations* report for a description of this process.

the immediate risk. If a judge grants custody to the Department, the child is immediately removed from the home and enters state custody until a summary preliminary hearing (also known as a C-1 hearing) can be held within seven to fourteen days of the filing of the PPO.

## Placement Options

Once a child is in the custody of the Department, a safe, temporary placement for that child must be secured. Placement decisions are made with input from the parent(s), other significant adults in the child's life, the caseworker, and, when appropriate, the child. There are multiple placement options for the Department, as described below in order of statutory preference:

- Kinship Placement. A placement in which the child is cared for by an individual who is related to the child by blood, marriage, or adoption, or through close family relationships ("fictive kin") that are acknowledged by the child's parents. Statute requires that the Department place children with an adult relative when possible[5] and that the Department shall give preference to an adult relative over a nonrelated caregiver when determining placement for a child, as long as the adult relative meets all relevant state child protection standards.[6]
- Resource Home. Commonly referred to as a "foster home," a placement in which a child is cared for by unrelated person(s) in that person's private home. These homes are licensed by the Department, and, as such, caregivers have completed and passed a background check, a home inspection, a home study, and pre-service training.
- Children's Residential Care Facilities. In some cases, a child with behavioral health or physical health needs will be placed in a children's residential care facility. A contracted agency oversees MaineCare eligibility for these placements, which, depending on the child's specific treatment needs and the availability of specific services, may be located in or out of Maine. Placements outside of Maine are subject to the Interstate Compact on the Placement of Children (ICPC), which is a statutory agreement among Maine, all 49 other states, the District of Columbia, and the U.S. Virgin Islands, that provides the requirements that must be met before a child can be placed out of state.[7]
- Emergency Placement. This is not a placement per se, but rather a situation in which a child who is in immediate risk of serious harm has been removed from their home, but an appropriate placement given the child's needs is not readily available. In these cases, the child may be temporarily cared for and supervised by OCFS caseworkers in a hotel.

## Court Appointments

All parents are entitled to legal counsel in child protection proceedings, and, upon receipt of the petition(s), the court will appoint an attorney to each parent.[8] These attorneys are rostered with the

[5] § 4003(3-A)
[6] § 4005-G(1)
[7] Under the ICPC, both the sending state and the receiving state cooperate with each other so that each child will receive the maximum opportunity to be placed in a suitable environment and with persons or institutions that have appropriate qualifications and facilities. The ICPC ensures prospective placements are safe and suitable before approval.
[8] Exceptions are a request for a PPO or a petition for a medical treatment. Parents are, however, entitled to legal counsel in hearings on these orders (§ 4005(2)).

Maine Commission on Indigent Legal Services (MCILS) and have been approved by MCILS to accept child protective assignments.[9]

The court will also appoint a Guardian ad Litem (GAL) to gather information and make recommendations to the court about what is in the child's best interest. In child protection cases, the GAL must be either a licensed Maine attorney or a Court Appointed Special Advocate (CASA). A GAL or CASA will meet with and interview the child on a regular basis[10], interview those caring for or treating the child, access and review all records and reports relevant to the case, file their own reports with the court, and participate in hearings by giving testimony, presenting evidence, being cross-examined by the parties, and protecting the child as a witness.[11]

### The Parent's Attorney and Initial Court Hearings

Once assigned a case, the parent's attorney will contact their client (which, in itself, may prove challenging as the parent may not have a phone or permanent address) to first hear from the parent's perspective what has occurred, what they believe the issue(s) to be that resulted in the petition(s) being filed, and what the parent's goals are. During this initial contact, the attorney will also explain the petition, the court process, what the parent can expect, and the parent's rights.

The parent attorney will also contact the Department through either the caseworker or AAG to request discovery—i.e. the Department's evidence and supporting documentation for the petition(s).

Continuing their work with the parent, the attorney will propose a strategy for court to the parent in advance of the parent's first court hearing. Additionally, the attorney may play a role in advising the parent on what services they will likely need to complete to regain custody of their child as quickly as possible—either through contesting the Department's actions in court, or through alleviating the immediate risk of serious harm that led to a PPO—and promptly engaging in services.

The attorney may continue to represent the parent during meetings with the Department, in the development of various service plans for the parent and family, and during court hearings—among the earliest of which are the Summary Preliminary Hearing, and the Case Management Conference.

### Role of the AAG in Child Protection Cases

The AAGs of the Child Protection Division represent the Department in all child protection litigation throughout the state. AAGs represent the interest of the state, as the state fulfills its statutory obligation to protect abused and neglected children. The Division's trial AAGs generally become involved in child protection cases once Petitions for Child Protection Orders are filed with the court, but are frequently

[9] All parents are initially appointed an MCILS attorney and the costs of any initial work performed on a case are borne by MCILS. However, parents are then required to complete a financial affidavit to determine their eligibility for continued representation at state expense. If a parent is found ineligible (or does not complete the affidavit), the parent may keep their appointed attorney, but do so at their own expense. According to interviews, the overwhelming majority of parents qualify for an attorney at state expense.

[10] GALs must meet with the child every three months. CASA GALs must meet with the child monthly.

[11] The GAL or CASA GAL will advocate for the best interest of the child in court hearings when the child is called to testify. This includes special procedures to protect the child witness from unnecessary psychological harm resulting from the child's testimony.

consulted on the law by OCFS staff prior to the filing of the petitions. AAG's are responsible for developing litigation strategy, managing dockets, preparing caseworkers and other witnesses for trial, admitting record evidence, and other related court activities. They also communicate and interact with OCFS caseworkers, supervisors, and program administrators; as well as parents' attorneys and GALs throughout the course of a child protection case. The Division's appellate attorney handles Appeals to the Law Court and administrative appeals to the state's Superior Courts.

## Summary Preliminary Hearing (C-1 Hearing)

As noted previously, the Summary Preliminary Hearing (also called a C-1 Hearing) occurs within seven to fourteen days of granting the PPO. The purpose of this hearing is to ensure that the Department proves its case, that the child is in immediate risk of serious harm to a judge.

There are two options for the parent at the Summary Preliminary Hearing:

- The parent can waive the hearing, and, instead, agree to have the PPO remain in effect until the next stage of the case, which allows the Department to continue to have custody of the child, if that is what was initially requested and granted; or
- The parent can require the Department to prove its case at a hearing where the Department's case will be presented by the AAG to the judge and the parent's attorney will present the parent's case. The court may limit testimony to that of the caseworker, parent, custodian, legal guardian, the GAL, and relatives or foster parents caring for the child, and may admit evidence, including reports and records that would otherwise be inadmissible as hearsay evidence. At the contested hearing, if the court has found that returning the child to their home would place the child in immediate risk of serious harm, the court will either continue the order (with the child remaining in their foster placement) or amend the order—for example, the child can return to their home, but the court requires the parent to engage in services and cooperate with the Department and the GAL. If the court does not find that the child is in immediate risk of serious harm, the order is vacated and the child returns home to their parent without conditions.

## Case Management Conference

If the Department did not ask for a PPO, the Case Management Conference (CMC) will be the first time a parent meets with a judge. The CMC is used to plan for the jeopardy hearing, including how many witnesses are likely to testify, whether there will be expert witnesses, how many days will be needed for trial, which docket to put the trial on, when the GAL report is due, whether there will be a settlement conference, whether there are any issues that need to be resolved before trial, such as whether the Indian Child Welfare Act (ICWA)[12] applies, whether the appropriate parties have been served, and whether parentage has been established. The parents, the parents' appointed attorneys, the GAL, and the AAG

[12] ICWA establishes minimum federal standards for the removal of American Indian and Alaska Native children from their families, delineates the roles of state and Tribal governments in child welfare cases, establishes preference for placement with family and Tribal members, and institutes protections for parents regarding the termination of parental rights. Child protective cases subject to ICWA differ in several ways from those cases not subject to ICWA, including (but not limited to) placement considerations, the required burden of proof, and active vs. reasonable efforts by the Department to engage the family.

representing the Department all attend the CMC. If a PPO was granted, the CMC is often held at the same time as the Summary Preliminary Hearing.

## Early Planning

Regardless of whether a child enters state custody as the result of a PPO or a finding of jeopardy (as described later in this brief), the responsibility for rehabilitation of the family and reunification is, by statute, shared between the Department and the child's parents.[13] Specifically, the Department must develop and execute a plan for reunification in concert with the parent, and the parent is responsible for addressing the issues that prevent the return of the child to their home. Upon removal of the child from the home—and absent any aggravating factors[14]—the caseworker begins developing this and other related plans.

## Preliminary Reunification and Rehabilitation Plan

To start this process, the caseworker will convene a Family Team Meeting (FTM) to discuss the identified safety threats and develop a Preliminary Reunification and Rehabilitation Plan (Preliminary R&R Plan) with the family and other team members.[15] The resulting Preliminary R&R Plan will include the following components:

- a statement of the safety concerns and risks to the child;
- the preliminary reunification services needed by the family to eliminate the safety concerns and risks to the child;
- an outline of the Visit Plan; and
- relative resources and use of kinship support to include placement, visit supervision, in-home support, or respite care.

**Family Team Meeting (FTM)**
Family Team Meetings are coordinated and facilitated by OCFS caseworkers for the purpose of collaboratively identifying and developing strengths to support the family in making necessary changes to increase the child's safety, permanency, and well-being. The team may consist of the parents, family members, resource parents, service providers, Tribal partners, GALs, parent attorneys, visit supervisors, and other formal and informal supports.

Aiding the caseworker in the development of the Preliminary R&R Plan is the Structured Decision Making (SDM) Case Plan Tool[16], which evaluates the strengths and needs of the family and outlines effective services that address the behavioral changes necessary to increase safety for the child.

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[13] § 4041(1)
[14] Aggravating factors are circumstances that increase the severity of an allegation or finding of abuse or neglect. These circumstances are described in § 4001(1-B), and can be found in Appendix A.
[15] A family's team members may include the parents, the child, that parents' attorneys, the GAL, resource parents, formal and informal supports, and service providers, and Tribe.
[16] Maine has several Structured Decision Making (SDM) tools designed to improve the consistency and validity of decisions.

### The Child Plan

Another plan that is developed shortly after a child enters state custody (and is also informed by the SDM Case Plan Tool) is the Child Plan. The Child Plan reflects the child's perspectives about the reunification process and the child's needs related to school, placement, and their physical, emotional, and mental health. The purpose of this plan is to document how the child's needs will be met during the next six months.

### The Visit Plan

For children in foster care, visitation strengthens the relationship between the child, their parents, and their siblings, as well as providing the Department the opportunity to ensure the child's safety while gathering information to assess a parent's readiness for change, and to evaluate the quality of the parent-child relationship.

In addition to scheduling visitation for the child, their parents, and their siblings within seven days of the issuance of a PPO, the caseworker also must engage the family in developing the Visit Plan. At an FTM with the family, the caseworker will discuss the timing, length, and frequency of visits, the level of supervision that will be provided (supervised, monitored, or unsupervised), and the necessary steps to complete to move to unsupervised visits—all of which is documented in the Visit Plan. (See page 13 for more on Changes to Visitation).

### Concurrent Planning

While planning and undertaking efforts to safely reunify a child with their family, caseworkers also engage in concurrent case planning in which a secondary permanency goal, such as adoption or a permanency guardianship, is established in the event reunification efforts are unsuccessful. Concurrent case planning acknowledges a child's need for a timely, safe, and appropriate permanent placement, and may begin as early as when a child is first being considered for placement outside of their home and will continue throughout the life of the case.

The family's team members may all participate in this process as the caseworker discusses with parents the purpose and importance of a secondary permanency goal. The caseworker will encourage parents to identify possible alternative permanency options, such as appropriate relatives. Caseworkers are to make every effort to reach agreement with parents regarding the secondary permanency goal. If agreement cannot be reached, the caseworker, in consultation with their supervisor, AAG, and the GAL, is responsible for determining the secondary permanency goal.

### Ongoing Monitoring and Assessment, and Provision of Services

The caseworker's involvement with a family extends well beyond the initial planning efforts as they continually monitor and assess the family's needs, goals, and progress; the child's needs for safety, well-being, and permanency; and coordinate and facilitate the provision of services, visitation, and all necessary transportation. This work includes the following components and requirements:

- Monthly contacts with the child to assess their needs for safety, well-being, and permanency, as well as determining other services or supports the child may benefit from, and reviewing and updating their Child Plan.
- Monthly contacts with the parent(s) to review the Preliminary R&R Plan, assess progress made and barriers to achieving goals, determine other services or supports the parent(s) may benefit from, and engage in building solutions with the family. Caseworkers are to also have discussions with the parent(s) about visitation, including the quality of visits, concerns, and progress toward reunification.
- Monthly contacts with resource parents to assess their needs related to caring for the children in their home and determine if other services or supports are needed. Caseworkers are to also have discussions with resource parents regarding how visits are progressing.
- Coordinate and facilitate FTMs in such a manner that the family and team collaboratively identify and develop strengths to support the family in making the changes necessary for reunification.
- Contacts with collateral persons and service providers to verify parent progress in services.
- Ensuring that the parent(s), child, and resource parents receive appropriate referrals for services.

***Provision of Services.*** Among many statutory responsibilities, the Department shall make reasonable efforts to rehabilitate the family when a child has been removed from the home (unless otherwise relieved of that responsibility by the court). The rehabilitation of a family is primarily achieved through the provision and completion of services relevant to the identified needs of the family and parent(s).

Such services are not directly provided by the Department, but instead through referrals made by the Department on behalf of the parent(s) to third-party providers. Referrals may be made for (but not limited to) the following services:

- case management;
- mental health evaluation and treatment;
- court ordered diagnostic evaluation[17];
- counseling;
- parenting classes;
- daily living skills classes;
- substance use testing, evaluation, and treatment;
- in-home behavioral health services; and
- domestic violence treatment and intervention programs.

Caseworkers will also refer parents to other resources that may help address other issues facing the family, such as housing assistance programs.

[17] A Court Ordered Diagnostic Evaluation (CODE) is a comprehensive psychological evaluation, to better understand a parent's mental health concerns, cognitive abilities, and parental capacity.

### The Rehabilitation and Reunification Plan (R&R Plan)

As the case nears the jeopardy hearing, the caseworker will develop the Rehabilitation and Reunification Plan, and is to do so with input from the parent(s), family team members, and service providers; and through the use of the SDM Case Plan Tool.

The R&R Plan outlines safety threats, behavioral changes and required services to increase child safety and reduce risk to the child. The R&R Plan specifically includes the following components:

- reasons for the child's removal from the parents' home;
- behavioral changes required by the parent(s) in order to eliminate jeopardy concerns;
- services that the parents must satisfactorily participate in before the child can be returned home;
- rehabilitation and reunification services to be provided by the Department, either through caseworker services or referrals to service providers;
- methods by which behavioral change will be measured;
- outline of the visit plan;
- relative resources and use of kinship support to include placement, visit supervision, in-home support, or respite care;
- timeframe for reunification reasonably calculated to meet the child's needs; and
- financial responsibility of the parents during reunification.

The caseworker will circulate the R&R Plan to the parents' attorneys and the GAL at least ten days prior to the jeopardy hearing, and the caseworker will file the plan with the court at the hearing.

### Draft Jeopardy Order

As the jeopardy hearing approaches, the AAG representing the Department in the case will draft a proposed jeopardy order that outlines the reasons for a finding of jeopardy. In many instances, the proposed order will also list the services that each parent must engage in to be successfully reunified with their child.

The draft order is circulated by the AAG to the parents' attorneys and the guardian ad litem to see if an agreement can be reached as to the contents of the order. The parties will provide their feedback—including suggested changes to the services requested by the Department—to the AAG. In consideration of the law, the facts of the case, and the goals of the Department, the AAG may accept and integrate the proposed changes into the draft order and present it to the court as an agreement. If the proposed changes are inconsistent with the Department's position or facts of the case, the AAG will communicate to the court and to the parties that a trial will have to be held.

### Jeopardy Hearing and Jeopardy Order

The jeopardy hearing, which is held within 120 days of the filing of the petition for a child protection order, is the point at which the court may hear evidence to determine whether it is more likely than not that the child is in circumstances of jeopardy to their health or welfare by either returning to or remaining in the home.

At the outset of the hearing, the AAG will state whether there is an agreement to the proposed jeopardy order. If there is an agreement, the court will inquire of the parties about the process of reaching the agreement and then "put the agreement on the record" with the AAG describing the agreement in general terms. The judge will then ask the other party questions about the order to ensure the parent understands the order and that the parties do in fact agree. If the court is convinced the agreement is sound, the draft order is signed by the judge and it becomes the court's jeopardy order.[18]

If there is no agreement, the parties proceed to trial. At the contested jeopardy hearing, the Department carries the burden of proof. The AAG will present witnesses and exhibits to prove its case. Witnesses may include the parents, caseworker, GAL, foster parents, law enforcement, doctors, therapists, teachers—anyone with relevant and admissible evidence relating to whether the child is in jeopardy. Evidence may include medical records, mental health assessments, photographs, videos, recordings, diagnostic evaluations, and other relevant documentation. If the court finds that the child is not in jeopardy, the case is dismissed and the child returns to, or remains in, the parent's custody.

If the court determines that jeopardy exists, the judge can either consider the evidence already presented during the jeopardy hearing to craft a disposition, or can hear additional evidence to determine the appropriate disposition relating to the child.[19] The principles upon which the court will determine the disposition of the child are listed in statute in order of priority:

1. protect the child from jeopardy to their health or welfare;
2. give custody to a parent if appropriate conditions can be applied;
3. make disposition in the best interest of the child; and
4. terminate Department custody at the earliest possible time.

Based on those principles and the evidence and recommendations presented during the hearing, the court will determine the disposition of the child, which is incorporated into the court's jeopardy order.

## Parental Rights and Responsibilities Order

In some cases, the court may determine that there is jeopardy as to one parent and not the other. When this happens, the court and the parties may create a Parental Rights and Responsibilities Order, which will determine who the child resides with (even a formerly non-custodial parent), how contact with each parent will or will not occur, and how important decisions for the child will be made.[20] In most cases, when a Parental Rights and Responsibilities Order is established, the child protective case is dismissed, although the Department may remain involved with one or both parents in a service case.

[18] Occasionally, a judge will disagree with the agreed upon terms, and, instead, incorporate their desired conditions into the order.
[19] A disposition is the court-ordered action or outcome. § 4036 lists twelve such dispositions, which include (but are not limited to) the changes in the custody of the child, removal of the perpetrator from the child's home, and the provision of necessary emergency medical treatment for the child when the custodians are unwilling or unable to consent to that treatment.
[20] A change in parental rights and responsibilities may occur whenever the court determines there is jeopardy as to one parent but not the other – and it may also occur for other reasons as part of the family court process.

## Continued Rehabilitation and Reunification Efforts

After a jeopardy order is issued by the court, the caseworker's involvement with the family continues as before: ensuring appropriate referrals for required services are made; making monthly contacts with the child, parent(s), and resource parent(s) to assess needs and barriers to progress, and to monitor progress; contacting collaterals and service providers; coordinating and facilitating FTMs; and updating all applicable tools and plans.

However, as the reunification case continues and time passes, other specific actions, tools and hearings occur to increasingly consider the child's need for permanency.[21]

**Permanency**
In the context of child welfare, permanency is defined as a legally permanent, nurturing family. A child in foster care is determined to have achieved permanency when they are either:

- reunified with their family,
- discharged from foster care to a legally finalized adoption, or
- discharged from foster care to the care of a legal guardian.

## Permanency Review Team

Once a child has been in foster care for at least six months, an OCFS permanency review team will begin reviewing the child's permanency goals on a weekly basis. Within each Child Protective Services District, there are one or two permanency review teams made up of a program administrator and/or assistant program administrator, children's behavioral program coordinator, district clinical consultant, resource supervisor, and a notetaker and facilitator (usually these roles are performed by other supervisors not overseeing the reviewed cases), who meet weekly with the caseworker and the caseworker's supervisor. During these meetings, case-specific information and tasks already completed are discussed and considered to assist in the development of action steps that will promote and support the achievement of permanency in a timely manner.

## SDM Reunification Assessment Tool

When a child is being considered for return home, and before or at six months in care when considering reunification, termination of parental rights, or other permanency options, the caseworker must complete the SDM Reunification Assessment Tool. This tool is used to evaluate risk, visitation compliance, and safety issues. The results guide placement recommendations and decisions regarding whether to reunify a child with their parent(s).

## Judicial Reviews

Following the issuance of a jeopardy order, the court must review the case once every six months (or sooner if requested by the child's parent(s), AAG, or GAL) in what is called a judicial review. Prior to this review, the Department and AAG will circulate a draft order to the parties who discuss potential

[21] Permanency definition from OCFS Child Welfare Policy Manual Glossary, www.maine.gov/dhhs/ocfs/about-us/policy-rules

changes to the proposed judicial review order. If the parties agree on the status of the case and the next steps, the judicial review serves as more of a status update meeting. At that review, the contents of the order will be discussed on the record, as well as what has occurred in the case since the last court date (such as the GAL's contact with the child and case members, the child's well-being, the progress the parent(s) have made toward the goals of the R&R Plan, and the efforts the Department has made to provide the parent(s) with the services necessary for reunification).[22] Based on what has occurred, the court may make changes to what the parent(s) or Department is required to do.

If there is no agreement between the parties, however, a case management conference will be held on the date of the judicial review where the disputed facts may be discussed and a contested judicial review hearing will be scheduled.

At the contested judicial review hearing, evidence and testimony is presented by the AAG, the parent's attorney, the GAL, and others. The court will then consider the original reasons for the jeopardy finding and the disposition of the child, the events that have occurred since those findings, and the respective efforts of the parent and the Department in working toward reunification. The judge then makes the following determinations for the judicial review order:

- the safety of the child in their current placement;
- the continuing necessity and appropriateness of the child's placement;
- the effect of a change in custody on the child;
- the extent of the parties' compliance with the case plan and the extent of the progress that has been made toward alleviating or mitigating the causes necessitating placement in state custody;
- a likely date by which the child may be returned to and safely maintained in the home or placed for adoption or legal guardianship; and
- if the child is 16 years of age or older, whether or not the child is receiving instruction to aid the child in independent living.[23]

It is important to note that most child protective cases have more than one judicial review before the case is resolved.

## Permanency Planning Hearing

Within 12 months of the child being brought into foster care, a permanency planning hearing will occur. Typically held at the same time as a regularly scheduled judicial review, the permanency planning hearing follows the same process as that for judicial reviews. A draft permanency planning order (which is a component of the Office of the Attorney General's (OAG) standardized judicial review order) is circulated by the AAG to the parties. The draft order will contain the Department's proposal for achieving permanency for the child. If the parties agree with the order, it will be reviewed in court at the hearing and signed by the judge. If the parties do not agree, a contested hearing will be scheduled. At this hearing, the parties provide testimony and evidence and then the court decides what is in the long-term

[22] Additionally, for children in residential care facilities, the court will determine the appropriateness of that placement within 60 days of the child entering the program and at each subsequent judicial review and permanency hearing (§ 4038(8)-(9)).
[23] § 4038(5)

best interest of the child, including whether the child should be cared for by a permanency guardianship, placed with a fit and willing relative, placed for adoption, placed in another planned permanent living arrangement, or returned to the child's parent(s).

### Successful Rehabilitation and Reunification Efforts

Reunification of a parent with their child is heavily dependent upon the following factors:

- the parent's engagement and progress in court-ordered services (such as participating in a substance use disorder treatment program or attending counseling sessions);
- the parent's demonstrated behavioral changes and appropriate protective capacity;
- the parent's compliance with court-ordered conditions (such as passing random drug screens or removing unsafe people from the home); and
- the parent's consistent attendance at scheduled visits with the child.

If a parent demonstrates consistent compliance with these components of their R&R Plan, the Department will provide the parent with greater opportunities to demonstrate that they have alleviated the threats and conditions that led to the removal of the child from the home, and that they can safely parent their child. Two such opportunities may occur in the forms of changes to visitation with the child and a trial home placement.

### Changes to Visitation

As a parent progresses through their R&R Plan and demonstrates safe and appropriate parenting during visitation with their child, the level of visit supervision required for future visits will be reevaluated by the caseworker and their supervisor, with input provided by the parent, GAL, AAG, and other family team members.

Per OCFS policy, there are three levels of visit supervision:

- Supervised. These visits will only occur when there is a safety concern that would cause the child to be unsafe should the visits occur without constant eyes-on supervision. When a visit needs this level of supervision, the person supervising the visit will remain in the room at all times during the visit between the parent and the child. This supervision is primarily provided through contract agencies. Prior to the visit(s), the caseworker should contact the visit supervisor to review the specific safety concerns, the level of supervision required, the behavioral changes required of the parent to address safety concerns, and how progress will be measured. Following the visit, the visit supervisor will document how the visit went, any concerns that came up, as well as any questions asked by the parent or the child.
- Monitored. These visits will occur when the parent's behavior does not compromise the child's safety, but there continues to be a need for support during the visit. Monitored visit supervision requires the visit supervisor to check in at the start of the visit to ensure the parent and child are prepared and able to have the visit, and then to periodically check in throughout the visit. At the end of each visit, the visit supervisor will do a check in with the parent and child to discuss how

the visit went, any questions or concerns the parent or child might have, and to document the visit.

- Unsupervised. These visits will occur when the parent's behaviors do not compromise the child's safety and the parent has shown the ability to provide consistent safe care for the child. These visits will be coordinated at an FTM and include input from the parent, child (if age appropriate), and resource parents to discuss how these visits are going. Unsupervised visits with the child may include overnights and weekends with the parent(s).

The parent's progression of visitation through these levels of supervision helps pave the way for a trial home placement.[24]

## Trial Home Placement

One of the final steps taken in the successful reunification of a family is the trial home placement, which is a period of time in which the child resides with the parent while the family is subject to ongoing monitoring and contact with the caseworker and service providers, but the child remains in the legal custody of the Department.

According to OCFS policy, the trial home placement is an opportunity for the parents to demonstrate the behavioral changes they have made to resolve child welfare concerns, support the child's transition into the home and to coordinate services and supports for long-term safety, well-being, and stability. OCFS supports trial home placement at the earliest possible time—as long as the child's safety can be ensured in the placement and is in the child's best interest.

When a trial home placement is being considered, the caseworker will complete the SDM Reunification Assessment Tool to evaluate risk, visitation compliance, and safety issues—all of which are reviewed by the caseworker's supervisor—with the results guiding the Department's permanency placement recommendations and the determination of whether or not to reunify the child with their parent.

If the Department determines that reunification remains the appropriate permanency goal for the child and that the safety threats that led to the removal of the child from the home have been ameliorated (or, if not entirely ameliorated, can be mitigated with safety interventions as part of an in-home safety plan)[25], the caseworker will proceed to schedule an FTM with the family and their team to develop a plan for trial home placement.

At that meeting, the caseworker outlines the expectations regarding their contact (including unannounced visits) with the child and parent during the trial home placement, as well as other logical considerations of the placement. These include the following topics:

- financial considerations of the family, such as additional costs for food and childcare;

[24] Alternatively, the caseworker may temporarily suspend or reduce visitation if at any time there is sufficient evidence that visitation is detrimental to the child, the parent does not attend visits, or there are frequent cancellations. According to the OAG's Child Protection Division, these decisions are made in consultation with the GAL.

[25] In such cases, a safety plan is used for the first thirty days of the trial home placement. During that 30-day period, an FTM must be scheduled to ensure the plan is being followed and the child continues to remain safe with the parent. Safety plans are to only be in place for 30 days and a case cannot be closed with a safety plan in place.

- educational needs of the child, which may include registering the child in a new school;
- the plan to meet the child's medical and dental needs, which may include establishing a new primary care physician and dentist for the child; and
- the services that need to be in place to ensure a successful reunification, per the parent and child's existing service providers.

The caseworker is expected to aid in the transition of the child from foster care to trial home placement by notifying the child's school and providers that the child is in trial home placement, assisting in the transfer of records to new providers, and coordinating needed services in advance of the trial home placement to ensure support is available for the family.

Perhaps most importantly, the caseworker is also responsible for ongoing contacts with the family over the duration of the trial home placement, which is primarily driven by the needs of the child and the family, but not to exceed six months.[26] The frequency and type of contact are prescribed in OCFS policy and become less frequent over the duration of the trial home placement:

- Week 1: minimum of one phone call and one home visit with family
- Weeks 2-6: weekly face-to-face contact with the parent and child with one unannounced home visit per month[27]
- Weeks 7-12: biweekly face-to-face contact with the parent and child with one unannounced visit per month
- Weeks 13-24: monthly face-to-face contacts with the parent and child

Additionally, the caseworker will contact the family's service providers and other collateral contacts at least twice a month to ensure the family's participation in services and determine whether the family's needs are being met in a way that supports reunification.

### Custody of the Child Returned to Parent(s)

If the caseworker, supervisor, and program administrator agree that the trial home placement is successful and the child can safely be returned to the parent's custody, the caseworker will contact the assigned AAG. The AAG will draft a motion to dismiss the case and file it with the court. If the court agrees and the Order Dismissing Child Protection Proceeding is signed by the judge, custody of the child reverts to the arrangement that was in place prior to the child protection case.

However, if the Department believes the underlying custody arrangement is unsafe, the Department will ask the parents prior to the dismissal of the child protection case to amend the existing custody arrangement in some fashion so that an order reflecting a safe arrangement survives beyond the case.[28]

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[26] Pursuant to 45 CFR 1356.21 (e), the court must find that there is a sufficient factual basis to extend the trial home placement beyond a six-month period and make specific findings in support of that.
[27] If the child is school-aged and in school, the caseworker will visit every other week, as long as the child's teacher and appropriate school administrators have been notified that the child is in a trial home placement.
[28] For example, if there was a Parental Rights and Responsibilities Order in place prior to the child protection case that specified the child's primary residence was with the child's father, but the father is the person who created the circumstances of jeopardy for the child.

Additionally, if there was no Parental Rights and Responsibilities order in place and the parents became joint custodians of the child once again, the Department would request that the parents enter into an order that provides for the safety of the child.

## Unsuccessful Rehabilitation and Reunification Efforts

During the course of a reunification case, the Department expects the parent to make efforts to engage in services, make sufficient progress in those services, attend and engage in quality visits with the child, and meet certain conditions in order for reunification to continue as the child's primary goal for permanency. However, when parents do not meet these expectations—particularly in the latter stages of a case when the child has spent a longer time in foster care and the child's need for permanency becomes a greater consideration—the Department will consider the individual facts of the case to determine whether a change in the child's primary goal for permanency is warranted. Sometimes—even beyond the one-year mark of a child being in foster care and when the permanency hearing occurs—reunification will remain the child's primary goal, particularly if an otherwise engaged parent cannot access a required service (i.e. they remain on a waitlist), or the Department believes that although the parent may not be ready to reunify at that moment, the parent will be able to in a reasonable amount of time. Other times, the Department will determine that a change in the child's permanency goal is appropriate, and, if the court agrees, the Department will begin pursuing one of three alternative placement options for the child—adoption, permanency guardianship, or other planned permanent living arrangement—each of which has its own requirements and processes that are described below.

## Adoption

Adoption is a legal process through which the parenting of a child and all rights and responsibilities for the child are transferred from the child's birth parents to the child's adoptive parents. Adoption represents a lifelong commitment to a child, and is the Department's preferred permanency option when reunification is not successful, as it creates a permanent legal relationship between the child and the adoptive parents. Adoption also requires the termination of the birth parents' parental rights.

## Termination of Parental Rights (TPR)

Once reunification efforts are determined to be unsuccessful, the caseworker will file a petition asking the court to permanently end the legal rights of the biological parent(s) to the child by issuing an order terminating the parents' parental rights, which, in turn, frees the child for eventual adoption. In that petition, the Department will document the facts that they believe constitute the basis for the request, as well as an allegation that is sufficient for termination, and a statement of the effects of a termination order.

The specific time at which the petition is filed can vary. Statute does not preclude filing a termination petition earlier in the case if reunification is determined to be unsuccessful, but does specify three timeframes and conditions under which the Department is required to file the termination petition:

- before the end of the child's 15th month in foster care when that child has been in foster care for 15 of the most recent 22 months;

- within 60 days of a court finding that there is an aggravating factor and an order to cease reunification on both parents; and
- within 60 days of a court finding that the child has been abandoned.

However, statute also includes exceptions to these requirements:

- when a child has been in foster care for 15 of the most recent 22 months, the Department does not need to file the petition if the Department is required to undertake reunification efforts and the Department has not provided the family the services determined by the court to be necessary for the safe return of the child to the child's home consistent with the time period in the case plan;
- the Department does not need to file a termination petition if the Department has chosen to have the child cared for by a relative; and
- the Department does not need to file a termination petition if the Department has documented to the court a compelling reason for determining that filing such a petition would not be in the best interests of the child.[29]

These exceptions provide the Department with the latitude to file the termination petition at the most appropriate time based on the facts and circumstances of the individual case (for example, current parent engagement and progress, the availability of services, and the trajectory of the case) rather than a set time for all cases (for example, the child's 15th month in foster care), and, especially, if a compelling reason exists.

Once the petition is filed, the court sets a date and time for a hearing and the petition is served by the Department on the parents and the guardian ad litem for the child at least 10 days prior to the hearing date. The Department also provides written notice of the hearing to foster parents, pre-adoptive parents, and relatives providing care to the child.

At the hearing, parents have the right to participate, testify, and present evidence. The parents' attorneys may call witnesses to support the parents' case and may question or cross-examine the Department's witnesses as well as the GAL, who will also submit a report to the court with recommendations concerning the child.

The court may order the termination of parental rights if the parent consents to the termination after a judge has fully explained the effects of a termination order, and the parent's consent is written, voluntary, and happens in court before a judge.

If a parent does not agree to the TPR order, the court will only terminate parental rights if it makes two findings. First, the court must first find clear and convincing evidence that the parent is unfit; to do so, the court considers whether one or more of the following factors exist:

[29] Statute does not specify how the Department is to document the compelling reason to the court. Current practice is to capture that reason in the draft orders submitted to the court at the regularly scheduled hearings and judicial reviews within the existing court process. As such, there are no standalone filings of the compelling reason at the specific timeframes described in statute.

- the parent is unwilling or unable to protect the child from jeopardy and these circumstances are unlikely to change within a time which is reasonably calculated to meet the child's needs[30];
- the parent has been unwilling to or unable to take responsibility for the child within a time which is reasonably calculated to meet the child's needs;
- the child has been abandoned; or
- the parent has failed to make a good faith effort to rehabilitate and reunify with the child pursuant to § 4041 (Departmental responsibilities for family reunification).

If the court finds one of those factors exist, the court must secondly[31] determine whether the termination of parental rights is in the best interest of the child.

When the court finds both standards to be met, the court will issue an order terminating parental rights. The parents then have no legal rights or obligations to the child, including custody, visitation, or any decision-making authority. The parents also have no right to object to the child's subsequent adoption or participate in those proceedings.[32]

If the court denies the TPR because the Department has not proved parental unfitness and the child's best interest by clear and convincing evidence, the child will remain in the Department's custody, and, typically, the parent(s) will be given more time to resolve the circumstances of jeopardy. Occasionally, the judge will deny the TPR and decide a different permanency plan is appropriate and then issue an order moving the case in that direction.

### Permanency Guardianship

If reunification or adoption are not suitable permanency options for a child, the Department may pursue a permanency guardianship for the child, which must be determined by the court to be in the best interest of the child. In a permanency guardianship, a person is established by the court to be the legal guardian for a child and that guardian will have the rights of a parent in day-to-day matters.[33] To be a permanent guardian, a person must:

- have the ability to provide a safe home for the child,
- have a reciprocally close emotional bond with the child,
- be willing and able to make a long-term informed commitment,
- have the skills to care for the child, and
- be finger-printed for a national criminal history records check.

30 §4055 (1-A) specifies five circumstances which the court can infer to meet this standard.

31 Although Title 22 § 4055 (1)(B)(2) lists the two findings necessary for a termination of parental rights in a different order (first being best interest of the child and second being parental unfitness), the U.S. Constitution requires that a trial court must first find parental unfitness before it proceeds to consider the best interest of the child.

32 § 4059 provides for a process by which the Department may petition the court to reinstate the parental rights of a parent whose parental rights have been previously terminated by the court.

33 A permanency guardian is given all the powers and duties of a guardian of a minor which are specified in 18-C M.R.S. §§ 5-207 to 5-208.

The child's parent(s) may petition the court to terminate the permanency guardianship annually if they believe there is a change of circumstances regarding the child's welfare. As this potentially introduces some continued uncertainty regarding the child's permanency, it is believed that permanency guardianship is better suited for older children. This is reflected in OCFS practice that permanency guardianships are generally reserved for children over the age of 12.

Prior to establishing a permanency guardianship, a cease reunification order regarding both of the child's parents is required. According to the OAG's Child Protection Division, often, the cease reunification and the permanency guardianship orders are entered contemporaneously.

### Cease Reunification Order

If issued by the court, a cease reunification order allows the Department to discontinue its reunification effort with regard to one or both of a child's parents.

Prior to requesting a cease reunification order, the caseworker will complete the SDM Reunification Assessment Tool and consult with their supervisor and AAG to determine whether such an action is appropriate. If the decision is made to seek a cease reunification order, the caseworker must send written notice of that decision to the parent.[34] The caseworker is also expected to continue engaging with the parent(s) in identifying possibly alternative permanency options (such as relatives and fictive kin), and to have meaningful contact with the parent at least every three months to update them about the child's safety, permanency, and well-being. Visitation between the parent and child also continues regardless of whether there is a cease reunification order in place unless there is a specific determination that continued visitation would be detrimental to the child's best interest.

Once the request is made to the court, the court can order that the Department cease reunification if the court finds at least one of the following:

- the existence of an aggravating factor; or
- that continuation of reunification efforts is inconsistent with the permanency plan for the child.[35]

### Other Planned Permanent Living Arrangement (OPPLA)

OPPLA is a permanency option for children aged 16 or older and for whom reunification, adoption, and permanency guardianship have been ruled out. In this arrangement, children generally continue to live with a resource parent while the Department maintains custody of the child, and has a responsibility for the care and supervision of the child. As this arrangement provides a lesser degree of permanency, it is

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34 Per policy, this written notice must include the specific reasons the decision to seek a cease reunification order was made, the specific efforts OCFS has made in working with the parent, and a statement of the parent's rights under § 4038.

35 § 4041(2)(A-2)(2) references two situations in which there may be a finding that the continuation of reunification efforts is inconsistent with the permanency plan for the child: when two placements with the same parent have failed and the child is returned to the custody of the Department, and when the permanency plan provides for a relative or other person to have custody of the child and the court has ordered custody of that child to that relative or other person. There may also be other situations warranting a finding that continued reunification would be inconsistent with the child's permanency plan.

the Department's least preferred permanency option, and, as such, changing a child's case goal to OPPLA requires a court order.

OCFS casework activities for a youth with a case goal of OPPLA focuses on preparing the young person for success in adulthood. To that end, the caseworker is to have monthly contact with the youth and resource parents to assess safety, permanency, and well-being; ensure that the youth and resource parents receive appropriate referrals for services; and facilitate ongoing FTMs to assess progress, identify barriers toward achievement of goals, and work on solutions with the youth and their team.[36]

[36] OCFS Permanency Policy, July 2022

# Part 2: OPEGA's Analysis of OCFS Performance in Reunification Cases

In order to assess various aspects of OCFS's practice and performance in reunification cases, and to ultimately identify potential challenges and the factors contributing to those challenges, OPEGA employed a methodology that leveraged the structure, sampling, and rigor of the federal government's Child and Family Services Review (CFSR) and OCFS's existing quality assurance results to inform structured interviews with those most closely involved with the reunification process.

## The Child and Family Services Review and OCFS Quality Assurance (QA) Program

The CFSR is the U.S. DHHS's oversight mechanism for examining state conformity with federal child welfare expectations and promoting continuous improvement, and relies upon the sampling and review of individual cases to assess performance. Every six months, 65 cases are selected for review in accordance with a federally established sampling methodology.

These case reviews are conducted through OCFS's established QA Program in which OCFS QA Specialists conduct detailed assessments in accordance with the federal Onsite Review Instrument and Instructions (OSRI), which contains 18 "Items" that reflect federal expectations for caseworker practice. These assessments include examining electronic case records and conducting interviews with children, parents, foster parents, caseworkers, and other professionals involved with the case. QA Specialists rate each case either Strength or Area Needing Improvement on every applicable item, and provide narrative rationales for those scores in each case.

## OPEGA's Analysis of Case Review Results

While the OSRI contains 18 Items that span the entirety of the larger child protective process, our scope was specifically focused on reunification, and, as such, OPEGA selected the six Items that were most applicable to reunification. (See Appendix B, Table B.1).

For those six items, we requested QA results data for the ten most recent reporting periods (April 2017 to March 2023) from OCFS QA staff. We received 400 records and identified 235 cases that had reunification as a goal at any point during the life of the case, and would be subject to further review. For any of those 235 cases in which one of the six selected Items was scored as an Area Needing Improvement, we reviewed the QA Specialists' narrative rationales and coded the underlying reasons for the score and potential challenges.

## Structured Interviews and Identifying Potential Challenges

To further explore the most common potential challenges identified in our analysis of the case review results, we selected a random sample of permanency caseworkers and supervisors representing all district offices to interview. In these interviews, we explored what factors may impede reunification and potential reasons why casework may not meet federal expectations. Additionally, we interviewed parent attorneys and representatives of groups that work with biological and resource parents to obtain their perspectives.

We also reviewed recent OCFS federal annual reports to compare our issues to OCFS's assessments, goals and strategies, and interviewed OCFS management about these issues. Taken together, this work revealed four cross-cutting challenges most prevalent in reunification casework. (See Appendix B for full methodology).

## Summary of OPEGA's Results

### Challenge 1: Caseworker Practice Concerns

#### *A. Assessment of parents' substance use*

The federal review expectation is for caseworkers to conduct an initial and ongoing assessment that accurately identifies the parents' needs. In OPEGA's analysis of the cases rated Area Needing Improvement for this Item, we found that the majority of cases (54% or 94 of 175 cases) specifically mentioned inadequate assessment of substance use by parents.

In interviews with caseworkers and supervisors, OPEGA explored factors that make assessing substance use challenging. The most commonly cited challenge was caseworker inexperience. Permanency supervisors and OCFS management reported that new caseworkers may be less likely to confront substance use directly with parents. Interviewees explained that caseworkers' comfort with looking through parents' homes for evidence of substance use, and being frank and direct in speaking with parents about the sensitive topic of substance use, generally improves with more time and experience in the job.

Caseworkers and supervisors explained that drug screening is the most commonly used tool to assess substance use. They noted the following challenges with drug screening:

- Logistics of screening: difficulty scheduling random tests around parent's work schedule; lack of drug testing resources or convenient locations available; difficulty scheduling transportation, especially for random screens; and difficulty documenting test results in Katahdin (including being less likely to document negative results).
- Test results: difficulty interpreting test results; delayed test results; alcohol and certain street drugs not included in standard test; false positives, especially with rapid tests; difficulty determining abuse of prescription medication; and difficulty understanding prescribed vs. illicit drugs in results. Those interviewed noted a lack of available staff expertise in this area.

We asked representatives working with biological parents for their perspectives on substance use assessments. They said that parent experiences with drug screens vary widely by district office and by caseworker. Those interviewees representing parents believe that substance use assessment during reunification should address whether the parent is impaired and if substance use is affecting their parenting. They assert that drug screens are not effective in helping caseworkers answer those questions, and that other assessment skills like observing parent behaviors and speaking with parents' treatment providers should be given more weight rather than relying solely on drug screens.

### *B. Caseworker engagement with family*

Two of the Items in the CFSR that we focused on for this review have an emphasis on caseworker engagement with parents. Federal expectations associated with this topic include the agency making concerted efforts to engage the family in case planning on an ongoing basis and visits with the family are expected to occur at a frequency and quality to sufficiently ensure safety, permanency, well-being, and achieve case planning goals. In OPEGA's analysis of these cases rated Area Needing Improvement, we found themes related to lack of parent engagement, described below.

For the Item related to case planning, OPEGA found:

- lack of discussion with parents on goals and services and/or parents not feeling listened to by caseworkers including at family team meetings (63% or 133 of 211 cases)

For the Item related to caseworker visits, OPEGA found:

- inadequate conversations with parents about case planning (67% or 152 of 227 cases); and
- meeting in environments not conducive to case planning (58% or 131 of 227 cases).

Interviews with permanency supervisors identified caseworker inexperience as a potential cause for this concern, specifically:

- a lack of training and shadowing with senior workers to learn how to have difficult and honest conversations with parents;
- challenges related to facilitating family team meetings, including focusing on a family's case plan and goals, and performing a dual role as a facilitator and active participant in the meeting; and
- a lack of use of strategies to engage with domestic violence-involved families, such as finding ways to separate parents to have confidential interviews without the abusing partner present.

Biological and resource parent representatives report concerns with caseworkers not giving parents the opportunity to participate in developing the reunification plan and a lack of communication with parents on the requirements in their plan. They reported that some caseworkers do not engage with parents regularly and are not responsive to parent concerns, such as required treatment not being available and insufficient opportunities to visit with their children.

Biological and resource parent representatives agree that family team meetings are often not productive because caseworkers fail to address the key question of what the parent is doing or needs to do to move closer to alleviating jeopardy. They feel caseworkers should be trained or mentored more extensively to improve facilitation of family team meetings.

These interviews also suggested a potential cause of lack of time to adequately engage with families with case planning, due to high workloads. (See Challenge 2).

## Challenge 2: High Workloads Impacting Safety, Permanency, and Well-Being Outcomes

The CFSR process focuses on achieving outcomes in safety, permanency, and well-being for children and families. In order for these outcomes to be reached, caseworkers need sufficient time and resources. We

found three interrelated factors contributing to a strong theme from interviews about high workloads: caseworker vacancies, lack of support staff, and lack of visitation supervisors and transportation for families. Together, these factors increase the workload of permanency caseworkers, contribute to not meeting federal expectations, including potentially lengthening the time to permanency for children.

### *A. Permanency caseworker vacancies*

Several of the federal review expectations involve thoroughness of casework to ensure safety, permanency, and well-being of children. To be thorough in all aspects of permanency casework, caseworkers need sufficient time and resources. In our interviews with permanency caseworkers and supervisors, a strong theme emerged around workloads that are unreasonable for CPS staff. Interviewees consistently mentioned the number of vacancies within their districts and related impacts of vacancies on the workloads of the remaining caseworkers.

As of January 31, 2024, the overall vacancy rate for permanency caseworkers, specifically, was just under 18% and varied significantly among districts. Table 1 shows this variability - where District 2 and District 8 had no vacancies; while District 7, Ellsworth & Machias, showed a 42% vacancy rate. Interviews with caseworkers and supervisors also reported that caseworkers in the Permanency unit may be assigned investigations when there are staffing shortages in the Investigations unit, further increasing the workload for permanency caseworkers.

**Table 1. Permanency Caseworker Vacancy Rates**

| District | Vacancy Rate | Total Permanency Caseworker Positions |
|---|---|---|
| 1 – Biddeford & Sanford | 29% | 21 |
| 2 – Portland | 0% | 24 |
| 3 – Lewiston | 39% | 33 |
| 4 – Rockland | 19% | 13 |
| 5 – Augusta & Skowhegan | 11% | 37 |
| 6 – Bangor | 7% | 27 |
| 7 – Ellsworth & Machias | 42% | 12 |
| 8 – Caribou & Houlton | 0% | 15 |
| **Total** | **18%** | **182** |

Source: OPEGA Analysis of OCFS Organization Charts updated January 2024. https://www.maine.gov/dhhs/ocfs/about-us

Biological parent and resource parent representatives interviewed reported the observations of permanency caseworker workloads being too high and believe that this has a negative effect on caseworkers' ability to respond timely and address issues with parents and foster families during reunification. Parent attorneys reported that high workloads impede caseworkers' ability to thoroughly and timely prepare for court hearings and to work consistently on addressing parent needs.

### *B. Lack of support staff*

Interviews of permanency caseworkers and supervisors identified a lack of support staff as a challenge to thoroughness of casework to ensure safety, permanency, and well-being of children. In particular, lack of case aides, legal aides, and clerical staff were cited throughout interviews. Caseworkers reported the need to spend work hours on tasks that could be assigned to support staff, such as scanning and uploading documents, faxing referrals, making records requests, and scheduling transportation. Caseworkers described the challenge of fitting these tasks into their workweek, with the need to prioritize monthly contacts with parents and children to assess for risk and safety throughout the case.

We note that the Governor's Biennial Budget Change Package (P.L. Chapter 412), which took effect October 25, 2023, reorganized the Customer Representative Associate II - Human Services position into the CPS Case Aide position, which included a pay grade increase. We also note that five Legal Administrative Professionals were recently added to five district offices, while the three remaining district offices do not have these positions allocated at this time.

### *C. Lack of visitation supervisors and transportation for families*

Interviews with permanency caseworkers and supervisors, as well as with representatives of biological and resource parents, described challenges with access to particular contracted services: visitation supervision and transportation. Lack of supervised visitation and transportation to required services may have negative impacts, including increasing the workload of permanency staff and potentially lengthening the time to reunification.

As described on pages 13-14, parents in the process of reunification are often required by the Department to have supervision when they visit with their child. These visits may be supervised by staff who are contracted by OCFS. Parents and children may need transportation to the services indicated in their Reunification and Rehabilitation plan. The Department assists families by contracting with transportation agencies to provide rides to counseling, drug screenings, and other appointments. Those interviewed by OPEGA described a shortage of supervised visitation staff and transportation staff, resulting in OCFS case aides and caseworkers taking on these roles.

Those interviewed representing both biological and resource parents identified access to supervised visitation and transportation to be a challenge. Parent attorneys stressed the critical importance of frequent visitation for biological parents to maintain relationships with their children during reunification and to demonstrate their ability to safely parent. Transportation was described by several parent representatives as a major challenge with frequent last-minute cancellations or no-shows by the transportation agency. Interviewees estimate that well over one-half of biological parents engaged in reunification need transportation services.

## Challenge 3: Waitlists for Evaluations and Treatment

The federal review expectation is for the agency to make concerted efforts to assess the needs of, and provide services to parents to achieve case goals and the address issues relevant to the Department's involvement with the family. In OPEGA's analysis of these cases rated Area Needing Improvement, we found that in the majority of cases (70% or 148 of 210 cases), the needs of parents were not adequately assessed and services were not adequately provided. Specifically, we found that mental health evaluations and treatment, as well as substance use disorder treatment, were not satisfactorily provided, creating potential delays in reunification.

### *A. Mental health evaluations and treatment*

Interviews with permanency caseworkers and supervisors, parent attorneys, assistant attorneys general, court representatives, and representatives of biological parents, all identified chronic issues with waitlists for mental health services for parents in the reunification process. Caseworkers and supervisors reported that waitlists for mental health evaluations, in particular, are several months long. Those interviewed expressed that these long waits for the assessment and treatment of mental health may delay reunification, as parents often must be assessed and complete treatment in order to alleviate the circumstances associated with jeopardy to their child's welfare.

### *B. Substance use disorder treatment*

Interviewees reported similar concerns related to long wait lists for substance use disorder services. They noted that substance use is a factor in many reunification cases, and that many parents have to wait for a provider to be available in order to begin to receive treatment for their substance use. Parents may need to satisfactorily participate in substance use disorder treatment before their child can reunify and return to the home. Waitlists for these services may contribute to delays in permanency for the child.

## Challenge 4: Timeliness of TPR Filings and Other Legal Concerns

The federal review expectations include establishing permanency goals timely that are appropriate for the child's needs and the circumstances of the case, and, if reunification efforts are not successful, filing a termination of parental rights (TPR) petition in a timely manner. Both federal and state statute require OCFS to seek termination of parental rights when the child has been in foster care for 15 of the most recent 22 months. Exceptions to this requirement include: when the Department has not provided services; the child is cared for by a relative; and the Department documented a compelling reason that a TPR is not in the best interest of the child. (See page 17). In OPEGA's analysis of the cases rated Area Needing Improvement, we found that in the majority of cases reviewed (62% or 91 of 146 cases), reunification remained the goal too long, and about one-half of the cases reviewed (51% or 74 of 146 cases identified) had delays in TPR filing.

We interviewed permanency caseworkers and supervisors to understand what factors may contribute to reunification remaining a child's goal for too long. We heard that the backlog of cases in the judicial system causes delays in scheduling and holding court hearings that are necessary for judicial decisions to

cease reunification efforts. Interviewees reported that TPR hearings have low priority in the trailing docket[37] hearing prioritization process, and may be delayed for months. Hearings early in the case may be delayed if there is not an attorney available to represent the parent, and hearings throughout the case may also be delayed due to scheduling conflicts with a smaller number of parent attorneys assigned to a large number of cases.

Some permanency staff explained that reunification efforts can stall when parents have to wait for diagnosis and treatment, and that judges are unlikely to agree to TPRs if parents are not provided services in a timely manner.

Caseworkers and supervisors reported that TPR petitions may not be filed timely due to workloads. Some caseworkers said that writing TPR petitions is time-consuming, cumbersome, and difficult to accomplish timely given other priorities, such as ensuring children are safe in placements and assessing whether parents have alleviated circumstances of jeopardy. [See Challenge 2].

Biological parent representatives described challenges with parents getting timely legal representation and the quality of their legal representation. They said that it is not uncommon for parents to meet their court-appointed attorney for the first time at the first court hearing, with no opportunity for advance planning. They further stated that parents may be advised to not contest a jeopardy hearing by an attorney who knows very little about their situation. Parent representatives also note that GALs are required to meet with the child and the resource parent but not the biological parent before making recommendations to the court.

### Conclusion

Reunification is a complex process in which a child's needs for safety, well-being, and permanency are continually assessed while the parent attempts to address the concerns and conditions that resulted in their child being removed from the home. This continual assessment, and, subsequent decision-making, rely upon the caseworker's ability to conduct thorough and comprehensive casework. However, high workloads driven by caseworker vacancies, a lack of support staff, and a lack of visitation supervisors and transportation for families, all place additional burdens on caseworkers which can adversely impact all parts of practice. One such practice challenge we noted was the inadequate assessment of parents' substance use, reportedly due to caseworker inexperience and challenges with the logistics and results of drug screens. Another practice challenge was caseworker engagement with the family, particularly with inexperienced caseworkers employing specific strategies to engage parents. Both of these practice challenges are further impacted by high workloads.

[37] For each month, the court has a list of cases that are ready for a contested hearing. This is called a "trailing docket." In assigning trial dates, it prioritizes cases with upcoming statutory deadlines. If there is not sufficient trial time to accommodate all cases, lower priority hearings such as TRPs are set as backup cases to the priority cases, meaning the case will be heard in place of a case that settles without a hearing at the last minute. This ensures that trial time is not wasted, but if the court does not designate enough trial time for each trailing docket, cases can be delayed to the next month or beyond. The FFY23 Annual Progress and Services Report notes: "The key to the success of the trailing docket is for the court to effectively predict case surges to expand court trial time accordingly and thereby improve date certainty for litigants" (p. 138).

Relatedly, successful reunification requires the parent addressing the concerns that led to their child being brought into state custody, which is dependent upon the availability and access to required services. We noted two such service types with waitlists were related to assessing and treating mental health issues, and treating substance use disorders.

When reunification efforts stall or are otherwise unsuccessful, the permanency goal for the child may change, and, often, a petition for a termination of parental rights is appropriate. However, we noted that the Department was frequently cited for reunification remaining a child's permanency goal for too long and/or not filing a TPR in a timely manner, both which may be partially impacted by the prioritization of TPR hearings in the court, the lack of available parent attorneys on child protective cases, high caseworker workloads, and waitlists for mental health and substance use disorder services.

We note that the aforementioned challenges are broadly known by the OCFS management, and to various extents are addressed in the most recent FFY24 Maine Annual Services and Progress Report.

## Scope and Timing of this Information Brief

Given the GOC's stated timeline and interest in potential legislative action this session, we have adjusted the scope and timing of our deliverable accordingly. In the interest of timeliness, we have opted to issue an information brief now that describes the reunification process, the primary challenges within that process, and some of the factors contributing to those challenges, rather than a full report requiring additional fieldwork to develop issues and recommendations that would not be completed in time for the current Legislative session. We believe our chosen approach will allow the results of our work completed to date to be considered by both the GOC and the Department as they undertake reform of the child protective system.

# Appendix A. Aggravating Factors

| Table A-1. Aggravating Factors (22 M.R.S. §4002(1-B)) | | |
|---|---|---|
| A. | The parent has subjected any child for whom the parent was responsible to aggravated circumstances, including, but not limited to, the following: | |
| | 1. | Rape, gross sexual misconduct, gross sexual assault, sexual abuse, incest, aggravated assault, kidnapping, promotion of prostitution, sexual exploitation of a minor, sex trafficking or aggravated sex trafficking, abandonment, torture, chronic abuse or any other treatment that is heinous or abhorrent to society. |
| A-1. | The parent refused for 6 months to comply with treatment required in a reunification plan with regard to the child. | |
| B. | The parent has been convicted of any of the following crimes and the victim of the crime was a child for whom the parent was responsible or the victim was a child who was a member of a household lived in or frequented by the parent: | |
| | 1. | Murder; |
| | 2. | Felony Murder; |
| | 3. | Manslaughter; |
| | 4. | Aiding, conspiring or soliciting murder or manslaughter; |
| | 5. | Felony assault that results in serious bodily injury; |
| | 6. | Any comparable crime in another jurisdiction. |
| C. | The parental rights of the parent to a sibling have been terminated involuntarily. | |
| D. | The parent has abandoned the child. | |
| Source: https://legislature.maine.gov/legis/statutes/22/title22ch1071sec0.html (last visited Feb. 14, 2024). | | |

# Appendix B. Methodology

Preliminary research for the reunification portion of OPEGA's Child Protective Services review began in April 2022. The Government Oversight Committee then directed OPEGA to pause work on reunification in September 2022. In March 2023, the GOC approved OPEGA staff to return to this work.

The preliminary research conducted in 2022 included collection and analysis of data from various sources. To understand the legal and policy framework for child protective services, OPEGA examined relevant state statutes, agency rules, and OCFS policies, particularly those governing permanency of children in state custody. We also reviewed federal and state statutes governing OCFS, including but not limited to the Child and Family Services and Child Protection Act (22 M.R.S. §§ 4001 to 4099-P)[38]

OPEGA interviewed a range of stakeholders. To understand key aspects of OCFS policy and expectations in family reunification, OPEGA interviewed 9 OCFS staff members. We had a series of meetings with the OCFS Director and Assistant Director. We then interviewed several district office staff members (program administrators, supervisors, and caseworkers) to learn more about OCFS practice and current conditions. We sought to understand the perspectives of other stakeholders in reunification by conducting a total of 21 interviews with:

- Maine Child Welfare Services Ombudsman;
- Judges;
- Guardians ad Litem (GALs) and Court Appointed Special Advocates (CASAs);
- Assistant Attorneys General in the Child Protection Division (who represent OCFS);
- Defense attorneys (who represent biological parents);
- Organizations that support and advocate for biological and resource parents involved with CPS; and
- Service providers.

## Case Reviews

In order to assess the thoroughness of reunification casework, and to identify any specific practice concerns and the extent to which those are occurring, OPEGA analyzed data from the agency's internal quality assurance (QA) program. OCFS uses the federal government's Child and Family Services Review (CFSR) model to evaluate child welfare practice. The CFSR is the U.S. Department of Health and Human Services oversight mechanism for examining state conformity with federal child welfare expectations and promoting continuous improvement.

Every six months, OCFS QA randomly selects a sample of cases for review. QA reviews are conducted by a team of nine QA Specialists who typically have experience as OCFS caseworkers or supervisors. QA Specialists conduct detailed assessments that include examining electronic case records and conducting interviews with children, parents, foster parents, caseworkers, and other professionals involved with the case.

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[38] https://legislature.maine.gov/legis/statutes/22/title22ch1071sec0.html (last visited Feb. 12, 2024).

QA reviews are structured around the federal Onsite Review Instrument and Instructions (OSRI). The OSRI contains 18 areas or "Items" for review, and QA Specialists rate each case either *Strength* or *Area Needing Improvement* on every applicable Item. The performance standards for a *Strength* rating are very high, and may exceed the expectations set forth in OCFS policy. For this evaluation, OPEGA selected the six OSRI Items most central to reunification work, including safety assessment throughout the case, effectiveness of work to achieve permanency for the child, and several aspects of casework with parents, since resolving jeopardy caused by parents is essential for reunification. The following table lists each Item we analyzed and its guiding questions.

**Table B.1. Child and Family Services Review (CFSR) Onsite Review Instrument and Instructions (OSRI): Items Examined in OPEGA Analysis**

| CFSR Item | Specific Questions Pertinent to OPEGA Analysis |
|---|---|
| Item 3: Risk & safety assessment and management | |
| | Did the Agency accurately assess all risk and safety concerns for the child in foster care and any children remaining in the home? |
| | Was there a safety concern during visitation with parent(s) or other family members? |
| Item 5: Permanency goal for child | |
| | Were permanency goals established in a timely manner? |
| | Were permanency goals appropriate to the child's needs and circumstances of the case? |
| Item 6: Achieving reunification or other form of permanency | |
| | Did the agency and courts make concerted efforts to achieve permanency timely? |
| Item 12B: Needs assessment and services to parents | |
| | Did the agency conduct a comprehensive assessment that accurately assessed the parent(s)' needs? |
| | Did the agency provide appropriate services to meet identified needs? |
| Item 13: Child and family involvement in case planning | |
| | Did the agency make concerted efforts to involve the parent(s) in case planning? |
| Item 15: Caseworker visits with parents | |
| | Was the frequency of caseworker visits with parent(s) sufficient to (1) address child's safety, well-being, and permanency and (2) promote achievement of case goals? |
| | Was the quality of caseworker visits with parent(s) sufficient to (1) address child's safety, well-being, and permanency and (2) promote achievement of case goals? |

Source: US Department of Health and Human Services, Administration for Children and Families, https://www.acf.hhs.gov/cb/report/cfsr-r4-osri

OPEGA requested QA results data files from the ten most recent reporting periods, from April 2017 to March 2023.[39] As expected, we received a total of 400 foster care case records. Of those 400 foster care cases, only 235 cases (68%) had reunification as a goal at any point during the case. We focused our review on those 235 cases. For each Item, we carefully reviewed narratives on the cases that were rated *Area Needing Improvement.* All 235 reunification cases were rated Area Needing Improvement on at least one of the six Items. The narrative rationales provided by QA staff explain both the expectations of the reviewers and how the casework did not meet expectations. OPEGA developed a coding scheme to categorize and quantify deficiencies that led to Area Needing Improvement ratings. We then identified the practice concerns and casework deficiencies that occurred in the majority of reviewed cases.

## Staff Interviews

After identifying the top reasons casework did not meet the federal expectations, we sought to understand the perspectives of front line OCFS staff about the reasons for these common shortcomings. The QA data files do not include identifying information about which staff worked on the cases. OPEGA decided to interview a randomly selected 10% of permanency staff. We requested a list of all permanency caseworkers and supervisors from OCFS, including data on their district office and tenure working for the agency. The staff list included 132 caseworkers and 34 supervisors. We used a random number generator to identify caseworkers and supervisors to contact. We compared the resulting sample to the overall distribution of staff experience and by district office, and determined that the sample contained a reasonably representative group.

OPEGA ultimately interviewed 13 permanency caseworkers and 5 supervisors, including at least one staff person from each district office. Our sample included caseworkers from every district, with an average tenure working at OCFS of three years and a range of less than one year to seven years. Supervisors interviewed are from four districts and have worked with OCFS for an average of 13 years, ranging from seven to 24 years.

**Table B.2. OCFS Permanency Staff, July 2023**

| Role | Total | OPEGA Interviews |
|---|---|---|
| Permanency Caseworkers | 132 | 13 |
| Permanency Supervisors | 34 | 5 |
| **Total** | **166** | **18** |

The interview questions explored staff perspectives about the themes we identified, whether staff consider QA expectations reasonable, factors that may impede reunification, and reasons for the most common areas where casework does not meet federal expectations. We also interviewed the

[39] OPEGA's initial data request included nine reporting periods. When we resumed work in 2023, OCFS informed us that there was one more recent reporting period's data available (October 2022 – March 2023), and we added those records to the analysis.

Quality Assurance manager and a QA reviewer to ask specific questions about the case rating process.

OPEGA reviewed recent OCFS federal annual reports to compare our identified themes to the agency's assessments, goals and strategies. We developed a list of resulting questions, and interviewed OCFS management about their awareness of the deficiencies and what actions they are taking to address them.

### Other Stakeholder Perspectives

OPEGA also interviewed 17 stakeholders outside OCFS to hear their perspectives on the specific themes we identified in the case review analysis. We spoke with a parent attorney and representatives of six groups that work with biological and resource parents. The interview discussions explored recent experiences, potential reasons for OCFS practice deficiencies, and suggestions for improvement.

# *Maine* CHILD WELFARE SERVICES OMBUDSMAN

21ST ANNUAL REPORT • 2023

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I am honored to present the twenty-first annual report of the Maine Child Welfare Ombudsman. Maine Child Welfare Ombudsman, Inc. ("the Ombudsman") is a statutorily created non-profit solely dedicated to fulfilling the duties and responsibilities promulgated in 22 M.R.S.A. § 4087-A. The Ombudsman provides neutral objective assessment of concerns raised by individuals involved in child welfare cases through the Maine Department of Health and Human Services, Office of Child and Family Services ("the Department"). Our work continues this year with the addition of two new staff members, and I am very grateful for the increased support from the Governor and Legislature that has made this possible.

While discussions about child welfare frequently revolve around policy and practice, staffing and funding, parents' rights, and court procedures, I encourage everyone to keep at the forefront of their minds the purpose behind these and other discussions: the protection of Maine's children. Even in a system dedicated to child welfare, children seem to get lost in the shuffle. On the news, we hear stories about children involved in the most tragic child welfare cases, but in the vast majority of cases involving abused and neglected children, the children remain unnamed and their stories untold.

The examples in the following paragraph are all from actual cases involving Maine's children. Each of these children were removed from the harmful situations that they were in by the diligent work of Department caseworkers and supervisors, in collaboration with the courts and staff from the Office of the Attorney General. As these examples illustrate, frontline staff are engaged in protecting children under the most difficult of circumstances. Caseworkers, in particular, deserve our highest levels of support.

Consider the siblings who were screamed at by both parents, their prescription medications sold, and locked into an almost bare room for hours with no food or access to a bathroom; the child whose parents were actively using fentanyl and who witnessed their parent's frightening auditory and visual hallucinations; the children who were sexually abused and exposed to repeated instances of domestic violence; the newborn infant who was not gaining weight due to their parents' active refusal to feed them enough; and the child who was abandoned by their parent who was frequently intoxicated and physically abusive, who blamed the child for their desire to commit suicide.

The cumulative effects that abuse and neglect have on children can be devastating and life-long. We often discuss the trauma that removal of children from a parent's home can cause, but children also deserve to live in a home free from fear, abuse, neglect, and uncertainty. Children deserve caregivers who can give with peace and safety. The role of the child welfare system is to provide this for them. As soon as it is discovered that a child is unsafe, the child welfare system must intervene.

I would like to thank Governor Janet Mills and the Maine Legislature for the ongoing support to our program, and their continued dedication to improving child welfare and protecting the children of Maine.

Christine E. Alberi

Child Welfare Ombudsman

# WHAT IS *the Maine Child Welfare Services Ombudsman?*

The Maine Child Welfare Services Ombudsman Program is contracted directly with the Governor's Office and is overseen by the Department of Administrative and Financial Services.

The Ombudsman is authorized by 22 M.R.S.A. §4087-A to provide information and referrals to individuals requesting assistance and to set priorities for opening cases for review when an individual calls with a complaint regarding child welfare services in the Maine Department of Health and Human Services.

**MERRIAM-WEBSTER ONLINE defines an *Ombudsman* as:**

1: a government official (as in Sweden or New Zealand) appointed to receive and investigate complaints made by individuals against abuses or capricious acts of public officials

2: someone who investigates reported complaints (as from students or consumers), reports findings, and helps to achieve equitable settlements

*The Ombudsman will consider the following factors when determining whether or not to open a case for review:*

1. The degree of harm alleged to the child.
2. If the redress requested is specifically prohibited by court order.
3. The demeanor and credibility of the caller.
4. Whether or not the caller has previously contacted the program administrator, senior management, or the governor's office.
5. Whether the policy or procedure not followed has shown itself previously as a pattern of non-compliance in one district or throughout DHHS.
6. Whether the case is already under administrative appeal.
7. Other options for resolution are available to the complainant.
8. The complexity of the issue at hand.

*An investigation may not be opened when, in the judgment of the Ombudsman:*

1. The primary problem is a custody dispute between parents.
2. The caller is seeking redress for grievances that will not benefit the subject child.
3. There is no specific child involved.
4. The complaint lacks merit.

The office of the Child Welfare Ombudsman exists to help improve child welfare practices both through review of individual cases and by providing information on rights and responsibilities of families, service providers and other participants in the child welfare system.

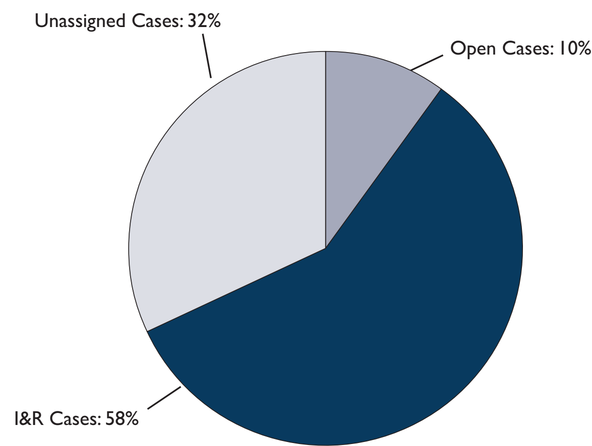
More information about the Ombudsman Program may be found at
http://www.cwombudsman.org

# DATA
## *from the Child Welfare Services Ombudsman*

The data in this section of the annual report are from the Child Welfare Services Ombudsman database for the reporting period of October 1, 2022, through September 30, 2023.

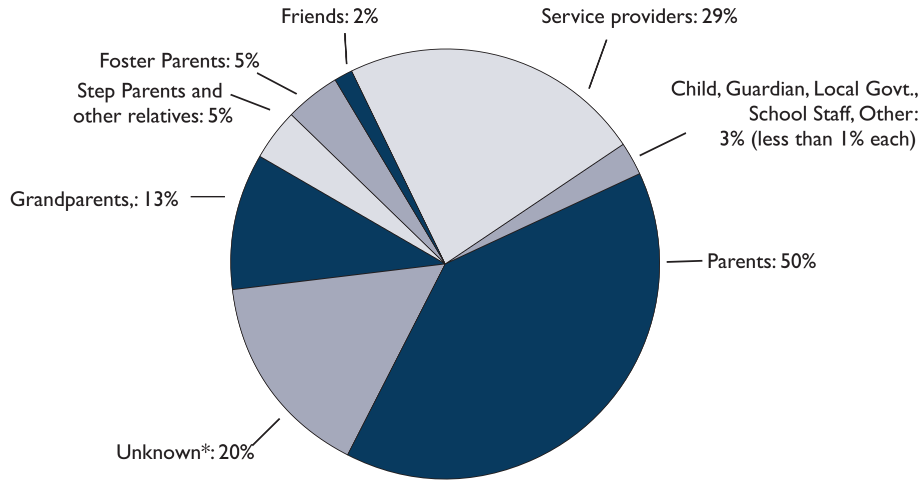
In Fiscal Year 2023, 737 inquiries were made to the Ombudsman Program, a decrease of 64 inquiries from the previous fiscal year. As a result of these inquiries, 77 cases were opened for review (10%), 422 cases were given information or referred for services elsewhere (59%), and 248 cases were unassigned (31%). An unassigned case is the result of an individual who initiated contact with the Ombudsman Program, but who then did not complete the intake process. Our scheduling protocols allow each caller an opportunity to set up a telephone intake appointment.

### HOW DOES THE OMBUDSMAN PROGRAM CATEGORIZE CASES?



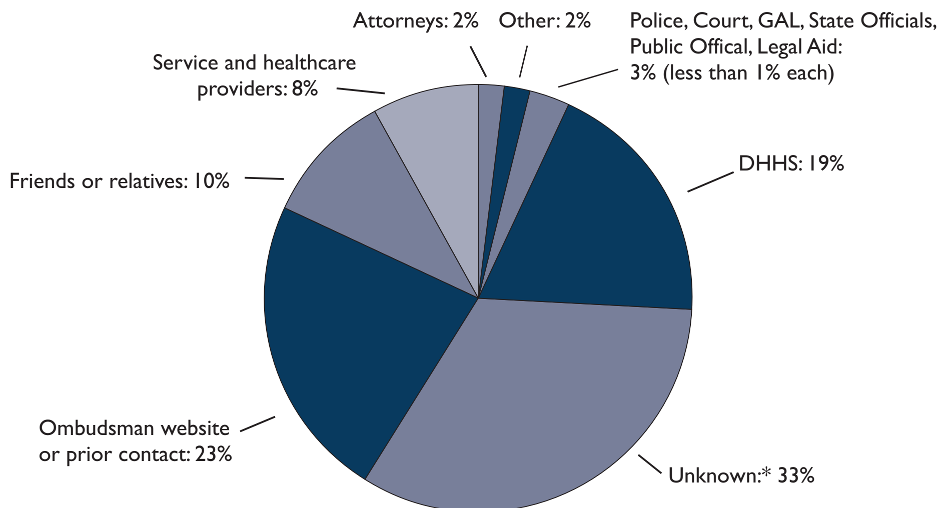
## WHO CONTACTED THE OMBUDSMAN PROGRAM?

In Fiscal Year 2023, the highest number of contacts were from parents, followed by grandparents, other relatives, stepparents, and then foster parents.




## HOW DID INDIVIDUALS LEARN ABOUT THE OMBUDSMAN PROGRAM?

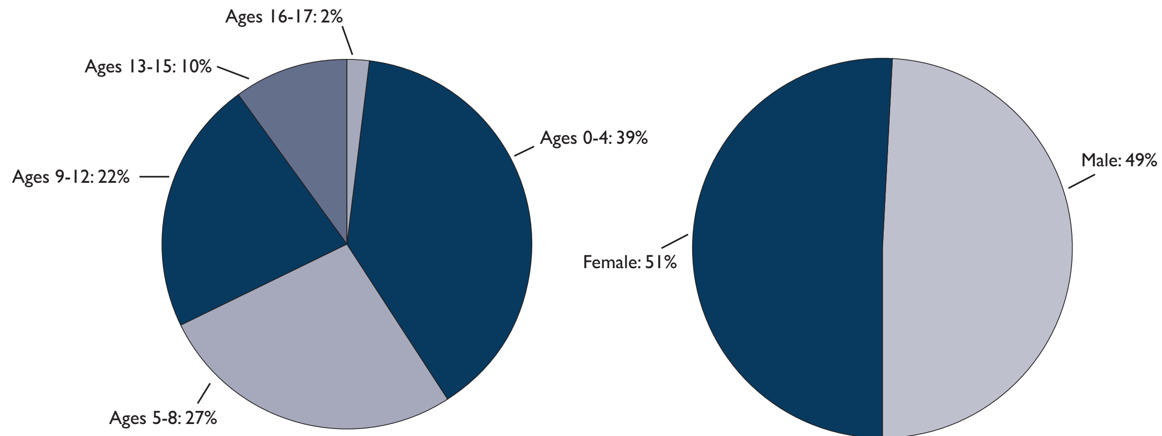
In 2023, 23.9% of contacts learned about the program through the Ombudsman website or prior contact with the office. 19% of contacts learned about the Ombudsman Program through the Department of Health and Human Services.




* *Unknown* represents those individuals who initiated contact with the Ombudsman, but who then did not complete the intake process for receiving services, or who were unsure where they obtained the telephone number.

## WHAT ARE THE AGES & GENDER OF CHILDREN INVOLVED IN OPEN CASES?

The Ombudsman Program collects demographic information on the children involved in cases opened for review. There were 151 children represented in the 77 cases opened for review: 49 percent were male and 51 percent were female. During the reporting period, 66 percent of these children were age 8 and under.



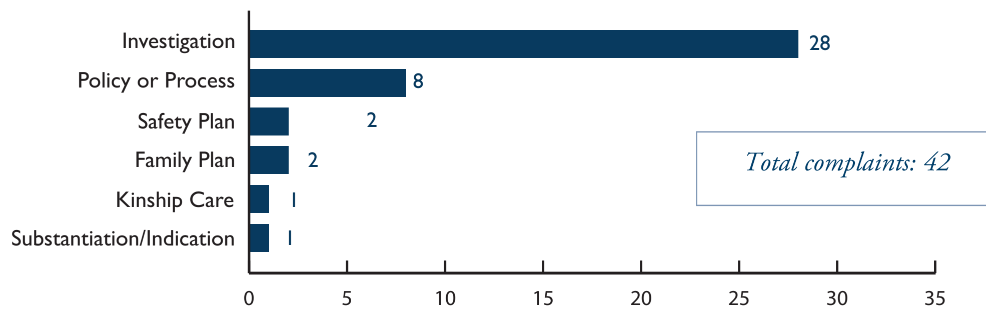

## HOW MANY CASES WERE OPENED IN EACH OF THE DEPARTMENT'S DISTRICTS?

| | | | DISTRICT | CHILDREN | |
|---|---|---|---|---|---|
| DISTRICT # | OFFICE | CASES | % OF TOTAL | NUMBER | % OF TOTAL |
| 0 | Intake | 1 | 1% | 1 | 1% |
| 1 | Biddeford | 7 | 9% | 16 | 11% |
| 2 | Portland | 11 | 14% | 21 | 14% |
| 3 | Lewiston | 11 | 14% | 20 | 13% |
| 4 | Rockland | 9 | 9% | 16 | 11% |
| 5 | Augusta | 22 | 29% | 38 | 25% |
| 6 | Bangor | 10 | 13% | 21 | 14% |
| 7 | Ellsworth | 5 | 7% | 12 | 8% |
| 8 | Houlton | 3 | 4% | 6 | 4% |
| **TOTAL** | | **77** | **100%** | **162** | **100%** |

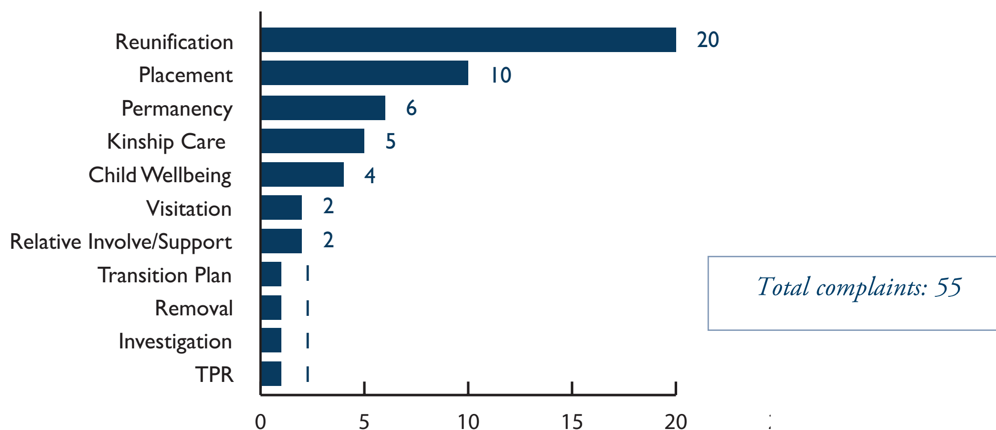
## WHAT ARE THE MOST FREQUENTLY IDENTIFIED COMPLAINTS?

During the reporting period, 77 cases were opened with a total of 98 complaints. Each case typically involved more than one complaint. There were 42 complaints regarding Child Protective Services Units or Intakes, 55 complaints regarding Children's Services Units, most during the reunification phase.

*Area of Complaint:* **CHILD PROTECTIVE SERVICES (INITIAL INVESTIGATIONS)**




*Area of Complaint:* **CHILDREN'S SERVICES UNITS (REUNIFICATION)**



## HOW MANY CASES WERE CLOSED & HOW WERE THEY RESOLVED?

During the reporting period, the Ombudsman Program closed 82 cases that had been opened for review. These cases included 108 complaints and those are summarized in the table below.

VALID/RESOLVED complaints are those complaints that the Ombudsman has determined have merit, and changes have been or are being made by the Department in the best interests of the child or children involved.

VALID/NOT RESOLVED complaints are those complaints that the Ombudsman has determined have merit, but they have not been resolved for the following reasons:

1. ACTION CANNOT BE UNDONE: The issue could not be resolved because it involved an event that had already occurred.

2. DEPARTMENT DISAGREES WITH OMBUDSMAN: The Department disagreed with the Ombudsman's recommendations and would not make changes.

3. CHANGE NOT IN THE CHILD'S BEST INTEREST: Making a change to correct a policy or practice violation is not in the child's best interest.

4. LACK OF RESOURCES: The Department agreed with the Ombudsman's recommendations but could not make a change because no resource was available.

NOT VALID complaints are those that the Ombudsman has reviewed and has determined that the Department was or is following policies and procedures in the best interests of the child or children.

| RESOLUTION | CHILD PROTECTIVE SERVICES UNITS | CHILDREN'S SERVICES UNITS | TOTAL |
|---|---|---|---|
| Valid/Resolved | 1 | 0 | 1 |
| Valid/Not Resolved* | 22 | 21 | 44 |
| 1. Action cannot be undone | 23 | 21 | |
| 2. Dept. disagrees with Ombudsman | 0 | 0 | |
| Not Valid | 34 | 29 | 63 |
| **TOTAL** | **58** | **50** | **108** |

* Total of numbers 1, 2

During the surveys of the 82 closed cases, the Ombudsman identified 6 additional complaint areas that were not identified by the original complainant. The complaints were found to be valid in the following categories: 14 investigation, 1 trial placement, 8 reunification, 4 safety planning, 4 Policy or Process (findings policy, documentation, consultation with expert medical opinion), and 1 Intake Screening.

# POLICY AND PRACTICE
## *Findings and Recommendations*

The findings and recommendations in this section are compiled from surveys of the findings made in the course of case-specific Ombudsman reviews. The Ombudsman and the Office of Child and Family Services, Department of Health and Human Services ("the Department") have an agreed upon collaborative process to finalize case-specific reviews.

Protecting children from child abuse and neglect is extremely difficult work with limited windows of opportunity to intervene. Ideally, enough services and resources would be available to families so that children are never unsafe. Unfortunately, we must continually face the reality that there are children that are or will be unsafe in their parents' care and the state is responsible for protecting those children. When we have those opportunities to intervene to protect children it is crucial that we act based on the facts available. This report is not meant as a call to take more children into state custody or reunify fewer children with parents, but to improve child welfare practice so that in each case and for each child the correct decisions can be made.

Out of the 82 cases surveyed this year, 49 had substantial issues. Cases with substantial issues are defined as cases where there was a deviation from best practices, adherence to policy, or both that had a material effect on the safety and best interests of the children, or rights of the parents. Out of these 49 cases, 27 primarily involved investigations and 18 primarily involved reunification. The remaining 4 cases had varying issues.

- Unfortunately, this year's review of case-specific reports continues to show a decline in child welfare practice. As has been true in previous annual reports, this year shows continued struggles with decision-making around child safety. Primarily, the Department has had difficulty in two areas: 1) during initial investigations into child safety and decision-making around whether a child is safe during an investigation, and 2) during reunification when making safety decisions about whether to send a child home.

Much of the public focus in child welfare has been on child deaths that continue to be reported in the news. These children who have died deserve our full attention and respect. It is equally important to remember that there are many children who are harmed repeatedly in the care of their parents, but never appear in the news. Children are living in difficult and traumatic circumstances all over the state every day. We have the responsibility, as a state, to protect those children. While there are many interlocking pieces to our child welfare system, including the courts, providers, relatives, and governmental entities--the Office of Child and Family Services has been tasked with protecting children who are experiencing abuse and neglect. They are the first responders to calls about unsafe children, and the first line of defense for those children.

The Ombudsman recommends that:

- The Department must continue to fully support the use of safety science in order to effect positive systemic change. Maine has contracted with Collaborative Safety LLC and begun to use Safety Science to review critical incidents, to improve practice, and determine the systemic and root causes of oversights and erroneous practice decisions. The results of the first year of these types of critical incident reviews have been released by the Department in the Maine Safety Science Model 2022 Report. The Department must take the findings in this, and in future safety science reports, and implement changes based on the outcomes of the safety science reviews. The Department must focus on child welfare practice issues within their own districts that are within their control, such as the need for increased staff training, time pressures affecting decision-making, and difficulties with safety planning.

- Continued support and funding for an increase in the availability of services is necessary for the well-being of children and families, prevention of child maltreatment, and for the success of reunification of children with parents. Essentially every case specific review completed this year by the Ombudsman detailed a case and a family that were negatively affected by a lack of services for both children and adults. Mental health services, substance use treatment services, trauma informed services, domestic violence services, housing, and transportation, are all examples of services that that are necessary for the safety and well-being of children.
- The Department should explore all possible methods, including statute changes, to provide increased transparency to the legislature and to the public about struggles within and progress towards addressing the complex problems that arise within the child welfare system.
- The Department must consider the opinions of outside stakeholders, in both assessing and naming the primary issues in child welfare, but also in providing solutions for those issues. And finally, it is crucial that frontline staff's experiences and opinions are given the utmost consideration and their recommendations are implemented when possible.

Note: there are two case-specific reviews that were considered for this report that have pending criminal charges due a death and a serious injury and therefore are not included in the below case summaries.

**A. Reunification**

A child abuse or neglect investigation is opened after an individual makes a report to the child protective hotline and that report meets the threshold necessary to assign it to a district office for investigation. Investigation policy requires that children be observed and interviewed, parents and caregivers that reside both in and out of homes are assessed and interviewed, home environments are observed, relevant collateral contacts are spoken to, additional information relevant to child safety is followed up on, and that all areas of child abuse and neglect are explored over the course of an investigation. In other words, child protective investigators must collect enough information to determine whether children are safe in their homes.

If the children are deemed unsafe during investigation, multiple avenues are available to protect those children. Ideally, the unsafe circumstance can be remediated through service arrangement to address an issue within the home, by an unsafe individual leaving the home, or by the child and safe parent leaving the home. The child can also move to the home of another safe parent or caregiver by agreement of the parents. These would be considered safety plans and are entered into voluntarily by the parents.

If safety planning or other action will not keep a child safe, a court petition can be filed. A jeopardy petition allows children to stay in parents' legal custody while waiting for a court date, and a petition for preliminary protection order can remove children from a parent's custody immediately.

In order to make safety decisions correctly during an investigation, 1) enough facts and evidence must be collected, and 2) the facts and evidence need to be interpreted correctly. This year a survey of case-specific ombudsman reviews found challenges in both areas. In some instances, not enough information was gathered to make an informed decision about safety, and in others, enough information was gathered but the appropriate action was not taken to protect the child.

Some examples of divergence from investigation policy were: an adult caregiver's significant child protective history was not considered; adult caregivers were not background checked and assessed for safety; parents and children residing out of the home were not interviewed or located; multiple family members were interviewed together; parents were interviewed together about domestic violence; collaterals were not contacted; multiple investigations were completed without addressing deficiencies in previous investigations; child abuse

pediatricians were not consulted about bruising and other injuries; and in one case an infant was not seen or located during an investigation of older children in the home.

Perhaps more concerning were investigations that gathered enough information to determine that children were unsafe but no safety planning or court action was taken to protect the children. These were not close cases, but instances where children were experiencing significant abuse and/or neglect. In many cases a court petition was filed eventually, but only after the children remained unsafe in the home for an unnecessary duration and were subjected to additional instances of abuse and/or neglect. See below under the case summaries for more detailed examples.

Safety plans continued to be of serious concern in this year's reviews. Safety plans were implemented and then not monitored, safety plans were not designed in a way that would ensure child safety, and multiple safety plans were made after previous plans failed.

### B. Reunification

Once a child enters state custody, the parents are provided with a reunification plan that details services and behavioral change needed to ensure that the children can be safely returned to the parents. In order to make the determination that children are safe to return to one or both parents, the Department must both provide the parents with good faith reunification services, but also perform ongoing assessment of the parent's progress in their services towards alleviating jeopardy.

For example, if a parent has a substance use issue that is causing the child to be unsafe, the parent might enroll in substance use counseling and medication assisted treatment. The Department would have an obligation to assess how the parent is progressing in treatment by talking to providers, obtaining treatment records, visiting the parent in the home and talking to the parent about their treatment engagement, providing support and encouragement to the parent, sending the parent for random substance screens, completing medication counts, and interviewing other collaterals such as family members. In assessing progress in substance use treatment, history of prior treatment and length and type of use, and the amount of time the parent has been sober are all relevant to determining the safety of the child going forward. This is one example of one issue that has contributed to unsafe circumstances for a child, but this example also makes clear that the evaluation of a parent's progress is complex and time-consuming work.

Decision-making around reunification of children with parents, including trial placements,  continues to be a challenge for the Department. This includes effective monitoring of trial placements for child safety. Trial placements are a moment of higher risk for children, and policy requires that assessment of safety increase during this period.

Reunification issues this year have included delays in filing petitions to terminate parents' rights; lack of monitoring for trial home placements especially when children were placed out of state; lack of contact with providers; inconsistent random drug screening; court petitions dismissed by the Department before issues causing children to be unsafe are resolved; regular monthly contacts not held with parents; and service cases opened for lengthy periods without court petitions filed.

### C. Case Summaries

#### 1. Investigation

1. A parent drove while intoxicated with the child and was arrested for multiple charges including assault on an officer. The parent had past charges of operating under the influence (OUI), disorderly conduct, and both parents had domestic violence charges. A safety plan was implemented but was terminated a month later and the child was allowed back in the parents' care unsupervised with no apparent improvement in circumstances. A parent continued to care for the child while impaired on drugs and alcohol and the other parent relapsed on drugs. A jeopardy petition was filed months later and a new safety plan was implemented, but the child remained in parental custody. The parent was arrested multiple times during the case. The child was unsafe in the care of the parents for over eight months.

2. A steady string of child protective reports were made for the nine months prior to the children entering custody. The facts found early in the first investigation warranted an emergency petition and subsequently there was enough information to warrant either a jeopardy petition or service case. Later investigations did not follow up on missed opportunities in previous investigations.

3. The children were taken on a high-speed police chase where drugs were found in a the car, the children were often tardy or absent from school and sometimes it was hours until the parent could be located. A child briefly entered custody due to serious medical neglect, the children met the legal threshold for truancy but no findings were made or jeopardy petition filed, the parent was summonsed for possession of methamphetamine and firearms during a traffic stop, and a bus driver found the parent passed out in a vehicle in the driveway. The children entered state custody when the children and parent were staying with the parent's significant other and during a bail check police discovered drug paraphernalia.

4. A parent took three years to reunify with a young child due to severe substance use issues. Once the child was returned and the case closed, the parent relapsed. Two investigations were opened with new reports, one with a service case and one without. The most recent investigation involved the parent admitting to relapse and the child's exposure to a domestic violence incident that involved strangulation. The parent was substantiated for threat of physical abuse and neglect, but months passed without any further work on the case or intervention such as a court filing.

5. A parent with severe mental health issues continued to care for the children for five months after the first appropriate chance to ask the court for a preliminary protection order passed. The children eventually entered state custody.

6. The parent drove while severely intoxicated with the child in the car. A very young child in the parents' care was unsafe while the parent was highly impaired. In three months, five reports were received about the parent's alcohol misuse. Four investigations and one service case were opened. Three weeks passed after the parent's OUI before a safety plan was implemented that the parent would not drive or be alone with the children. The first safety plan was violated so a second safety plan was implemented. A service case was opened but the parents refused to follow a third safety plan. A jeopardy petition was filed. During the three months of safety planning only one call to a collateral was made. The jeopardy petition was dismissed by the Department without a sufficient period of monitoring and no services for the other parent. A new report was made several months later with allegations that the parent was again drinking and caring for the children.

7. A child was not protected after the child was sexually abused and the child's primary caregiver did not believe the abuse happened.

8. A parent with a long history of substance use and mental health issues, and who had been a perpetrator of domestic violence, got into a car accident with the young child where the young child was seriously injured. The parent was impaired on substances and the child was not restrained in the car seat. Although findings were made after the investigation was closed the other parent allowed joint custody and unsupervised time with the unsafe parent to continue. Multiple investigations were opened after this. The unsafe parent was showing erratic and assaultive behavior and was abusing substances. Providers reported the parent tested positive for fentanyl. The other parent had been unable to protect the child through court action and the Department would not file in court.

9. No findings were made after children disclosed that their caregiver hit them with a metal coat hanger, "bashed" a child's head against the wall, and smacked a child around, all of which caused the children to be fearful and upset. The children involved had already experienced significant trauma in their lives with other caregivers.

10. An investigation was completed where all family members were interviewed together, the home was visited and family interviewed for less than an hour, the allegations in the report were only addressed for ten minutes, and one brief collateral call was made to the other family member who was not home.

**2. Reunification**

1. A mother tested positive for cocaine and fentanyl during pregnancy and had a previous termination of parental rights for an older child, as well as multiple serious mental health diagnoses that were untreated at the time of the birth. The child entered state custody but the mother did not engage in reunification services until a year after the child's birth. The mother became pregnant again and finally began intensive services. One month later the mother tested positive for fentanyl. The new baby was born and a request for a preliminary protection order was filed but then vacated by the Department after either one or two months of sobriety. The infant had tested positive for unprescribed drugs at birth. The newborn infant remained in the mother's custody for many months before the mother again tested positive for fentanyl and the baby entered state custody.

2. One five-year-old child has had the Department involved for all but 16 non-consecutive months of the child's life. The child has been in state custody twice. The parent has extensive history including not being able to reunify with older children. The parent has followed the same pattern of behavior throughout and despite this, trial placement started only six months into the current involvement. The most recent incident that precipitated the child re-entering custody was a frightening incident of domestic violence, where the child and parent had to be rescued by police. Both parents had been using heroin and cocaine.

3. Two years and ten months after children entered state custody petitions to terminate the parents' rights have not been filed. The Department stated that a petition to terminate the rights would be filed at the two-year mark but this did not occur. The parents have a significant child protective history including their rights terminated to two older children.

4. The child entered state custody after being exposed to domestic violence in the parent's care, including an assault on the child's other parent and on the child's caregiver during a safety plan. The court ordered the parent to participate in several services, but the parent only completed some and did not engage in individual counseling or a mental health evaluation as required. Other providers were not contacted. There were also concerns about the parents' continued relationship and reports that the parent had not changed despite participation in services. The other parents' providers had not been contacted in over a year. Eighteen months into the case, a trial placement began.

5. After children entered state custody regular monthly contacts with parents did not occur for eight months. Regular contact with the parents' services providers did not occur. Despite continuing reports of domestic violence, trial placement began. Visits to the home during trial placement did not occur as outlined in policy.

6. The family had a history of 18 years of child protective involvement, including 42 reports made to Intake and 12 investigations. The Department had not intervened during any period until the children's recent entry into state custody. As a result of this the children have significant needs including mental health issues, behavioral issues, and engagement in the juvenile justice system. The investigation before the current case closed without intervention or services despite the risk level having been assessed as high and the parent arrested for disorderly conduct in front of the children. Police reported serious concerns for neglect, physical abuse, and emotional maltreatment. These issues are ongoing and services and resources in the state are not sufficient to help the children.

7. A child with highly challenging behaviors returned home on trial placement before the parent had alleviated jeopardy and without adequate services in place. The parent did not have a safe and stable place to live. The parent also did not attend substance use counseling or mental health treatment consistently, not attending random drug screens, and had not completed a psychological evaluation. This continued during the trial placement. The parent refused to take the child to counseling and the child frequently missed specialized programming. Concerns about the child being brought around the other unsafe parent were not assessed.

8. After the court denied termination of the parents' rights despite ongoing safety concerns, children were reunified. Less than six months later the children witnessed a serious incident of domestic violence. There were also concerns for neglect and the condition of the home. A safety plan was implemented and an unsafe person was assigned to monitor the plan. Then a partial out of home safety plan was created. Safety plans and a service case continued for approximately a year with multiple reports and ongoing issues including bruising on the children. A jeopardy petition was filed ten months after it was clear that further intervention was needed. The three oldest children entered custody, while the youngest and most vulnerable remained in the care of the parent.

9. A child was in state custody for four years and the courts, the Guardian ad litem, and the Department have made a series of decisions over the four years that delayed permanency too long for the child, resulting in an outcome that was not in the child's best interests. These decisions left the child at serious risk of emotional harm.

10. A petition to terminate the parents' rights was denied by the court due to lack of communication with the parents' providers. The child has been in state custody for four years. Psychological evaluations were completed for both parents and these findings, as well as the jeopardy findings, were not shared with the parents' counselors or other mental health providers. The counseling services provided did not appear to focus on one of the important aspects of reunification.

**3. Positive Findings**

The following represents positive findings taken from case specific reviews representing each district in the state:

1. When the parents were in jail the caseworkers made many efforts to keep both parents engaged. The caseworker understood the parent's previous history of substance use and previous attempts at treatment and slowed down the case to accommodate this. The caseworker toured the parent's sober living facility and met the other residents prior to allowing overnight visits. The caseworker transported the children

to the first overnight visit. Regular family team meetings were held throughout the case and were well attended by providers. The children were successfully reunified with the parent.

2. The caseworker was able to clearly articulate and document how the parent's cognitive limitations negatively impacted the parent's ability to care for the child. A neuropsychological evaluation with a parenting component was requested to better inform decision-making. A petition to terminate the parents' rights was filed in accordance with the statute.

3. In multiple investigations victims of domestic violence were referred to domestic violence programs and/or referred to the district's domestic violence liaison, caseworkers met with victims of domestic violence separately from perpetrators, and appropriate findings were made regarding an unsafe parent exhibiting a pattern of domestically violent behaviors towards partners.

4. Child protective caseworkers worked closely with law enforcement, Spurwink, and the Child Advocacy Center to investigate allegations of sexual abuse. The caseworker's interviews with the mother and alleged perpetrator were thorough and all of the allegations were carefully considered. Multiple collateral contacts were made during both investigations, which were generally thorough.

5. The caseworker performed a thorough investigation both before and after the children entered custody. The caseworker supported visits for the children and their fathers and was careful to assess how the children felt about visiting with (and ultimately living with) an out-of-state father. Good faith reunification services were offered to the out-of-state father and the appropriateness of the placement was carefully assessed.

6. The initial investigation and safety planning was thorough and all plans were monitored effectively, both by checking in at the homes frequently and contacting plan monitors. Plans were modified due to changing facts and circumstances. Caseworkers visited children and homes frequently and checked in with children and their providers, grandparents, and foster parents as appropriate. Caseworkers investigated new information and allegations. The caseworker's ongoing assessment of how the parent was doing in reunification and articulation of how the mother could alleviate jeopardy were very thorough.

7. The caseworker made an unannounced visit to the home and then called police for assistance when there was an adult in distress. A preliminary protection order was denied and the caseworker continued to investigate. Further information was gathered, and another preliminary protection order was granted. A close relative was encouraged to make repairs to the home to become a kinship foster placement and was encouraged to keep in contact with the child. The new caseworker had the Guardian ad litem attend the first visit with the child to ease the transition.

8. The caseworker held several family team meetings in the most recent involvement and made sure that all of the providers were sharing information. The caseworker also made sure that providers had the most accurate history of the case. The caseworker held detailed conversations with the child and despite significant needs the child understood the caseworker well.

### D. Katahdin

On January 18, 2022, the new child welfare database, Katahdin, went live. This was a long-planned move due to the age of the previous database, the Maine Automated Child Welfare Information System (MACWIS).

Any child welfare database serves different purposes for different individuals. Caseworkers must be able to easily enter and upload the correct data and documents, be able to see the history of cases and families and provide discovery to the attorneys if there is a court case. Supervisors, program administrators, and

central office staff must be able to use a database to supervise cases and perform reviews of cases and critical incidents. Quality Assurance staff use the database to collect federal reporting data and perform case reviews that inform practice improvements in individual cases, as well as systemic reviews. Other central office staff use the database to present to the safety science selection team and the Serious Injury and Death Review Panel.

Katahdin has been in use for over a year. In any transition to such a complex database, there will be setbacks and training issues, and cultural adjustment to the change. However, Katahdin's issues go deeper this. Katahdin is negatively affecting the ability of child welfare staff to effectively do their work, and therefore keep children safe.

The Department has been working to address multiple issues within Katahdin, and has already implemented many fixes, but Katahdin continues to be a complex problem without an easy solution.

# ACKNOWLEDGMENTS

As the twenty-first year of the Maine Child Welfare Ombudsman Program comes to a close, we would like to acknowledge and thank the many people who have continued to assure the success of the mission of the Child Welfare Ombudsman: to support better outcomes for children and families served by the child welfare system. Unfortunately, space does not allow the listing of all of these dedicated individuals and their contributions.

> *The staff of public and private agencies that provide services to children and families involved in the child welfare system, for their efforts to implement new ideas and provide care and compassion to families at the frontline, where it matters most.*
>
> *Senior management and staff in the Office of Child and Family Services, led by Director Dr. Todd Landry,* for their ongoing efforts to make the support of families as the center of child welfare practice, to keep children safe, and to support social workers who work directly with families.
>
> *The Program Administrators of the District Offices, as well as the supervisors and social workers, for their openness and willingness to collaborate with the Ombudsman to improve child welfare practice.*
>
> *The Board of Directors of the Maine Child Welfare Services Ombudsman, Katherine Knox, Pamela Morin, Donna Pelletier, Courtney Beer, Craig Hickman, and Anne Sedlack.*

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BRIEF

# INFORMATION BRIEF

## Oversight of Maine's Child Protective Services

January 2022

January
2022

Prepared for the
Government Oversight Committee
By the
Office of Program Evaluation & Government Accountability

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# Structure of this Report

This Information Brief reports on the first of three components that will comprise OPEGA's review of child protective services (CPS) in Maine. This Brief presents facts and background information to describe state and federal oversight of child protective services. It begins with an overview of the scope of work, the five topics examined, and the entities that make up the CPS oversight landscape. It then presents key lessons and observations from the research. Following the introduction, the Brief includes four major sections that address: federal regulatory oversight; state advisory oversight; best practices in child protective services oversight; and other state approaches. Finally, four appendices to the brief present: the research methods used; tables of detailed information referenced in the main report; and a summary of recent reports, recommendations from the advisory oversight entities, and a listing of related bills before the second regular session of the 130th Legislature.

# I. Introduction

In July 2021, following the deaths of four Maine children ages four years or younger in the months of May and June, the Government Oversight Committee (GOC) directed the Office of Program Evaluation and Government Accountability (OPEGA) to initiate an immediate review of Child Protective Services (CPS) administered by the Department of Health and Human Services (DHHS), Office of Child and Family Services (OCFS). This immediate review was initiated in response to heightened concerns about the safety of Maine children in their homes following the four deaths and formal requests made by Senator Diamond and Senator Curry in early July for an OPEGA review of CPS and OCFS.

The GOC approved the scope of work for the CPS review in August 2021. The Committee divided this comprehensive review project into three components with staggered reporting dates, as follows:

- Oversight of Child Protective Services, with an Information Brief in January 2022;
- Protecting Child Safety – Initial Investigation and Assessment, with an evaluation report in March 2022; and
- Protecting Child Safety – Reunification and Permanency, with an evaluation report in September 2022

With this document, OPEGA delivers the Information Brief on oversight of child protective services.

## A. Scope of Work

The GOC directed OPEGA to narrow the scope of this component of the CPS review to produce an Information Brief rather than a full evaluation. In an Information Brief, OPEGA researches, synthesizes and presents relevant facts, background, and contextual information to the Legislature to build knowledge and understanding of a topic. This is distinctly different from, and more limited than, a full evaluation, in which OPEGA evaluates the performance and outcomes of an agency or

program through extensive data collection and analysis to deliver findings, conclusions and recommendations to the Legislature.

In limiting this first component of the CPS review to an Information Brief, the GOC ensured the Legislature would receive some information to work with early in the Second Regular Session of the 130th Legislature, while the full evaluation components of the CPS review are underway. In preparing this Information Brief, the GOC directed OPEGA to consider the following five topics:

1. ***Current oversight structure*** of DHHS/OCFS and child protective services broadly;
2. ***Roles and responsibilities*** of the entities involved in child protective services oversight, including Child Welfare Ombudsman and oversight panels required by law;
3. ***Information sharing*** between entities, including barriers or gaps;
4. ***Best practices and models*** of oversight of child protective services; and
5. ***Effectiveness*** of the structure of child protective services oversight.

Given the breadth and complexity of the overall child welfare system and oversight of that system, the GOC provided some direction to OPEGA on framing "oversight of child protective services" within the context of this assignment. Based on the GOC's guidance supplemented by initial research by OPEGA, the focused scope of this work addresses:

- **Child protective services** administered and delivered by the DHHS/OCFS;
- **Oversight** in the form of review and monitoring of these child protective services by state-level entities, in an advisory role, and by the federal government, in a regulatory role.[1]

OPEGA's research for this Information Brief was conducted between August and December 2021 and included in-depth interviews with state and federal agencies and review of documentation including relevant laws, regulations and other materials.[2]

## B. Oversight Landscape

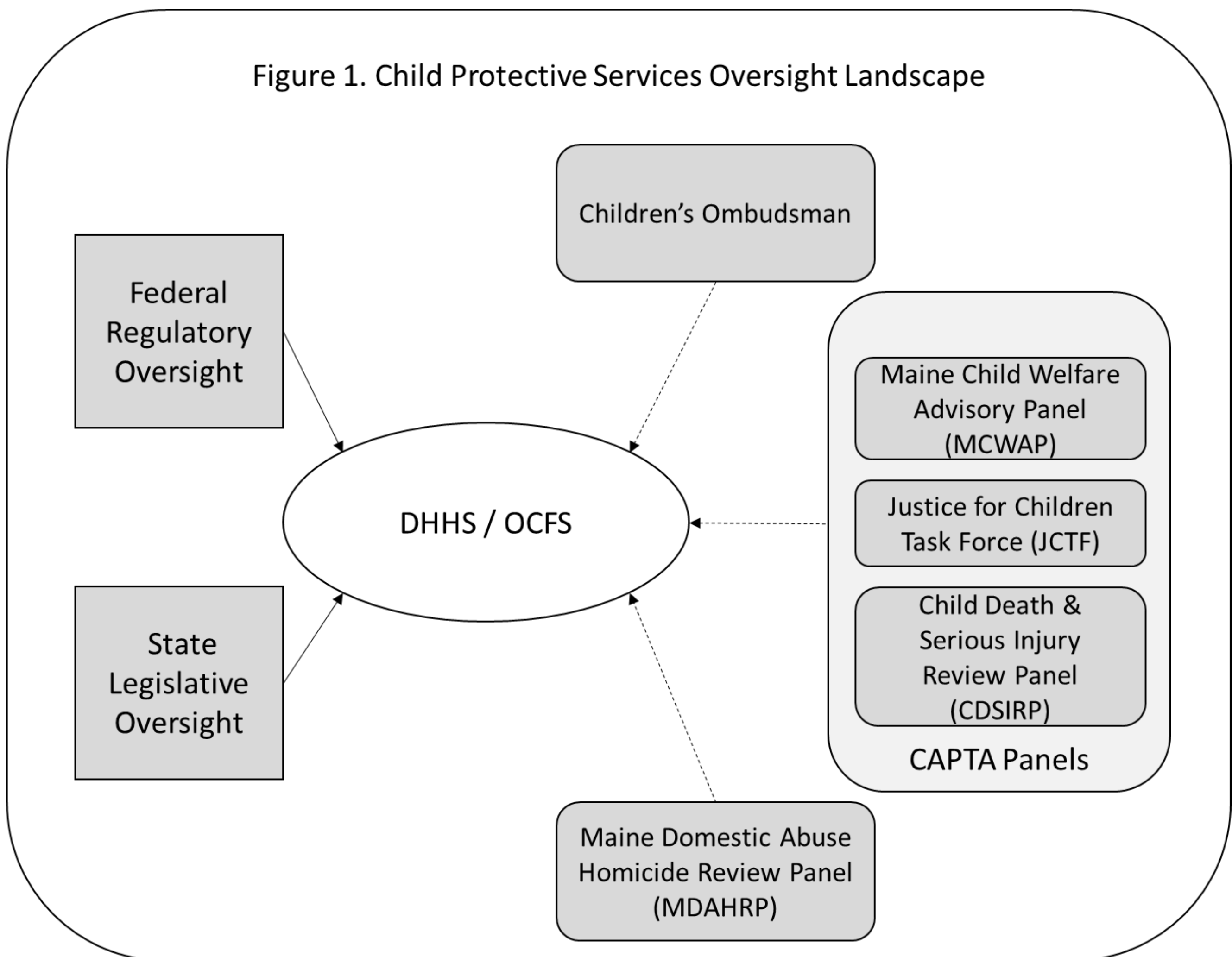
In this Information Brief, OPEGA addresses a defined set of state and federal elements within the overall landscape of child protective services oversight. Specifically, we address oversight of the child protective services delivered by Maine DHHS/OCFS as follows:

- **Federal regulatory oversight** provided by the U.S. DHHS Administration for Children and Families, which has regulatory authority over Maine DHHS/OCFS; and
- **State advisory oversight** provided by five entities that each have roles in reviewing and monitoring DHHS/OCFS from varying perspectives but do not have regulatory authority.
    - Children's Ombudsman; and
    - Four volunteer panels:
        - Maine Child Welfare Advisory Panel;
        - Justice for Children Task Force;

[1] While not addressed in this targeted scope, other forms of oversight include: joint standing committees of the Legislature, the additional DHHS/OCFS internal quality assurance unit activities, and a number of provider associations, such as the Maine Child Welfare Advocacy Network and the group Adoptive and Foster Families of Maine that provide advisory input to DHHS/OCFS.
[2] Additional information on methods is provided in Appendix A.

- Child Death and Serious Injury Review Panel; and
- Maine Domestic Abuse Homicide Review Panel.

Three of the four state advisory oversight panels have been designated as the citizen review panels that allow Maine to comply with the federal government's Child Abuse Prevention and Treatment Act (CAPTA). The oversight landscape is illustrated in Figure 1. In addition to the specific state and federal elements of child protective services oversight that are addressed in this Information Brief, this figure also notes the oversight role of the State Legislature which is carried out through lawmaking, including the state budget, and oversight by legislative committees. At the time of this report, there are eight bills before the 2nd Regular Session of the 130th Maine Legislature relating to oversight of Child Protective Services and related matters. A list of these bills is provided in Appendix D for reference.



## C. Lessons and Observations

1. ***Current structure of oversight*** of DHHS/OCFS and child protective services broadly:
   - Child protective services as administered by DHHS/OCFS are subject to in-depth regulatory oversight by the federal government as well as advisory oversight from a network of state-level entities.
   - Federal oversight is comprehensive and outcomes-oriented with financial penalties for nonconformity.
   - State-level advisory oversight engages all three branches of government and both public and private sector stakeholders.

2. ***Roles and responsibilities*** of the entities involved in child protective services oversight:
   - The roles and responsibilities of the different entities address both macro-level oversight of the system and micro-level review and oversight of specific CPS cases, including cases of death and serious injury.
   - The four state-level panels and the Ombudsman have distinct missions, but there is a degree of overlap as well as nuanced differences in the scope of their activities.

3. ***Information sharing*** between entities, including barriers or gaps:
   - Information is routinely and regularly shared among the state-oversight entities and DHHS/OCFS. This routine information sharing among the panels is often the result of individual panel members and DHHS/OCFS staff being members of more than one oversight entity.
   - Work is currently being done by several of the state oversight entities to formalize and institutionalize information sharing practices to ensure continuity in information sharing over time.

4. ***Best practices and models*** of oversight of child protective services:
   - The state-oversight entities, including the four panels and the Ombudsman, are structured in a manner, and are practicing in a manner, that generally conform to published best practices for entities overseeing child protective services.
   - Several of the entities have recently made or are in the process of implementing changes to improve alignment with published best practices.

5. ***Effectiveness*** of the structure of child protective services oversight. Without the benefit of a full evaluation, we cannot draw evaluative conclusions about effectiveness. However, based on the limited research for the Information Brief, we can say:
   - The oversight structure includes many opportunities for DHHS/OCFS to obtain multiple points of view and draw on the expertise of several professional disciplines engaged in child protection across the private sector and multiple levels and branches of government.

The oversight structure at the state-level is not significantly different than many other states. It is structured as a collaborative network of entities that provide advice and recommendations to DHHS/OCFS.

# II. Federal Regulatory Oversight

U.S. Department of Health and Human Services (U.S. DHHS) conducts regular and ongoing oversight of state child welfare agencies, including OCFS, to ensure conformity with federal requirements and promote continuous improvement in child welfare. This oversight role is authorized by Federal law and regulations and administered by the Children's Bureau, within the U.S. DHHS' Administration for Children & Families (ACF). Key elements of the oversight conducted by the Children's Bureau include:

- Child and Family Services Review (CFSR) and associated Program Improvement Plan (PIP) and financial penalties
- Child and Family Services Plan (CSFP) and associated Annual Progress and Services Report (APSR)

## A. Review of Services and Program Improvement

The Child and Family Services Review (CFSR) is central to federal oversight of state child welfare. The CFSR is used by the Children's Bureau: to ensure conformity with federal child welfare requirements; to determine what is happening to children and families as they are engaged in child welfare services; and to assist states in enhancing their capacity to help children and families achieve positive outcomes. The Children's Bureau conducts CFSRs with states on a rotating schedule (referred to as "rounds"). The third round of the CFSR was completed for Maine in 2017.

***What the CFSR Evaluates.*** Through the CFSR, state performance is assessed across two areas: (1) child and family outcomes and (2) underlying systemic factors that influence child and family outcomes. Each of these areas includes specific items that are measured and assessed. The child and family outcomes and systemic factors evaluated in the CFSR are listed below. A full listing, which includes the measured items associated with each of these outcomes and systemic factors, can be found in Tables B.1 & B.2 in Appendix B.

Child and family outcomes evaluated in the CFSR:

- Safety 1: Children are, first and foremost, protected from abuse and neglect.
- Safety 2: Children are safely maintained in their homes whenever possible and appropriate.
- Permanency 1: Children have permanency and stability in their living situations.
- Permanency 2: The continuity of family relationships and connections is preserved for children.
- Well-Being 1: Families have enhanced capacity to provide for their children's needs.
- Well-Being 2: Children receive appropriate services to meet their educational needs.
- Well-Being 3: Children receive adequate services to meet their physical and mental health needs.

Systemic factors assessed in the CFSR:

- Statewide information system
- Case review system
- Quality assurance system
- Staff and provider training
- Service array and resource development
- Agency responsiveness to the community
- Foster and adoptive parent licensing, recruitment and retention

***Components of the CFSR Process.*** The CFSR process incorporates three components – case reviews, stakeholder interviews and a statewide assessment – to complete the review of a state's performance against federal standards.

- **Case Reviews.** OCFS conducts case reviews[3] on a sample of 40 foster care cases and 25 in-home services cases, selected according to a methodology established by the Children's Bureau. Each individual case review includes examination and documentation of information from the case file relevant to specific items and outcomes. For each case, interviews are also conducted with children, parents, foster parents, caseworkers, and other professionals. These case reviews are conducted by experienced OCFS quality assurance staff, in teams of two, using the Children's Bureau CFSR Onsite Review Instrument and Instructions (OSRI). The OSRI contains definitions, instructions, and questions that reviewers must populate using information collected from the review of case file documentation or case-related interviews.
- **Stakeholder Interviews.** Staff from the Children's Bureau conduct interviews with a range of stakeholders in the state, including: child welfare agency senior management, program managers, supervisors and caseworkers; attorneys and judges; parents, foster parents, and children; and tribal representatives.
- **Statewide Assessment.** OCFS conducts the statewide assessment of performance in meeting federal standards. OCFS staff and stakeholders review the state's performance in each of the seven outcome areas and seven systemic factors. This work, along with the case review results, stakeholder interviews, and the state's current data indicators related to safety, permanency and well-being outcomes, form the basis of the statewide assessment.

***CFSR Final Report and Conformity with Standards.*** The Children's Bureau prepares and issues the CFSR Final Report which documents whether the child and family outcomes and systemic factors are in substantial conformity with federal standards and whether specific items are rated as strengths or areas needing improvement. The federal government, through the Children's Bureau, has set high standards for state child welfare agencies based on the understanding that only the highest standards of performance should be acceptable in working with our nation's most vulnerable children and families. These high standards also reflect the Bureau's interest in ensuring states have incentives to dedicate ongoing attention to improving outcomes and performance.

[3] States may conduct their own case reviews for the CFSR provided they meet certain criteria. These include using the Children's Bureau CFSR Onsite Review Instrument and Instructions (OSRI) and agreeing to secondary oversight by the federal government of a percentage of sampled cases to ensure accurate application of the OSRI and quality of case ratings. Maine is one of two New England states currently conducting its own case reviews.

***Program Improvement Plan.*** Any state that has not achieved "substantial conformity" for each of the child and family outcomes and systemic factors must develop and implement a Program Improvement Plan (PIP) to address these areas. Development of a state PIP is standard practice – in fact, no state has achieved substantial conformity with all seven outcome areas and systemic factors in round three of the CFSR. The state PIP must specify the state agency's goals, strategies and key activities designed to improve performance, and the plan must be approved by the Children's Bureau. Upon approval, the state has a two-year PIP implementation period followed by an evaluation period. During these periods, state progress is monitored through case reviews and any progress is measured against specific PIP goals. These goals are negotiated with the Children's Bureau and are based upon the state's actual CFSR results, rather than the CFSR's federal performance standards. These PIP goals are lower, more attainable than the CFSR standards, but still promote improvement.

***Financial Penalties.*** The federal government assesses financial penalties against states for non-conformity identified through the CFSR process. Although penalties are determined based on the CFSR results, the assessment of the financial penalties is suspended throughout the PIP implementation and evaluation periods. During this time, no funds are withheld as long as the State is actively engaging in and adhering to the provisions of the PIP. If a state successfully achieves its PIP goals, the financial penalty is rescinded, meaning that no funds are actually withheld at any point. If the state fails to make required improvements under the PIP, however; the financial penalty is imposed.

### B. Child and Family Services Plan and Annual Progress Reports

The Child and Family Services Plan (CFSP) is a federally required five-year strategic plan that sets forth a state's vision and the goals to be accomplished to strengthen the overall child welfare system. To receive federal funding under Title IV-B of the Social Security Act, states must submit the CFSP and Annual Progress and Services Report (APSR) to the federal government. The state plan and annual progress reports share many goals, action items, and review results as those captured in the CFSR and PIP.

The CFSP outlines the state's initiatives and activities to improve outcomes in the following areas: permanency for children; well-being of children and their families; and the nature, scope, and adequacy of existing child and family and related social services. The APSR provides an annual update on the progress made toward CFSP goals and objectives as well as planned activities for the upcoming fiscal year.

The state submits the CFSP and APSR first to the regional ACF office for initial review to ensure the reports include all information as outlined in the federal program instructions. The regional office provides feedback and questions, and once all requirements have been addressed, the report is submitted to the Children's Bureau for final review and approval.

### C. Maine's Performance in Brief

Maine has completed three rounds of the CFSR process in 2003, 2009, and 2017. In the third round, Maine was found to be in substantial conformity with one of the seven outcomes and four of the

seven systemic factors and was required to develop and implement a PIP to address the remaining areas. Maine's results in the third round CFSR are shown in Table 1 along with the other New England states for context.

| Table 1. New England States' 3rd Round CFSR Performance | | | | | | |
|---|---|---|---|---|---|---|
| | ME | CT | MA | NH | RI | VT |
| **Conformity with Child & Family Outcomes** | | | | | | |
| Safety 1: Children are, first and foremost, protected from abuse and neglect. | **No** | No | No | No | No | No |
| Safety 2: Children are safely maintained in their homes wherever possible and appropriate. | **No** | No | No | No | No | No |
| Permanency 1: Children have permanency and stability in their living situations. | **No** | No | No | No | No | No |
| Permanency 2: The continuity of family relationships and connections is preserved for children. | **No** | No | No | No | No | No |
| Well-being 1: Families have enhanced capacity to provide for their children's needs. | **No** | No | No | No | No | No |
| Well-being 2: Children receive appropriate services to meet their educational needs. | **YES** | No | No | No | No | No |
| Well-being 3: Children receive adequate services to meet their physical and mental health needs. | **No** | No | No | No | No | No |
| **Conformity with Systemic Factors** | | | | | | |
| Statewide information system | **YES** | No | YES | No | YES | YES |
| Case review system | **No** | No | No | No | No | No |
| Quality assurance system | **YES** | YES | No | YES | No | No |
| Staff and provider training | **No** | No | No | No | No | No |
| Service array and resource development | **No** | No | No | No | No | No |
| Agency responsiveness to the community | **YES** | YES | YES | YES | YES | YES |
| Foster and adoptive parent licensing, recruitment, and retention | **YES** | No | No | No | No | No |
| *Source: Child and Family Service Reviews 3rd Round* https://www.cfsrportal.acf.hhs.gov/cfsr-reports | | | | | | |

The Children's Bureau approved Maine's required PIP in February 2020, following a series of delays attributed to three changes in OCFS leadership between 2017 and 2019. The two-year implementation period for this PIP ran from February 2020 through January 31, 2022. Due to the COVID-19 pandemic, OCFS applied for and has recently received an extension from the Children's Bureau to meet the goals of the current PIP. Under the extension, Maine has until January 31, 2024 to meet the PIP goals. OCFS reported to OPEGA that the program improvement plan activities, along with other improvement strategies, will enable the State to meet the goals of the PIP and, in doing so, the penalties will be waived by U.S. DHHS' Administration for Children and Families.

# III. State Advisory Oversight

In this Information Brief, we describe five state entities, including four "panels" that have specific, but distinct, roles in reviewing and monitoring child protective services delivered by DHHS/OCFS. These are the:

- Maine Child Welfare Services Ombudsman;
- Maine Child Welfare Advisory Panel (MCWAP);
- Justice for Children Task Force (JCTF);[4]
- Child Death and Serious Injury Review Panel (CDSIRP); and
- Maine Domestic Abuse Homicide Review Panel (MDAHRP).

None of these entities has regulatory authority over DHHS/OCFS but each provides a form of oversight through formal and informal recommendations, advice, implementation of special projects and reporting – we refer to their role as "advisory oversight." Access to data, information sharing and relationships with DHHS/OCFS are integral to these entities' ability to provide advisory oversight.

Table 2. Advisory Oversight Entities

| Oversight Entity | Federally-required | Overall Focus/Mission/Goal |
|---|---|---|
| Maine Children's Ombudsman | | Provide ombudsman services regarding child welfare services provided by DHHS |
| Maine Child Welfare Advisory Panel | YES | Promote child safety and quality services for children, youth and families |
| Justice for Children Task Force | YES | Broad focus on safety, permanency, and well-being for children in the State of Maine child welfare system |
| Child Death and Serious Injury Review Panel | YES | Promote child health and well-being, improve child protective systems, and educate the public and professionals |
| Maine Domestic Abuse Homicide Review Panel | | Improve the coordinated community response to protect people from domestic abuse |

Three of these oversight entities – the Maine Child Welfare Advisory Panel, Justice for Children Task Force, and Child Death and Serious Injury Review Panel – are "citizen review panels" as specified and required under the federal Child Abuse Prevention and Treatment Act (CAPTA), or "CAPTA panels." The MCWAP and JCTF also meet requirements of funding under the federal Children's Justice Act.

According to CAPTA, the function of the designated citizen review panels for which the Act provides funding, is to examine the policies, procedures, and practices of state and local agencies and where appropriate, specific cases, in order to evaluate the extent to which the state and local child protection system agencies are effectively discharging their child protection responsibilities in accordance with:

- A state's plan for CAPTA funds (coordinated with the CFSP to the extent possible);
- The federal child protection standards set forth in CAPTA; and
- Any other criteria that the panel considers important to ensure the protection of children, including:
    - a review of the extent to which the state and local child protective services system is coordinated with foster care and adoption programs established under title IV-E of the Social Security Act; and

[4] This is also referred to as a "panel" throughout this document for ease of reference.

- a review of child fatalities and near fatalities.

Chairs of the CAPTA panels interviewed by OPEGA noted that they attempt to perform these duties in a complementary and collaborative manner with DHHS/OCFS and have an advisory role in relation to the department. According to the 2020 report from the Maine Justice for Children Task Force[5], a goal of all three CAPTA panels is to conduct complementary work without duplication. There is naturally, however, some overlap in focus among the CAPTA panels, the Domestic Abuse Homicide Review Panel, and the Ombudsman's program. Also, while CAPTA panels throughout the United States were originally envisioned to have more of an oversight role, they have evolved into a more collaborative advisory role to promote better outcomes for children and their families.[6] The panel members OPEGA interviewed consistently noted that much of their work is accomplished through communication, interaction and information sharing with DHHS/OCFS, and that collaboration with OCFS is critical to fostering improvement.

## A. Maine Children's Ombudsman

> "The Maine Child Welfare Services Ombudsman is an impartial office that specializes in assisting people with resolving concerns and complaints with Maine's Child Protective Services Department of the Department of Health and Human Services."[7]

The current children's ombudsman program in Maine was established by legislation in 2001. Pursuant to statute (22 MRSA §4087-A(2)), the program is "established as an independent program within the Executive Department to provide ombudsman services to the children and families of the State regarding child welfare services provided by the Department of Health and Human Services." The law requires that ombudsman services are delivered through a state contract with a nonprofit organization that the Executive Department determines to be free of potential conflicts of interest and best able to provide the services on a statewide basis.

***Duties.*** The duties of the Ombudsman, as specified in statute, are to: consider and promote the best interests of the child involved, answer inquiries, and investigate, advise and work toward resolution of complaints of infringement of the rights of the child and family involved. The Ombudsman must be an attorney or a master's level social worker with experience in child development and advocacy. The Ombudsman program is currently funded for two staff positions to carry out its work. The Ombudsman reported that the limited staffing makes it challenging to meet the demands on the office. At the time of this report, there is proposed legislation before the 130th Legislature to increase staff resources. [8]

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[5] Maine Justice for Children Task Force 2020 Report to the Supreme Judicial Court. January 13, 2021.
[6] Jones, Blake (2016). CRP Tip Sheet #6: Communicating with External Groups, University of Kentucky School of Social Work under the auspices of the National Child Abuse and Neglect Technical Assistance and Strategic Dissemination Center (CANTASD).
[7] Maine Children's Ombudsman website: http://cwombudsman.org/
[8] LD 1755, An Act To Enhance the Child Welfare Ombudsman Program, Sponsored by Senator Glenn Curry
LD 1812, An Act To Strengthen the Child Welfare Services Ombudsman Program by Providing for Increased Staffing, Sponsored by Senator William Diamond
LD 1824, An Act To Improve the Maine Child Welfare Services Ombudsman Program by Providing Additional Resources, Sponsored by Representative Holly Stover

***Operations.*** The Ombudsman reports that staff time and resources are divided fairly evenly between (1) answering inquiries – primarily responding to phone calls from the public – and (2) conducting investigations and related activities to respond to complaints. Time spent on the phone with individuals involves both listening to complaints with the child protective services system and also explaining state policies and procedures to callers who are new to the process. Some of these complaints result in the Ombudsman opening an individual case review to investigate. For context, a summary of case review activity of the Ombudsman since 2019 is provided in Table 3.

Table 3. Ombudsman Case Reviews 2019-2021*

| | 2019 | 2020 | 2021 |
|---|---|---|---|
| Case reviews opened | 109 | 90 | 95 |
| Case reviews closed | 98 | 82 | 84 |
| Closed cases with substantial issues** | 37 | 38 | 42 |

* Cases are opened for review as the result of one or more complaints made to the Ombudsman. As they are drawn from complaints, they are not a representative, or random sample of OCFS cases.
** Cases with substantial issues are defined as cases where the Ombudsman found a deviation from best practices or adherence to policy that had a material effect on the safety and best interests of the children, or rights of the parents.

Source: Maine Child Welfare Services Ombudsman Annual Reports 2019 - 2021

***Data access and information sharing.*** Pursuant to statute, the Ombudsman is provided access to files, records, and personnel of DHHS that are necessary for carrying out the Ombudsman's duties. DHHS and the Ombudsman have developed agreements for information sharing including an agreement that provides DHHS two weeks to respond to records requests and another agreement providing the Ombudsman access to the State's child welfare information system database (MACWIS[9]). The Ombudsman program is represented on the Maine Child Welfare Advisory Panel and the Justice for Children Task Force and provides and receives information through those groups.

***Reports and recommendations.*** The Ombudsman provides recommendations to DHHS of two types: confidential and public. Based on findings of individual case reviews, the Ombudsman may confidentially recommend changes to DHHS to address specific issues raised by a complaint, or any other issues the Ombudsman notes in the course of the review. Confidential recommendations can also result from combinations of cases which share common issues. These confidential recommendations are reported to DHHS throughout the year. The Ombudsman also prepares periodic interim reports as well as an annual report, due January 1st, to the Governor, Legislature and DHHS that summarizes common themes and makes recommendations for DHHS/OCFS based on the prior year of Ombudsman case reviews. This public document includes only de-identified information.

## B. Maine Child Welfare Advisory Panel

> "Formed in December 2015, The Maine Child Welfare Advisory Panel (MCWAP) is a multidisciplinary task force. It is comprised of private citizens and professionals from selected disciplines involved in handling child abuse and neglect. Meeting monthly, the panel ensures the state system is meeting the safety, permanency, and well-being of children and families through

[9] MACWIS is currently in the process of being replaced with a new DHHS/OCFS information system.

> assessment, research, advocacy, and greater citizen involvement. Its goal is to promote child safety and quality services for children, youth and families."[10]

MCWAP was formed in 2015 from the membership of two prior groups, the Child Welfare Steering Committee and Maine's Citizen Review Panel. This federally-required CAPTA panel reviews and provides advice regarding the delivery of child protective services.

***Duties.*** The Maine Child Welfare Advisory Panel's mission is to "assure that the state system is meeting the safety, permanency, and well-being of children and families through assessment, research, case reviews, advocacy, and greater citizen involvement."[11] To meet federal requirements, the MCWAP performs a range of duties that include examining and evaluating policies, examining state investigative, administrative and judicial handling of child abuse and neglect cases, providing for public outreach and input, and making policy and training recommendations.[12]

***Membership.*** The members of MCWAP are volunteers representing a wide range of public and private entities with an interest in the welfare of children. Several of the panel's members are OCFS staff who participate in a non-voting capacity, and the panel receives administrative support from a CAPTA coordinator employed by DHHS. Under the bylaws, panel membership includes, but is not limited to, representatives from the judicial system, health and mental health providers, law enforcement,[13] children and families and other service providers. Table B.3 of Appendix B includes a full list of membership as authorized by the panel's by-laws.

***Operations.*** The MCWAP is required by CAPTA to meet quarterly but typically meets on a monthly basis for 10 months per year. Much of the panel's work is conducted through subcommittees. Current subcommittees include: family-centered policy and practice; coordination of care for children entering the system; and father engagement. MCWAP conducts surveys of service providers and families every three years to fulfill its Children's Justice Act requirement to evaluate state handling of cases of child abuse and neglect, and uses its website as its required mechanism for receiving input from the public. MCWAP members also have the opportunity to review and provide feedback to OCFS on child welfare policies prior to their implementation.

***Data access and information sharing.*** MCWAP does not have access to confidential data but obtains information and aggregated data from DHHS/OCFS staff who serve on MCWAP as needed to conduct its work.

***Reports and recommendations.*** MCWAP issues annual reports that describe the panel's activities and recommendations for the improvement of CPS. Under CAPTA, DHHS is required to provide a written response to MCWAP recommendations within 6 months; however, MCWAP does not have

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[10] Maine Child Welfare Advisory Panel website: https://www.mecitizenreviewpanels.com/maine-child-welfare-advisory-panel/

[11] Maine Child Welfare Advisory Panel By-Laws, December 2018. (Note: The Panel voted to delete "case reviews" from the mission statement in 2021.)

[12] 2020–2024 Child and Family Services Plan. Office of Child and Family Services, State of Maine. https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/ocfs/documents/Maine%20OCFS%2020 20-2024%20CFSP%20-%20%20091219.docx

[13] The panel does not currently include a member from law enforcement but is continuing its recruitment efforts.

any authority to require OCFS implementation of its recommendations. MCWAP reported to OPEGA that in the past, obtaining feedback from DHHS/OCFS on the implementation of recommendations has been based on informal updates provided by the Department to the panel. The panel recently voted to establish a formal process for DHHS/OCFS to provide annual updates and comments on the Department's progress on MCWAP recommendations from the prior year.

***Evolving to citizen-led Model.*** Recently, the MCWAP co-chair position has evolved from being held by a non-voting co-chair from DHHS/OCFS, and a citizen co-chair who directs the meetings, to having two citizen co-chairs not affiliated with DHHS/OCFS. MCWAP is continuing to update its by-laws to reflect these changes. The panel has also built up its executive committee to include more representation of non-OCFS members. The 2020 annual report, published in early 2021, was written completely by citizen-members of the panel and this has been used by DHHS/OCFS to satisfy the federal CAPTA requirement for an annual report on the CAPTA panels' activities. Interviews with DHHS/OCFS management indicate that this shift to a more citizen-led MCWAP has been made with support of DHHS/OCFS.

## C. Justice for Children Task Force

> "The Maine Justice for Children Task Force ("the Task Force") is a collaborative, multidisciplinary task force. The Maine Judicial Branch convened it to improve safety, permanency, and well-being for children in the State of Maine child welfare system. Task Force membership consists of representatives from the legislative, judicial, executive branches, and other participants, including advocates for children, parents, and individuals involved in the child welfare system."[14]

The Maine Justice for Children Task Force is convened by, and operates as, a standing committee of the Maine Judicial Branch. The mission of this group is "to improve safety, permanency, and well-being for children in the State of Maine child welfare system."[15] The JCTF serves to meet federal requirements under both CAPTA and grant funding from the Children's Bureau to develop and implement recommendations to improve the court's role in achieving permanency for children.[16]

***Duties.*** The JCTF charter outlines specific duties the task force will fulfill. These duties include, but are not limited to:

- Identifying strengths and systemic barriers to the safety, permanency, and well-being of children in the State of Maine child welfare system, and solutions to barriers;
- Identifying training needs of stakeholders in child protective proceedings and adopting a training curriculum;
- Monitoring implementation of the Court Improvement Programs;
- Encouraging participation in Child and Family Services Reviews (CFSRs);
- Sponsoring local meetings with stakeholders for training and collaboration;

[14] Maine Justice for Children Task Force website: https://www.mecitizenreviewpanels.com/maine-justice-for-children-task-force/
[15] Maine Justice for Children Task Force 2020 Report to the Supreme Judicial Court, January 2021.
[16] Under the Court Improvement Program (CIP), the highest court of each state and territory receives a grant from the Children's Bureau to complete a self-assessment and develop and implement recommendations to enhance the court's role in achieving stable, permanent homes for children in foster care.

- Providing feedback on statewide performance standards; and
- Developing and implementing programs to improve assessment and investigation of suspected child abuse and neglect cases.

***Membership.*** The membership of the JCTF is set forth in the task force charter and includes representatives from the legislative, judicial, and executive branches and a spectrum of stakeholders including advocates for children, parents, foster parents, and other individuals involved in the child welfare system (See Table B.3 in Appendix B for a full list of membership categories). The JCTF is chaired by the Chief Justice of the Maine Supreme Judicial Court who also appoints members to the group.

As an entity under the Maine Judicial Branch, the JCTF has a distinct position separate from DHHS/OCFS in the Executive Branch. At the same time, as stated in the JCTF charter, "[i]t is anticipated that the work of the Task Force will regularly occur in conjunction and collaboration with the work of the Executive and Legislative Branches, along with appropriate child welfare entities." DHHS/OCFS staff who serve on the JCTF regularly present information on OCFS activities at task force meetings and actively work on the subcommittees and task force projects.

***Operations.*** The JCTF meets at least quarterly and maintains a strategic plan, which is revisited at each meeting, to guide its work. Areas identified for focus in the strategic plan are then worked on by subcommittees that may meet more regularly as needed. The task force has one standing subcommittee on continuing education that meets year-round and supports the annual judicial branch child protective conference. This annual conference provides a significant training and continuing education opportunity for many individuals in Maine's child welfare community.[17] The task force also currently has two other subcommittees, one focused on parent curriculum and another on race and equity data.

***Data access and information sharing.*** The JCTF, like MCWAP, does not have access to confidential data and instead, receives presentations of child welfare statistical data from DHHS/OCFS members at task force meetings. Members interviewed by OPEGA noted that this data is used in specific projects as well as to analyze child welfare trends in the State.

***Reporting and recommendations.*** The JCTF charter requires the submission of an annual report to be presented to the Supreme Judicial Court on January 15 or as otherwise requested.[18] The annual report details the activities of the panel for the prior year, including activities of its subcommittees and how they relate to the task force's strategic plan.

As an entity of the Judiciary, the JCTF does not make formal recommendations to DHHS/OCFS. The task force does, however, offer feedback to DHHS/OCFS on policies and practices.

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[17] The 3-day virtual session in 2020 averaged 205 participants at each session. 3,563 hours of CLE credits were reported along with 208 hours of ethics credits, 74 hours of self-study CLE credits, and 1900 guardian ad litem credits. Maine Justice for Children Task Force 2020 Report to the Supreme Judicial Court. https://www.mecitizenreviewpanels.com/wp-content/uploads/2021/02/Maine-Justice-for-Children-Task-Force-2020-Annual-Report-1.pdf

[18] Reports are available on the JCTF website: https://www.mecitizenreviewpanels.com/maine-justice-for-children-task-force/

## D. Child Death and Serious Injury Review Panel

> "The Child Death and Serious Injury Review Panel's mission is to promote child health and well-being, improve child protective systems, and educate the public and professionals who work with children to prevent child deaths and serious injuries. The Panel accomplishes this mission through collaborative, multidisciplinary, comprehensive case reviews, from which recommendations to state and local governments and public and private entities are developed."[19]

The CDSIRP is a multidisciplinary panel of professionals established in state law (22 MRSA §4004) to review child deaths and serious injuries to children and recommend methods of improving the child protection system, including modifications of statutes, rules, policies and procedures. The CDSIRP's goal is to help reduce the number of preventable child fatalities and serious injuries in the State; through comprehensive case reviews, summarizing findings, and making recommendations for system-level changes to increase protection, safety, and care for Maine's children.[20]

***Membership.*** Required membership of the CDSIRP is specified in statute (see 22 MRSA §4004(1)(E)). Membership is narrower than the other CAPTA panels due to the CDSIRP's specific focus on child deaths and serious injuries. The membership of the panel includes the Chief Medical Examiner[21] and other medical professionals including pediatricians, public health nurses, and forensic and community mental health clinicians. The panel also includes district attorneys, Assistant Attorneys General, law enforcement officers and DHHS/OCFS agency staff. (See Table B.3 in Appendix B for a full list of membership categories.) Beyond the required membership, the Chair indicated that the panel seeks to include other professionals with relevant perspectives, such as representatives from the Maine Coalition to End Domestic Violence, the Department of Corrections, the Maine CDC, and the Judicial Branch.

***Operations.*** The panel meets monthly, generally for 10 months out of the year, to conduct case reviews, evaluate sentinel events and patterns of injury and/or death, and analyze the effectiveness of state programs and systems that provide for child protection, safety, and care. For cases involving prosecution, the CDSIRP initiates a case review only after adjudication is complete. The CDSIRP conducts three different levels of case reviews:

- Level 1 – Periodic Summary Review: Involves a review of summaries of all child deaths and serious injuries that are reported to OCFS to identify the types of cases, injuries, and deaths being reported, themes warranting further review and potential recommendations.
- Level 2 – Cluster Review: Involves specific review of a cluster of cases (2-4) around a theme, for example, unsafe sleep practices – to seek to identify recommendations.

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[19] Child Death and Serious Injury Review Panel website: https://www.mecitizenreviewpanels.com/child-death-and-serious-injury-review-panel/

[20] 2020–2024 Child and Family Services Plan. Office of Child and Family Services, State of Maine. https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/ocfs/documents/Maine%20OCFS%202020-2024%20CFSP%20-%20%20091219.docx

[21] In practice the Chief Medical Examiner position on the panel has been filled by a representative or designee of the Examiner.

- <u>Level 3 – Individual Case Review</u>: Involves review of OCFS records and other related records (law enforcement, mental health, medical, or educational) and interviews with selected professionals involved in the case – for example the OCFS caseworker and supervisor, law enforcement, school personnel, or a child's pediatrician.

Additionally, sometimes the CDSIRP will jointly review cases with MDAHRP (described below). At the time of this report, the CDSIRP panel is nearing completion of by-laws designed to more consistently and clearly detail the group's practices and relationships with other entities.

***Data access and information sharing.*** The CDSIRP's authorities and restrictions associated with information, subpoena power, and confidentiality are provided within the framework of statute granting these authorities and restrictions to DHHS. The panel is provided confidential data from DHHS and panel members from DHHS/OCFS can answer further questions with their access to the OCFS database system, MACWIS[22].

***Reports and recommendations.*** Under the CAPTA requirements, the State is required to report annually to the federal government on the activities of the CDSIRP. This has been achieved historically through either a report submitted by the CDSIRP or, in years that the CDSIRP has not submitted a report, DHHS/OCFS has summarized the panel's activities for the purposes of federal reporting. At the time of this report, the CDSIRP is preparing a report on the last five years of activity. The chair has indicated that the panel plans to issue annual reports starting in spring of 2022 to coincide with the required report to the federal government. The panel has not routinely produced reports containing recommendations in the past; rather, the chair indicated that most of the panel's suggestions are implemented through ongoing communication and collaboration with OCFS or other parties in a position to make change. OCFS management does attend each CDSIRP case review and this involvement can inform modifications to OCFS policy and the content of DHHS-proposed legislation. Currently, the CDSIRP sends its reports to DHHS who may pass them on to the Legislature. In their on-going work to create by-laws, the panel is considering a broader distribution of their reports going forward.

## E. Maine Domestic Abuse Homicide Review Panel

> The mission of the Maine Domestic Abuse Homicide Review Panel is to engage in collaborative, multidisciplinary case review of domestic abuse related homicides for the purpose of developing recommendations for state and local government and other public and private entities to improve the coordinated community response that will protect people from domestic abuse.[23]

By law effective October 1, 1997, the Maine Domestic Abuse Homicide Review Panel (MDAHRP) was established under the Maine Commission on Domestic and Sexual Abuse "to review the deaths of persons who are killed by family or household members" (see 19-A MRSA §4013(4)). A subset of the deaths reviewed by MDAHRP involve children or child welfare cases. While the MDAHRP is another volunteer citizen review panel, it is not a CAPTA panel and therefore not subject to CAPTA requirements.

[22] MACWIS is currently in the process of being replaced with a new DHHS/OCFS information system.
[23] The 8th Report of the Maine Domestic Abuse Homicide Review Panel—January 2010

***Duties.*** As specified in statute, the MDAHRP is required: to collect and compile data related to domestic and sexual abuse following adjudication of the court case; and to recommend to state and local agencies methods of improving the system for protecting persons from domestic and sexual abuse. This includes recommending modifications to state laws, as well as state and local rules, policies, and procedures.

***Membership.*** Membership of the Panel is established in state statute and is multidisciplinary, including representatives from the fields of medicine, law enforcement, mental health, health and human services, corrections, public safety, and law, as well as domestic violence and family crisis service providers. By statute, the panel's membership includes the Commissioner of Health and Human Services, the Commissioner of Corrections, the Commissioner of Public Safety, the Chief Medical Examiner, two Assistant Attorneys General and one judge appointed by the Chief Justice. In practice, some of the seats for high-level government officials are filled by department designees of those officials with relevant expertise. (See Table B.3 in Appendix B for a full list of membership categories.) For about the past 20 years, an Assistant Attorney General (who is also the Criminal Division Chief) has chaired the panel.

***Operations.*** The panel operates out of the Office of the Attorney General, although this is not required by statute. The panel is supported by one, part-time, staff person. The MDAHRP meets monthly, generally for 10 months out of the year. At the meetings, the members review domestic abuse-related homicides cases that have been adjudicated to see what changes they could recommend that might have prevented the death. When the case under review includes the death of a child, the panel sometimes reviews cases in collaboration with the Child Death and Serious Injury Review Panel (CDSIRP) discussed above.

***Data access and information sharing.*** The MDAHRP has access to the confidential information from the Attorney General's case files of a homicide after the case has been adjudicated. These case files may also include any confidential information from DHHS/OCFS, when such information has been provided to the Attorney General under court order.[24]

***Reports and recommendations.*** MDAHRP's parent body, the Maine Commission on Domestic and Sexual Abuse, is required to submit a report on the panel's activities, conclusions and recommendations to the Legislature's Judiciary Committee by January 30th biennially (even numbered years). The biennial report includes recommendations, including specific recommended changes to practice by DHHS/OCFS as well as other parts of the broader system such as health care providers, Judicial Branch personnel and even the media.

# IV. Best Practices

For this Information Brief, OPEGA conducted limited research on best practices related to CPS oversight. We did not identify best practices that apply generally to state systems of oversight of child

[24] 22 M.R.S.A. §4008(3)(B). This is known as a "Clifford Order".

protective services. However, OPEGA gathered available information on best practices that may be relevant to the work of the specific advisory oversight entities addressed in this Information Brief.

### A. Ombudsman Offices

For best practices for ombudsman programs, OPEGA reviewed a National Conference of State Legislatures (NCSL) report on Children's Ombudsman Offices and Offices of Child Advocates.[25] The best practices cited in that report are from the United States Ombudsman Association (USOA). USOA standards include that an Ombudsman should:

(1) **Be independent** – free from outside control or influence;
(2) **Be impartial** – receive and review each complaint in an objective and fair manner, free from bias, and treat all parties without favor or prejudice;
(3) **Control confidentiality** – have the privilege and discretion to keep confidential or release any information related to a complaint or investigation[26]; and
(4) **Create a credible review process of complaints** – perform his or her responsibilities in a manner that engenders respect and confidence and be accessible to all potential complainants.

As shown in Table 4, elements of the Maine Children's Ombudsman program's design promote independence and impartiality. Its access to and uses of confidential information are specified in state statute. The program's statute also includes elements to help the credibility of its review process.

Table 4. Best Practices for Ombudsman Offices Overseeing Child Protection Services

| Best Practice | Maine's practice |
|---|---|
| *Independence* | The ombudsman program is established in 22 MRSA §4087-A as an independent program within the Executive Branch. The Ombudsman operates by an annual contract with a non-profit organization. The Department of Administrative and Financial Services (DAFS) manages the contract rather than DHHS. |
| *Impartiality* | Pursuant to statute, the program must be operated by contract with an organization that the Executive Branch determines to be free of potential conflicts of interest. Statute restricts state-level partisan activities of the incumbent ombudsman by specifying: "The ombudsman may not be actively involved in state-level political party activities or publicly endorse, solicit funds for or make contributions to political parties on the state level or candidates for statewide elective office." |
| *Confidentiality* | Information held by, or records or case-specific reports maintained by, the program are confidential (22 MRSA §4087-A). Disclosure may be made as allowed or required in accordance with the provisions of §4008 which reflects a description regarding the information that can be disclosed, and limitations under which it might be made public. |
| *Creation of a Credible Review Process for Complaints* | Creating a credible review process entails providing personnel and systems that<br>(a) engender respect and confidence and<br>(b) are accessible to all potential complainants.<br><br>• Staff qualifications: Statute prescribes that the program be staffed "by an attorney or a master's level social worker who must have experience in child development and advocacy, and support staff as determined to be necessary."<br>• Accessibility to complainants: The Ombudsman employs a website to provide general information to the public and provides numerous options to make a |

[25] Children's Ombudsman Offices | Office of the Child Advocate. National Conference of State Legislatures. https://www.ncsl.org/research/human-services/childrens-ombudsman-offices.aspx
[26] In the original USOA document, it is made clear that an ombudsman's discretion to release confidential information continues to be constrained by law.

Table 4. Best Practices for Ombudsman Offices Overseeing Child Protection Services

| Best Practice | Maine's practice |
|---|---|
| | complaint, including online forms, telephone, and email access. The Ombudsman states that the office spends about half of their time in communications with the public. The Ombudsman has also noted that resources often limit the ability to mediate between the Department and the individual complainant. |

In Maine, the ombudsman program appears to have many of the elements that help to ensure its independence, impartiality, control of confidential information, and requirements that help ensure a credible review process. As noted on page 10, the duties of the Ombudsman program are extensive, and in interviews with OPEGA, the Ombudsman stated that they lack resources to be able to mediate individual complaints with the Department. Instead, the Ombudsman reviews specific cases and makes recommendations to the Department that may address a complainant's problem. The complainant's case may prompt an improvement, but it may occur in a time period that does not aid the initial caller.

## B. Advisory Oversight Panels

The MCWAP, JCTF and CDSIRP, are examples of CAPTA citizen review panels (CRPs) which are featured in most U.S. states. Currently, 48 states plus D.C. and Puerto Rico receive a CAPTA grant and as a result are required to have citizen review panels.[27] Because of their ubiquity, much work is being conducted to provide information to states to help structure and improve the performance of these entities.

Based on interviews of stakeholders and public documents, OPEGA observes that the CAPTA panels in Maine are employing many of the best practices for structuring the citizen review panels as well as performing the panels' work. Table 5 is a comparison of Maine's CAPTA panel practices to published best practice guides.[28] While the Maine Domestic Abuse Homicide Review Panel (MDAHRP) is not a CAPTA panel, it is included here as it performs similar oversight activities in the State.

Table 5. Best Practices for Citizen Review Panels Overseeing Child Protection Services

| Best Practice | Maine's practice |
|---|---|
| *CRPs should be given access to information* | All of the CAPTA panels are provided information needed to perform their tasks. MCWAP and the JCTF include DHHS/OCFS personnel on their panels and they provide updates on the department's activities at each meeting. Panels receive statistical information from the department to examine data trends. MDAHRP obtains its confidential data from the case files of the Attorney General and CDSIRP receives confidential case information from DHHS/OCFS. CDSIRP includes panel members who have access to the department's case record database. The |

[27] Children's Bureau, an Office of the Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/cb/grant-funding/child-abuse-prevention-and-treatment-act-capta-state-grants

[28] Jones, Blake (2015 & 2016). Tip sheets for CRPs 1-7. University of Kentucky School of Social Work under the auspices of the National Child Abuse and Neglect Technical Assistance and Strategic Dissemination Center (CANTASD). CANTASD is funded by the U.S. Department of Health and Human Services, Administration for Children, Youth and Families, Office of Child Abuse and Neglect.

| Table 5. Best Practices for Citizen Review Panels Overseeing Child Protection Services | |
|---|---|
| **Best Practice** | **Maine's practice** |
| | timeliness of receiving information only after adjudication is a concern to some panel members. |
| *CRPs should be consulted early in the policy development process* | DHHS/OCFS has a structured policy development system which includes numerous stages in a policy's development. Members of CRPs and the Ombudsman are invited to participate in the policy development focus groups at the same time as the general population of departmental case workers. The policies are not final at this stage, however; it is one of the last levels of review and much of the policy is already structured. |
| *CRPs should be given feedback about their recommendations.* | DHHS/OCFS is required by CAPTA to respond to recommendations from CAPTA panels in writing within six months. These responses are usually written within the annual reports, describing intended actions to address the issue. Some panels are working to formalize requesting and receiving progress updates on recommendations. |
| *CRPs should be provided staff and other logistical support.* | DHHS currently provides a CAPTA Panel Coordinator for staff support to MCWAP and the CDSIRP. The Attorney General's Office provides a person to support MDAHRP – and the Judiciary, through the Court Improvement Program, provides staff support for the JCTF. Additionally, the CAPTA panels have developed a linked website with the support of the DHHS. Staff turnover was mentioned as an issue for at least two of the panels: the CDSIRP reported that 10 different individuals have filled the staff support role since 2008; and over the 20-year history of the MDAHRP, the longest tenure in the staff support role has been four years. |
| *CRPs should be connected to the child welfare agency, but not controlled by it.* | CRPs in Maine vary in their independence from the department but are all moving toward more independence. MDAHRP is statutorily quite independent and the JCTF's independence comes from its position as primarily an entity of the judiciary. MCWAP's recent history has been moving toward being more citizen-led, and the CDSIRP is creating by-laws to regulate its relationship with DHHS. |
| *CRPs should formalize the relationship with the child welfare agency.* | The trend to formalization is a continuing effort. Proponents of formalization interviewed by OPEGA believe institutionalizing processes helps to maintain CRP effectiveness over time, but does not replace the need for the collaboration between all the groups involved. |
| *Members of CRPs should have diverse backgrounds.* | Statute, by-laws and charters dictate the diverse types of occupations and stakeholders that must be represented but remain silent on additional members. MCWAP by-laws note as a CAPTA requirement that "MCWAP will be composed of volunteer members who are broadly representative of the community." OPEGA was informed of the concern for gender diversity of the MDAHRP which was estimated to be overwhelmingly female. |
| *CRPs should ensure membership expectations and duration of service are clear.* | Member attendance was stated to occasionally be an issue in our interviews of panel members. These are volunteer positions held by professionals with multiple responsibilities living in communities across the State. At times, panels have had an issue obtaining a quorum for voting. Several interviewees have stated that attendance has improved significantly with the advent of video-meetings. |
| *CRPs should produce an annual report.* | The MDAHRP is required by state statute to produce a biennial report. DHHS must submit a report on the activities of the CAPTA panels to the federal government to comply with CAPTA. The JCTF submits an annual report to the Supreme Judicial Court that has been used as one of these reports. In the past, the reports for MCWAP and the CDSIRP have at times been written by DHHS, but MCWAP has produced a completely citizen-led report since its 2020 report and the CDSIRP is completing a 5-year lookback and plans to submit annual reports starting the spring of 2022. |
| *CRPs should connect with other groups of advocates and stakeholders.* | Along with the recent improved coordination of the CAPTA panels, the panels continue to reach out to other stakeholders in Maine's child welfare system. The MDAHRP and CDSIRP have coordinated on certain homicide reviews in order to gain more perspectives as well as to more efficiently use the time of people they interview. MCWAP and JCTF continually hear from service providers, parents' groups, adoptive families' groups and others. JCTF partners with the judicial branch, DHHS, the Department of Corrections, the Department of Public Safety, and the Department of Education. The varied membership of the CRPs results in natural connections with other stakeholders. |

As can be seen from the above examples, the citizen review panels overseeing child protection services in Maine are evolving in a direction that conform with the accepted best practices. Recent movements toward formalizing relationships, taking responsibility for reporting, and potentially formalizing updates of the Department's implementation of recommendations are increasing the independence and oversight potential of the CRPs.

# V. Other State Approaches

## A. Children's Ombudsman/Advocate

According to the NCSL, approximately 23 states, including Maine, have established a Children's Ombudsman or Office of the Child Advocate with duties and purposes specifically related to children's services. Another five states have a statewide Ombudsman program that addresses the concerns of all governmental agencies, including children's services. Nine states have related Ombudsman services, program-specific services, or county-run programs.[29]

OPEGA reviewed information regarding the structure and duties of child welfare ombudsman and child advocate offices in the New England states. All New England states, except Vermont, have either an office of the child ombudsman or an office of the child advocate.[30]

In all New England states, the ombudsman or children's advocate is described as an independent entity. The location of advocates and ombudsman offices within state government varies, but the offices are typically independent agencies or part of the executive branch. Maine is the only New England state that contracts the position.[31] Where qualifications are stated, ombudsman and child advocates in New England are typically required to be attorneys. The duties of these positions in New England are generally similar to those in Maine. Some offices include more services such as providing training to attorneys and guardians ad litem. Rhode Island's Child Advocate can also litigate against the state on behalf of a child. Many of the offices have subpoena power. Maine's ombudsman program does not have subpoena power, but does have statutorily guaranteed access to DHHS files, records and personnel. Table B.4 in Appendix B compares Children's Ombudsman and Advocate Offices for each of the New England states.

## B. Overall approach to CPS Oversight

To complete this Information Brief, OPEGA also performed limited research to identify ways in which other states' approach CPS oversight. CAPTA panels are ubiquitous across the nation.

[29] Children's Ombudsman Offices | Office of the Child Advocate. National Conference of State Legislatures. https://www.ncsl.org/research/human-services/childrens-ombudsman-offices.aspx
[30] Vermont does not currently have an ombudsman or child advocate, but there is a bill before the Legislature to create an Office of the Child Advocate.
[31] According to NCSL data (see footnote 28), Maine is unique in the U.S. in contracting its ombudsman services.

Currently, 48 states, D.C. and Puerto Rico receive CAPTA funding.[32] Along with this form of citizen review, states employ other mechanisms for oversight of child protective services. Forms of oversight in some other states include full legislative committees and joint committees dedicated only to child welfare issues. Other state bodies of oversight OPEGA noted are independent advocates, standing commissions, legislative panels, and oversight boards. Alternate approaches that we identified are summarized in Table 6, below.

**Table 6. Summary of Some Alternate Approaches to CPS Oversight in Other States**

| State | Entity | Description |
|---|---|---|
| Arizona | Joint Legislative Oversight Committee on the Department of Child Safety | Legislative committee established to review the implementation of policy and procedures, and program effectiveness of the department responsible for child safety. (This Committee is still authorized, but appears inactive.) |
| Kentucky | Child Welfare Oversight and Advisory Committee | Legislative committee that reviews, analyzes, and provides oversight on child welfare, including but not limited to foster care, adoption, and child abuse, neglect, and dependency. |
| Utah | Child Welfare Legislative Oversight Panel | Legislative panel established to oversee child protective services. |
| Vermont | Joint Legislative Child Protection Oversight Committee | Joint legislative committee established to oversee child protective services. |
| Nebraska | Office of Inspector General of Nebraska Child Welfare | Office that provides independent review of the actions of individuals and agencies responsible for the care and protection of children in the Nebraska Child Welfare and Juvenile Probation systems. The OIG is a subdivision of the Office of Public Counsel (Ombudsman's Office). |
| New Hampshire | Child Advocate Office | Office that provides independent and impartial oversight of the NH child welfare and juvenile justice systems to promote effective reforms that meet the best interests of children. Complaints about CPS must first be exhausted by all other avenues, including the DHHS Ombudsman, before coming to them. |
| Indiana | Commission on Improving the Status of Children in Indiana | Statewide commission including members from all three branches of government. It includes a number of committees and task forces, including a Child Health & Safety Task Force and a Child Services Oversight Committee. |
| Washington State | Department of Children, Youth & Families (DCYF) Oversight Board | Board established to monitor, and ensure, that DCYF achieves its stated outcomes, and to ensure that the Department complies with administrative acts, relevant statutes, rules, and policies pertaining to early learning, juvenile rehabilitation, juvenile justice, and children and family services. |

[32] Children's Bureau, an Office of the Administration for Children and Families, U.S. Department of Health and Human Services. https://www.acf.hhs.gov/cb/grant-funding/child-abuse-prevention-and-treatment-act-capta-state-grants

# VI. Conclusion

For this Information Brief, OPEGA reviewed five aspects of child protective services oversight in Maine: current oversight structure, roles and responsibilities, information sharing, best practices and models, and effectiveness of the oversight structure. The review focused on child protective services administered and delivered by the DHHS/OCFS, and examined the review and monitoring of those services conducted by the U.S. Department of Health and Human Services Administration for Children and Families in a regulatory role and five state-level entities in an advisory role. This Brief offers ten lessons and observations from the research along with detailed descriptions and a series of tables presenting contextual information.

OPEGA's review of child protective services will include two evaluation reports to be delivered to the Government Oversight Committee later this year. Protecting Child Safety – Initial Investigation and Assessment is slated for March 2022 and Protecting Child Safety – Reunification and Permanency is scheduled for completion in September 2022.

# VII. Acknowledgements

OPEGA would like to thank the staff of Maine's Office of Child and Family Services for their cooperation and assistance in developing this Information Brief to the Government Oversight Committee. OPEGA also thanks the Maine Children's Ombudsman and the representatives of the Maine Child Welfare Advisory Panel (MCWAP); the Justice for Children Task Force (JCTF); the Child Death and Serious Injury Review Panel (CDSIRP); and the Maine Domestic Abuse Homicide Review Panel (MDAHRP). Their assistance and review made this Information Brief possible.

## Appendix A. Information Brief Methods

In light of the fact that this project was an Information Brief, and not an evaluation, OPEGA's work for this product did not include the evaluation of performance or outcomes, audit testing, data analysis, or other evaluative work. Instead, OPEGA's work included gathering, synthesizing and presenting descriptive, contextual information to build knowledge and understanding of the topic by the GOC and the Legislature.

Data sources included:

- Relevant state and federal statutes;
- Materials and testimony submitted to the GOC to date related to oversight of CPS;
- Legislator requests for review of CPS submitted to the GOC;
- Materials available on the websites of the entities included in this review and the website of DHHS/OCFS;
- Reports published by the state oversight entities (Ombudsman and citizen review panels);
- Report by the Casey Family Services in October 2021
- Federal Child and Family Services Review (CFSR) reports for each of the New England states;
- DHHS/OCFS's 2020-2024 Child and Family Services Plan (CFSP);
- DHHS/OCFS's FFY 2022 Annual Progress & Service Report (APSR);
- Published research and information on best practices for oversight of CPS generally or for citizen review panels and offices of ombudsman specifically;
- Interviews with the management of DHHS/OCFS;
- Interviews with the chairs of each of the five state advisory entities, or their designees;
- Interviews with U.S. DHHS, Administration for Children and Families, Children's Bureau representatives;
- Interviews with DHHS/OCFS Quality Assurance Program Manager; and
- Published information on alternate structures, or entities, that other states are currently using in their oversight of child protective services.

# Appendix B. Tables

| Table B.1. Child and Family Outcomes and Measured Items in the Child and Family Services Review (CFSR) |
|---|
| **Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect.** |
| Item 01: Timeliness of Initiating Investigations of Reports of Child Maltreatment. |
| **Safety Outcome 1: Children are safely maintained in their homes whenever possible and appropriate.** |
| Item 02: Services to Family to Protect Children in the Home and Prevent Removal or Re-Entry into Foster Care. |
| Item 03: Risk and Safety Assessment and Management. |
| **Permanency Outcome 1: Children have permanency and stability in their living situations.** |
| Item 04: Stability of Foster Care Placement |
| Item 05: Permanency Goal for Child |
| Item 06: Achieving Reunification, Guardianship, Adoption, or Other Planned Permanent Living Arrangement |
| **Permanency Outcome 2: The continuity of family relationships and connections is preserved for children.** |
| Item 07: Placement with Siblings |
| Item 08: Visiting with Parents and Siblings in Foster Care |
| Item 09: Preserving Connections |
| Item 10: Relative Placement |
| Item 11: Relationship of Child in Care with Parents |
| **Well-Being Outcome 1: Families have enhanced capacity to provide for their children's needs.** |
| Item 12: Needs and Services of Child, Parents, and Foster Parents<br>Item 12a: Needs Assessment and Services to Children<br>Item 12b: Needs Assessment and Services to Parents |
| Item 13: Child and Family Involvement in Case Planning |
| Item 14: Caseworker Visits with Child |
| Item 15: Caseworker Visits with Parents |
| **Well-Being Outcome 2: Children receive appropriate services to meet their educational needs.** |
| Item 16: Educational Needs of the Child |
| **Wellbeing Outcome 3: Children receive adequate services to meet their physical and mental health needs.** |
| Item 17: Physical Health of the Child |
| Item 18: Mental/Behavioral Health of the Child |
| *Source: Child and Family Service Reviews: Maine Final Report 2017* |

| Table B.2. Seven Systemic Factors and Measured Items that Affect Outcomes for Children and Families Assessed in the CFSR |
|---|
| **Statewide Information System** |
| Item 19: Statewide Information System has certain required functionality. |
| **Case Review System** |
| Item 20: Written Case Plan for each Child. |
| Item 21: Timely Periodic Review for Child. |
| Item 22: Timely Permanency Hearing for Children. |
| Item 23: Termination of Parental Rights occurs in accordance with required provisions. |
| Item 24: Foster Parents, Pre-adoptive Parents, and Relative Caregivers are notified of any review or hearing held with respect to the child. |
| **Quality Assurance System** |
| Item 25: Quality Assurance System includes certain characteristics |
| **Staff and Provider Training** |
| Item 26: Initial Staff Training |
| Item 27: Ongoing Staff Training |
| Item 28: Foster and Adoptive Parent Training |
| **Service Array and Resource Development** |
| Item 29: Array of Services |
| Item 30: Individualizing Services |
| **Agency Responsiveness to the Community** |
| Item 31: State Engagement and Consultation with Stakeholders Pursuant to CFSP and APSR |
| Item 32: Coordination of CFSP Services with Other Federal Programs |
| **Foster and Adoptive Parent Licensing, Recruitment, and Retention** |
| Item 33: Standards Applied Equally |
| Item 34: Requirements for Criminal Background Checks |
| Item 35: Diligent Recruitment of Foster and Adoptive Homes |
| Item 36: State Use of Cross-Jurisdictional Resources for Permanent Placements |
| *Source: Child and Family Service Reviews: Maine Final Report 2017* |

| Table B.3. Membership of Maine's Child Welfare Citizen Review Panels | |
|---|---|
| **Oversight Entity** | **Membership either required by statute, charter or by-laws** |
| Maine Child Welfare Advisory Panel | Chair: Until recently the panel was co-chaired by a citizen chair and a non-voting chair representing the State's child protective service agency. The panel is moving toward two citizen co-chairs.<br>Required members:<br>• Individuals representing law enforcement (currently recruiting for this category)<br>• Judges & attorneys involved in criminal or civil court proceedings related to child abuse and neglect<br>• Child advocates: attorneys for children, Court-appointed special advocates<br>• Health and mental health professionals<br>• Individuals representing child protective services agencies<br>• Individuals experienced in working with children with disabilities<br>• Parents who have been involved with the child welfare system<br>• Representatives of parents' groups<br>• Representatives from at least one of the following: foster, adoptive, or kinship families<br>• Youth survivors of child abuse or neglect who are over 18 years of age<br>• Tribal representatives<br>• Individuals representing early childhood development and school systems<br>• Individuals representing substance use treatment and recovery<br>• Individuals representing domestic violence services<br>• Individuals representing sexual assault services<br>• Legislators<br>• Clergy<br>• Individuals experienced in working with homeless children and youth |
| Justice for Children Task Force | Chair: The chair is the Chief Justice of the Maine Supreme Judicial Court<br>Required members:<br>• Child advocates: attorneys for children, guardians ad litem, court-appointed special advocates<br>• Parents or their advocates: representatives from parents' groups, parents' lawyers or advocates<br>• Judges & attorneys involved in criminal or civil court proceedings related to child abuse and neglect<br>• Individuals representing law enforcement<br>• Health and mental health professionals<br>• Individuals representing child protective services agencies<br>• Individuals experienced in working with children with disabilities<br>• Tribal representatives<br>• Adults who were victims of child abuse or neglect<br>• Individuals experienced in working with homeless children and youth<br>• Other members appointed by the Chief Justice at her discretion |
| Child Death and Serious Injury Review | Chair: The chair is selected by the group from its membership.<br>Required members:<br>• Chief Medical Examiner<br>• A pediatrician<br>• A public health nurse<br>• Forensic and community mental health clinicians<br>• Law enforcement officers<br>• Departmental child welfare staff<br>• District attorneys |

| Table B.3. Membership of Maine's Child Welfare Citizen Review Panels | |
|---|---|
| **Oversight Entity** | **Membership either required by statute, charter or by-laws** |
| | • Criminal or civil assistant attorneys general |
| Maine Domestic Abuse Homicide Review Panel | Chair: The chair of the panel has been the same appointee by the Attorney General's Office for most of the life of the panel.<br>Required members:<br>• Chief Medical Examiner<br>• A physician<br>• A nurse<br>• A law enforcement officer<br>• The Commissioner of Health and Human Services<br>• The Commissioner of Corrections<br>• The Commissioner of Public Safety<br>• A judge as assigned by the Chief Justice of the Supreme Judicial Court<br>• A representative of the Maine Prosecutors Association<br>• An Assistant Attorney General responsible for the prosecution of homicide cases<br>• An Assistant Attorney General handling child protection cases<br>• A victim – witness advocate<br>• A mental health service provider<br>• A facilitator of a certified domestic violence intervention program under §4014<br>• 3 persons designated by a statewide coalition for family crisis services |

| Table B.4. State Children's Ombudsman/Advocate Offices in New England | | | | |
|---|---|---|---|---|
| **State** | **Office** | **Jurisdiction & Location Within Government** | **Appointment & Qualification** | **Duties & Powers of the Ombudsman / Child Advocate** |
| CONNECTICUT<br><br>Conn. Gen. Stat. § 46a-13k | Connecticut Office of the Child Advocate | The Child Advocate shall act independently of any state department. The Office of the Child Advocate is located within the Office of Governmental Accountability. | The Child Advocate is appointed by the Governor with Approval by the General Assembly to serve a four-year term and may be reappointed. | The Child Advocate receives and investigates complaints; periodically reviews institutions; recommends policy changes; provides training to attorneys and guardians ad litem; has access to confidential information; issues subpoenas; maintains confidentiality; maintains a child fatality review panel; represents a child in court; produces annual and public reports. |
| MAINE<br><br>Me. Rev. Stat. 22 MRSA § 4087-A | Maine Child Welfare Services Ombudsman | The Ombudsman is established as an independent program within the Executive Branch, and contracted to a non-profit organization to oversee the Office of Child and Family Services. | Contract to a nonprofit organization by the Governor.<br>The Ombudsman may not be actively involved in state politics and must be an attorney or master's level social worker with experience in child development and advocacy. | The Ombudsman receives and investigates complaints; provides public outreach; has access to persons, files, and records, does not have the power to subpoena; maintains confidentiality; provides recommendations to the child welfare agency as well as annual and public reports. |
| MASSACHUSETTS<br><br>Mass Gen. Laws ch. 18 § 1-13 | Massachusetts Office of the Child Advocate | The Child Advocate is an independent office within the Executive Branch with the jurisdiction to oversee children served by the child welfare or juvenile justice systems. | The Child Advocate is appointed by the Governor and a nominating committee and serves a term coterminous with that of the governor. | The Child Advocate investigates critical incidents; receives and investigates complaints; reviews and makes recommendations for system-wide changes; educates the public; has access to facilities and records; has the power to subpoena; |

| Table B.4. State Children's Ombudsman/Advocate Offices in New England | | | | |
|---|---|---|---|---|
| **State** | **Office** | **Jurisdiction & Location Within Government** | **Appointment & Qualification** | **Duties & Powers of the Ombudsman / Child Advocate** |
| | | | | provides annual and public reports. |
| NEW HAMPSHIRE<br><br>Section 170-G:18 | New Hampshire Office of the Child Advocate | The Office of the Child Advocate shall be an independent agency, administratively attached to the department of administrative services pursuant to RSA 21-G:10 | The office shall be under the supervision of an unclassified director of the office of the child advocate. The director shall possess a professional graduate degree in law, social work, public health, or a related field and be qualified by reason of education, experience, and expertise to perform the duties of the office. | The Office of the Child Advocate provides independent oversight of the division for children, youth, and families to assure that the best interests of children are being protected. |
| RHODE ISLAND<br><br>R.I. Gen. Laws § 42-73-1 et seq. | Rhode Island Office of the Child Advocate | The Office of the Child Advocate (OCA) is an independent and autonomous state agency responsible for protecting the legal rights and interests of children in state care. | The Child Advocate is appointed by the Governor, with the advice and consent of the Senate. The Advocate shall have a term of five years.<br><br>The Child Advocate shall be a member of the Rhode Island Bar for at least three years and must be qualified by training and experience to perform the duties of the office. | The Child Advocate provides an annual report to the Governor and Legislature; insures all children in the child welfare system are appraised of their rights; reviews procedures; reviews complaints; provides training; has access to confidential information; has the power to subpoena; commences civil action against the state on behalf of a child; maintains confidentiality. |
| VERMONT* | ***Proposed –*** Office of the Child Advocate | ***Proposed –*** The Office shall act independently of any State agency in the performance of its duties. | ***Proposed*** – The Oversight Commission on Children, Youths, and Families established pursuant to section 3210 of this chapter shall recommend qualified applicants for the position of the Child, Youth, and Family Advocate to the Governor for consideration. Subject to confirmation by the Senate, the Governor shall appoint an Advocate from among those applicants | ***Proposed*** – The Office of the Child Advocate shall: (1) collect and analyze data regarding the well-being of children in Vermont; (2) identify systemic shortcomings in Vermont's justice-involved youth and child welfare systems; and (3) make recommendations to the General Assembly regarding any |

| Table B.4. State Children's Ombudsman/Advocate Offices in New England | | | | |
|---|---|---|---|---|
| **State** | **Office** | **Jurisdiction & Location Within Government** | **Appointment & Qualification** | **Duties & Powers of the Ombudsman / Child Advocate** |
| | | | recommended by the Oversight Commission for a term of four years. | necessary reforms to better serve Vermont children and youths. |

*(Primary Source: Children's Ombudsman Offices / Office of the Child Advocate. National Conference of State Legislatures. https://www.ncsl.org/research/human-services/childrens-ombudsman-offices.aspx )*

** Information on Vermont's proposed Office of the Child Advocate is taken from the Vermont Legislature's H-0265 which was passed by the Vermont House and was referred to the Committee on Health and Welfare of the Vermont Senate on 01/04/2022 as per Temporary Senate Rule 44A.*

## Appendix C. Recommendations from Oversight Entities

The Ombudsman and most of the state-level oversight panels make recommendations to improve the delivery of services by DHHS/OCFS, and often the broader child welfare system. These recommendations are often communicated in published reports, some of which are directly reported to the Legislature. However, some of these advisory oversight entities make confidential recommendations directly to OCFS that are not publicly accessible due to the confidential nature of the information on which they are based. Any recommendations made to DHHS/OCFS by these advisory entities are strictly advisory and the agency is not obligated to implement them.

Table C.1. Public Reports from Maine's Oversight Entities

| Oversight Entity | Confidential case-specific recommend-ations to DHHS/OCFS? | Published (aggregate) recommend-ations | Published reports & frequency | Reports submitted to: |
|---|---|---|---|---|
| Maine Children's Ombudsman | Yes | Yes | Annual Reports | Governor, Legislature and DHHS. |
| Maine Child Welfare Advisory Panel | No | Yes | Annual Reports | Health and Human Services Committee through DHHS/OCFS |
| Justice for Children Task Force | No | No* | Annual Reports | Maine's Supreme Judicial Court |
| Child Death and Serious Injury Review | Yes | Yes | Periodic Reports | DHHS |
| Maine Domestic Abuse Homicide Review Panel | Yes | Yes | Biennial Reports | Judiciary Committee |

*JCTF provides feedback to the Executive Branch, but not formal recommendations.

OPEGA reviewed the two most recent published reports of each of the five advisory entities for this Information Brief. We found that the recommendations reported publicly by the Ombudsman and the four panels vary widely in number, content and specificity. Some of these entities don't include anything termed "recommendations" while others include a large number of recommendations, including many not directly linked to DHHS/OCFS. Some recommendations outline very specific desired changes to processes or procedures, whereas others describe a general area of difficulty that needs to be addressed. For a summary list of published recommendations (or findings that appear to recommend an action) we reviewed, see Table C.2 (below).

None of the five entities have a formal process for tracking whether, and how, OCFS implements the recommendations made. OCFS management reports that they provide responses directly on recommendations made by the Ombudsman and the MCWAP, JCTF, and CDSIRP (the three CAPTA panels). The OCFS responses are often in writing but may also include additional discussion during meetings of the panels. The Maine Child Welfare Advisory Panel and Ombudsman's Office have historically printed an OCFS response to recommendations within their annual reports in the past. Going forward, the Ombudsman reported that they will discontinue that practice, citing that it has created timing issues and that keeping OCFS's response separate from the

Ombudsman's report should make it cleaner for both parties to communicate their sometimes-differing perspectives.

| Table C.2. Summary of Recently Recommended Changes Specific to OCFS Child Protective Services | |
|---|---|
| **Description of Recommended Change** | **Data Year** |
| **Ombudsman's Office** (Source: Annual Reports) | |
| More staff training and support, particularly training of casework supervisors | 2020 |
| Recognize risk when evidence is clear, complete basic investigation practices, thoroughly investigate caregivers' histories, make and monitor safety plans, ensure children have legal protection | 2020 |
| Avoid arriving at the end of a case, or other crucial decision-making points, without enough information to make an informed decision | 2020 |
| Ensure consistently accurate determinations about the safety of children at the outset of child welfare involvement | 2019 |
| Ensure sufficient data is collected (particularly via contact with parents and collaterals), and used, to support key decisions | 2019 |
| Recognize truancy as a sign of risk to a child, as educational neglect rarely exists in isolation | 2019 |
| **Maine Child Welfare Advisory Panel** (Source: Annual Reports) | |
| Improve the Department's ability to effectively engage the fathers of children involved with OCFS | 2020 |
| Strengthen current training and professional development for caseworkers and supervisors in areas of communication and engagement with caregivers | 2020 |
| Continue exploring options to meet 24-hour response timelines, which may include more staff, different staff structures, and appropriate supervision and support | 2019 |
| Prioritize and implement the recommendations of the PCG and OPEGA assessments | 2019 |
| Continue to collaborate with Maine Courts to increase timeliness of court cases | 2019 |
| Create opportunities for relationship building between law enforcement, district staff, and forensic medical experts at the local level | 2019 |
| Increase the child welfare workforce knowledge base regarding children and adults with disabilities | 2019 |
| **Justice for Children Task Force** (Source: Annual Reports) | |
| Provided feedback to DHHS/OCFS to revise content and form of reunification plans to more clearly present a roadmap for parents to follow to regain custody of their children | 2020 & 2019 |
| **Child Death and Serious Injury Review Panel** (Source: 2014-2016 Report) | |
| Improve the health and wellbeing of substance exposed newborns | 2014 -2016 |
| Create a public education program regarding indicators, in children under six months, of abuse and neglect that should be reported; support strengthening mandated reporter laws | 2014 -2016 |
| **Maine Domestic Abuse Homicide Review Panel** (Source: Biennial Reports) | |
| Implement strategies to address training needs, caseload challenges, and adequate supervision for CPS staff to ensure that reports of suspected child abuse and neglect are thoroughly investigated, and appropriate and effective interventions can be implemented | 2014 - 2019 |
| Sustain the Child Protective Liaison collaboration between OCFS and Maine Coalition to End Domestic Violence | 2014 -2019 |

| Table C.2. Summary of Recently Recommended Changes Specific to OCFS Child Protective Services | |
|---|---|
| **Description of Recommended Change** | **Data Year** |
| Immediately identify a plan for the safest and appropriate placement and services for surviving children in cases when a child loses a parent(s) and/or sibling(s) to homicide or homicide-suicide, and especially if children have witnessed a homicide or discovered the body. | 2014 - 2019 |
| Develop and update training for all legally mandated reporters, as laws change and vigilance declines | 2014 - 2019 |
| Review OCFS intake processes and identify additional training for intake workers on identification and documentation of high-risk offenders who use specific tactics | 2012 - 2016 |
| Interview all household members during an investigation, and consider interviewing neighbors that may have had an opportunity to observe the family, to gather pertinent information to support safety planning and to document facts and circumstances that may not otherwise present themselves | 2012 – 2016 |
| Provide ongoing training regarding mandated reporting to all agencies providing direct care or other services to children, such as law enforcement, healthcare providers, domestic violence resources center staff, and other community services | 2012 – 2016 |

# Appendix D. Bills Before the 2nd Regular Session of the 130th Legislature Related to Child Protective Services Oversight

**Table D.1. Bills Before the 2nd Regular Session of the 103th Legislature Related to Child Protective Services Oversight**

| LD # | Title | Sponsor | Committee | Summary |
|---|---|---|---|---|
| 1755 | An Act To Enhance the Child Welfare Ombudsman Program | Senator Curry | HHS | This bill makes numerous changes to the laws governing the ombudsman program that provides ombudsman services to the children and families of the State regarding child welfare services provided by the Department of Health and Human Services. For all changes, refer to full bill summary: http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0615&item=1&snum=130 |
| 1812 | An Act To Strengthen the Child Welfare Services Ombudsman Program by Providing for Increased Staffing | Senator Diamond | HHS | This bill provides ongoing funding for two additional associate ombudsman positions and one administrative assistant position for the child welfare services ombudsman program in the Executive Department. |
| 1824 | An Act To Improve the Maine Child Welfare Services Ombudsman Program by Providing Additional Resources | Representative Stover | HHS | This bill is a concept draft. This bill, as emergency legislation, proposes to enact measures to provide additional resources to the office of the child welfare services ombudsman to enhance the capacity of that office to improve child welfare practices through both the review of individual cases and the provision of information on the rights and responsibilities of families, service providers and other participants in the child welfare system. |
| 1825 | An Act To Establish Limits on the Number of Hours Worked by and Workloads of Child Protective Services Caseworkers in the Department of Health and Human Services | Representative Madigan | HHS | This bill requires that the Department of Health and Human Services ensure that a caseworker in the Office of Child and Family Services does not work or drive more than a maximum number of hours in a certain period. It repeals Resolve 2019, c.34, which required DHHS to develop a standard case load recommendation and instead requires that DHHS establish a maximum workload for caseworkers. It requires DHHS to report to the HHS Committee and the child welfare ombudsman whenever a caseworker's workload exceeds the maximum workload. It also requires DHHS to report annually to the HHS Committee on the staffing, case load and workload assignments of caseworkers by county and district office. |

| Table D.1. Bills Before the 2nd Regular Session of the 103th Legislature Related to Child Protective Services Oversight | | | | |
|---|---|---|---|---|
| **LD #** | **Title** | **Sponsor** | **Committee** | **Summary** |
| 1834 | An Act To Establish Ongoing Monitoring of Maine's Child Protective Services | Senator Diamond | HHS | This bill requires the Government Oversight Committee to create a system designed to monitor, on an ongoing basis, the DHHS, Office of Child and Family Services regarding the effectiveness of the office in protecting the safety of children in state care. The committee may create a working group that has the purposes of monitoring the policies and practices used by the office to maintain the safety of children in state care, reporting to the committee on a quarterly basis and providing an annual report to the committee and the Legislature. |
| 1850 | An Act To Ensure the Continuation of Services to Maine Children and Families through the Alternative Response Program | Representative Hymanson | HHS | This bill provides ongoing funding for the Department of Health and Human Services to continue the alternative response program services contract |
| 1853 | An Act To Support Improvements in Child Protective Services | Senator Claxton | HHS | This bill is a concept draft. This bill proposes to enact measures to support improvements in child protective services. |
| 1857 | An Act To Prioritize the Prosecution of Child Murder Cases | Senator Diamond | JUD | This bill requires the Attorney General to prioritize the investigation and prosecution of cases involving the murder of a child and to request the judicial branch to give priority in scheduling to those cases. |

# Report of the Government Oversight Committee

## 131st Maine State Legislature

## Second Regular Session

## Frontline Perspectives in Child Protection as Catalysts for Reform

**February 2024**

SEN. CRAIG V. HICKMAN, SENATE CHAIR

REP. JESSICA L. FAY, HOUSE CHAIR

MEMBERS:

SEN. LISA KEIM
SEN. RICHARD BENNETT
SEN. JILL C. DUSON
SEN. JEFF TIMBERLAKE
SEN. MIKE TIPPING
REP. AMY ARATA
REP. MARK BLIER
REP. MARGARET M. O'NEIL
REP. ANNE-MARIE MASTRACCIO
REP. H. SAWIN MILLETT, JR.

# MAINE STATE LEGISLATURE
# GOVERNMENT OVERSIGHT COMMITTEE

March 1, 2024

The Honorable Troy D. Jackson, President of the Senate
Members of the 131st Maine Senate
3 State House Station
Augusta, Maine 04333

The Honorable Rachel Talbot Ross, Speaker of the House
Members of the 131st Maine House of Representatives
2 State House Station
Augusta, Maine 04333

The Honorable Joseph P. Baldacci, Senate Chair
The Honorable Michele Meyer, House Chair
Members of the 131st Committee on Health and Human Services
100 State House Station
Augusta, Maine 04333

The Honorable Jill Duson, Senate Chair
The Honorable Margaret Craven, House Chair
Blue Ribbon Commission to Study the Organization of and Service Delivery by the Department of Health and Human Services
100 State House Station
Augusta, Maine 04333

Commissioner Jeanne M. Lambrew, Ph.D.
Maine Department of Health and Human Services
11 State House Station
Augusta, Maine 04333

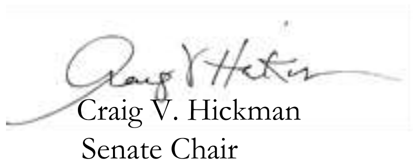
Director Bobbi Johnson
Office of Child and Family Services
Maine Department of Health and Human Services
2 Anthony Avenue
Augusta, Maine 04330

Dear Senators, Representatives, Health and Human Services Committee Chairs and Members, Blue Ribbon Study Commission Chairs and Members, Commissioner Lambrew, and Director Johnson:

On behalf of all of our colleagues on the Committee on Government Oversight of the 131st Maine State Legislature, we are pleased to transmit the following report: "Frontline Perspectives in Child Protection as Catalysts for Reform" (February 2024), which was adopted by a unanimous vote of those Members present on February 23, 2024. We offer this report for your consideration in the context of pending and future legislation, as well as internal Department reform initiatives. This report was developed following committee work sessions held since November 2023. For your reference, an Executive Summary may be found on page 5 of this report. We wish to emphasize that most of our recommendations received unanimous or nearly unanimous support among our Committee members, and we were greatly informed by those on the frontlines who were able to share with us their real-world experiences and vital perspectives.

Thank you for your attention to these matters.

Very truly yours,



Craig V. Hickman
Senate Chair

Jessica L. Fay
House Chair

cc: Members of the 131st Committee on Appropriations and Financial Affairs
Members of the 131st Committee on Judiciary
Members of the 131st Committee on Government Oversight

Enclosure: "Frontline Perspectives in Child Protection as Catalysts for Reform", A Report of the Committee on Government Oversight of the 131st Maine State Legislature (February 2024)

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## Executive Summary

**To those on the frontlines of child protection in Maine: We See You and We Hear You.**

The Government Oversight Committee of the 131st Maine State Legislature conducted a series of work sessions from November 2023 to January 2024, with the goal of understanding from those on the frontlines of child protection in Maine the extent and nature of needed reforms. The Committee heard from case workers, Guardians ad Litem, resource (foster) families, biological parents, mandated reporters, and others. **It became clear that many in key roles are simply overwhelmed, and that the general state of Department staff burnout, turnover, and vacancies increases the risks of potential negative consequences for the safety and well-being of vulnerable Maine children.**

From the work sessions, the Committee coalesced around certain key conceptual goals for reform and then reached consensus on specific relevant recommendations (see page 6 for a summary list, and page 8 for brief narratives). Most of our recommendations received unanimous or nearly unanimous support from Members.

**Stabilizing and supporting the child protection workforce is a critical and urgent need, and other needed reforms are unlikely to succeed or be sustainable otherwise.**

Many if not most of our recommendations may be pursued by Department leadership without additional legislation. We encourage Department leaders to carefully consider the extent to which such action may be taken, if not already underway, with the benefit of their expertise and experience. The Committee is also mindful of pending legislation that may address some of these matters, directly or indirectly, and which are summarized beginning on page 38 of this report.

We further welcome progress updates from the responsible Department at regular and reasonable intervals. **The Legislature is in a better position to perform its independent role and provide needed assistance when there is complete candor by the responsible Department as to the nature and extent of conditions and challenges. We anticipate a renewed commitment to collaboration and consistent communication about implementation of improvements.**

The Committee welcomes and appreciates the attention to these matters by Members of the Maine State Legislature, the Committee on Health and Human Services, and Department leadership.

## Recommendations of the Committee sorted by degree of consensus

| Item | | Current Bills | Vote of Committee[1] |
|---|---|---|---|
| Unanimous Recommendations | | | |
| **Category:** Front Line Staff | | | |
| A1 | Recruit and retain more case aides. | LD 2097 | Unanimous |
| A2 | Address burnout, turnover, vacancies, and workload. | | Unanimous |
| A3 | Provide specific coaching/mentoring opportunities. | | Unanimous |
| A4 | Increase and enhance ongoing training opportunities, including job shadowing. | | Unanimous |
| A5 | Create special teams to deal with complex cases. | | Unanimous |
| **Category:** Services for Families | | | |
| B2 | Improve family team meetings. | LD 857 | |
| **Category:** Resource Families and Other-Placement Support (Relative; Non-Relative; Other) | | | |
| D1 | Ensure placement options exist other than in hotels or hospital emergency departments. | | Unanimous |
| D2 | Improve home-based therapeutic and other resource family (foster care) resources and supports. | | Unanimous |
| D3 | Expand financial support to resource (foster) families and ensure timely reimbursements for appropriate expenditures. | | Unanimous |
| **Category:** Department Management, Plans, and Reporting | | | |
| E1 | Task the new Department director with an improvement plan containing short, medium, and long-term strategies and metrics, with regular public updates on progress and challenges. | | Unanimous |
| E2 | Require outcomes data. | LD 50 | Unanimous |
| E3 | Require specific public reporting on any hospital, hotel, or Department office stays (age, length of stay, district). | | Unanimous |
| E4 | Improve culture and job satisfaction. | | Unanimous |
| **Category:** The Courts | | | |
| F1 | Improve Access to Courts for Children and Families. | | Unanimous |
| F2 | Improve Child and Family Access to Legal Services. | | Unanimous |
| **Category:** Statute | | | |
| G1 | Initiate a Review of Statutes Relevant to Child Protection. | | Unanimous |
| **Category:** Technology | | | |
| H1 | Fix issues with critical Department technology (Katahdin). | | Unanimous |
| **Category:** Child Safety | | | |
| I3 | Address Department struggles to determine the safety of children 1) at the beginning of involvement during child protective investigations and 2) when deciding whether or not to reunify children with their parents. | | Unanimous |
| I4 | Share Safety Science recommendations with stakeholders and implement systemic recommendations. | | Unanimous |
| Recommendations with Bipartisan Majority | | | |
| **Category:** Child Safety | | | |
| I2 | Make consultation with child abuse pediatricians more routine in the child protective intake process and investigations. | | 11 in support |
| I5 | Join the National Center for Fatality Review and Prevention's Case Reporting System. | | 11 in support |

[1] Votes are of those members present for the specific vote. The GOC is a 12-member, bipartisan, bicameral Committee with equal representation between the two major political parties. All affirmative votes are bipartisan by nature of the Committee's structure.

| Item | | Current Bills | Vote of Committee[1] |
|---|---|---|---|
| I1 | Support the current child abuse pediatricians and hire more child abuse pediatricians through appropriate financial support from the state in addition to the pre-existing contract with the Department. | | 10 in support |
| **Category:** Department Management, Plans, and Reporting | | | |
| E5 | Review and assess informal policies and practices. | | 10 in support |
| **Category:** Services for Families | | | |
| B3 | Conduct an outside evaluation of the family team meeting model and create a structure for ongoing quality assurance monitoring. | | 10 in support |
| B1 | Increase access to mental health, behavioral health, substance use disorder, domestic violence, and other services for families, as well as housing and transportation. | LD 50; LD 353; LD 907; LD 1236; LD 1494; LD 1506 | 9 in support |
| B4 | Greater supports for new mothers with substance use disorder. | | 8 in support |
| B7 | Implement the Nurse Family Partnership model of public health nursing to prevent child maltreatment. | | 8 in support |
| **Category:** Separate Office of Child and Family Services from the Department of Health and Human Services (or study this idea) | | | |
| C2 | The Department should conduct a cost-benefit analysis and present a plan to committees of oversight with their position on Department restructuring. | | 8 in support |

## Items Considered that are not Recommendations of the Committee

| Items Considered that are not Recommendations of the Committee | | | |
|---|---|---|---|
| Item | | Current Bills | Vote of Committee[2] |
| **Category:** Services for Families | | | |
| B5 | Increase access to low-barrier wraparound services, with peer support and flex funds | | 6 in support |
| B6 | Expand financial assistance to low-income families | | 6 in support |
| **Category:** Separate Office of Child and Family Services from the Department of Health and Human Services (or study this idea) | | | |
| C1 | Proceed to separation | LD 779 | 6 in support |

[2] Votes are of those members present for the specific vote. The GOC is a 12-member, bipartisan, bicameral Committee with equal representation between the two major political parties. All affirmative votes are bipartisan by nature of the Committee's structure.

## Recommendations in Detail

On January 26, 2024, the Committee took a series of "straw" votes to indicate the extent of conceptual Member support for the recommendations listed below, after some preliminary action to refine the list.[3]

These recommendations may be pursued through legislation or Department action. Legislation pending in the Second Regular Session of the 131st Legislature, relating directly or indirectly to child protective services, is summarized in Appendix A, and referenced at times by LD No. throughout Part I.[4]

### A. Front Line Staff

With regard to stabilizing and supporting staff, the Committee recognizes that this is inherently a Department management function, and that it will be up to Department leadership to leverage existing authorized funds within appropriate procedures. Within that context, the Committee nevertheless urges that the following recommendations be pursued:

1. **Recruit and retain more case aides.**[5]
   (Unanimous Support of those Members Present) (See LD 2097)

   - The Committee heard consistently from case workers that they were required by necessity to handle a range of tasks which took vital time away from social work. These tasks included preparing certain documents for court, providing transportation for parents and children, and supervising children in hotels and emergency departments when other placement options were not available. The Committee also

[3] A recording of the January 26, 2024, GOC meeting may be found here: January 26, 2024 Committee Meeting. Specifically, from a list of proposed recommendations, one of the Chairs or another Member moved each "in" or "out", and offered amendments at times, which was then followed by Committee discussion and action. The recommendations listed in this report were those that were moved "in", including as amended, and then received a "straw" vote of the Committee to reflect relative support.

[4] Some Committee Members have sponsored or co-sponsored legislation currently pending. The vote tallies indicating conceptual support for the recommendations in this report are not intended to imply or represent final Member agreement with the terms of any legislation pending, which will be subject to the regular legislative process.

[5] One Member indicated he would extend this to case workers (increasing their numbers).

heard that the level of compensation offered case aides may be limiting interest in those positions.

2. **Address burnout, turnover, vacancies, and workload.**
(Unanimous Support of those Members Present)

- The Committee heard consistently from case workers that the workload was overwhelming and that this was continuing to be aggravated by frequent staff turnover, and the inability to recruit and retain additional workers for existing positions. As case workers continue to leave, those remaining are bearing an ever-increasing load, with negative cascading and compounding effects. It was also apparent that the minimal tenure and corresponding experience of so many existing caseworkers was far from ideal in confronting and addressing complex family situations.

3. **Provide specific coaching/mentoring opportunities.**[6]
(Unanimous Support of those Members Present)

- The Committee heard from case workers that guidance and assistance from others with more experience, including managers, was seen as vital, and was in shorter supply than it should be, including due to workloads.

4. **Increase and enhance ongoing training opportunities, including job shadowing.**
(Unanimous Support of those Members Present)

- The Committee heard that new case worker training was unrealistic and needed improvement and that there was a desire for more job shadowing early in the tenure of a case worker. Other initiatives should be pursued, as necessary and deemed appropriate.

5. **Create special teams to deal with complex cases.**
(Unanimous Support of those Members Present)

- The Committee urges the Department to increase and enhance multi-functional and cross-functional expertise in a manner best designed to engage in comprehensive and appropriate case management tailored to the needs of a child.

[6] Two Members generally supported dedicating positions to this role, whether or not that required an increase in authorized positions. A number of Members emphasized that this should be addressed within existing authorized staffing levels.

## B. Services for Families

1. **Increase access to mental health, behavioral health, substance use disorder, domestic violence, and other services for families, as well as housing and transportation.**
   (9 Members Support) (See LD 50; LD 353; LD 907; LD 1236; LD 1494; LD 1506)

   - The Committee heard from many on the frontlines that the availability of services and supports for families was falling short of the need, including at times when parents were subject to mandated timelines to take steps to address the very conditions resulting in the removal of children from the home, and to avoid potential termination of parental rights.

2. **Improve family team meetings.**
   (Unanimous Support of those Members Present) (See LD 857)

   - It was clear from the Committee work sessions that the family team meeting is an essential element of measuring and guiding progress toward family rehabilitation, and the Committee supports efforts to better ensure that this critical element functions effectively and meaningfully.

3. **Conduct an outside evaluation of the family team meeting model and create a structure for ongoing quality assurance monitoring.**
   (10 Members Support)

   - Please see the narrative under B.2., above.

4. **Greater supports for new mothers with substance use disorder.**
   (8 Members Support)

   - A number of the cases involving child fatalities under review by the Committee involved babies born (or even multiple babies born in succession) affected by substances. The Committee supports greater efforts to provide support to new mothers in this context.

5. **Increase access to low-barrier wraparound services, with peer support and flex funds.** (High-Fidelity Wraparound)
   (6 Members Support. **As such, this is <u>not</u> a recommendation of the Committee**).

   Please see: Intensive Care Coordination Using High Fidelity Wraparound (hhs.gov)

6. **Expand financial assistance to low-income families.**
   (6 Members Support. **As such, this is <u>not</u> a recommendation of the Committee**).
   (See LD 1877)

   - The Committee was divided on whether this was beyond the scope of the Committee's work. Among those in support, it was believed that this is an essential element of prevention to help avoid more families falling into crisis.

7. **Implement the Nurse Family Partnership model of public health nursing to prevent child maltreatment.**
   (8 Members Support)

   Please see, e.g.: Home Visiting Evidence of Effectiveness (hhs.gov)

**C. Separate the Office of Child and Family Services from the Department of Health and Human Services (or study this idea)**

1. **Proceed to separation.**
   (6 Members Support. **As such, this is not a recommendation of the Committee.**
   (See LD 779)

   - Among the points made by Members in support were the asserted futility and near-term inaction of waiting for yet another study, the lack of accountability, candor, and cooperation by responsible Department officials which forced the Committee to go to extraordinary lengths to demand accountability, that such an action would be seen as elevating the status and importance of child welfare as a priority, and that structural reform is vital and overdue.

- Among those in opposition, it was seen as an inefficient deployment of resources away from meeting immediate family needs and not fairly raised by the frontline perspectives received.

2. **The Department should conduct a cost-benefit analysis and present a plan to committees of oversight with their position on Department restructuring.**
   (8 Members Support)

   - Following Committee Member discussion, this recommendation was revised to specify that the Department itself come forward with a plan describing the costs and benefits of taking or not taking such an action. Two Members suggested that their support was not intended to convey a lack of support for separation now.

**D. Resource Families and Other-Placement Support (Relative; Non-Relative; Other)**

1. **Ensure placement options exist other than in hotels or hospital emergency departments.**
   (Unanimous Support of those Members Present)

   - The extent to which case workers and children were suffering from such placements was described vividly by many frontline workers, and was consistently cited as a key factor in staff burnout, turnover, and vacancies. The Committee believes it will be difficult if not impossible to achieve success with other reforms unless and until this situation is addressed.

2. **Improve home-based therapeutic and other resource family (foster care) resources and supports.**
   (Unanimous Support of those Members Present)

   - The Committee heard from many resource (foster) parents, who shared their frustrations with how they were treated by the Department, including when and for what they were reimbursed, how they felt marginalized as a voice for the children in their care, and how the demands placed on them were frequently unreasonable.

3. **Expand financial support to resource (foster) families and ensure timely reimbursements for appropriate expenditures.**
   (Unanimous Support of those Members Present)

   - Please see the narrative under D.2., above.

## E. Department Management, Plans, and Reporting

1. **Task the new Department director with an improvement plan containing short, medium, and long-term strategies and metrics, with regular public updates on progress and challenges.**
   (Unanimous Support of those Members Present)

   - It was well recognized by Committee Members that many of the negative conditions must be addressed by the Department leadership itself. It is vital that there be real, qualitative, and meaningful performance measures established, to drive Department improvement, to promote public confidence, and to permit the Legislative Branch to assist when needed. The Committee looks forward to a renewed commitment for candor, transparency, and accountability.
   - To the same end as the first bullet, the GOC requests that the Department develop a plan to improve child protection in Maine. The structure of this plan should include:
     - developing specific definitions of successful child protection in Maine;
     - detailing the obstacles that are in the way of achieving that success as well as factors that promote that success;
     - developing plans to remove the obstacles and/or enhance the factors that will move toward the definition of success.
     - It is imperative that the Department also include measurement of key metrics of *outcomes* that reflect the definitions of success rather than simply measuring the activities that are thought to be linked with that success.
     - Rational timeframes within which to expect to see results of the various activities should also be determined. The objective is to use the metrics to determine, as quickly as possible, if an activity is moving the Department toward success or not – and continuing, or scaling up those showing success; and discontinuing or changing the others.
     - The federal CFSR methodology may be a backbone structure for this effort, but the Committee is interested in greater specificity with respect to Maine's issues of child welfare than what may be linked to federal funding.
     - This overall plan should be presented to either the GOC or Committee of Jurisdiction (HHS) in stages – reflecting the development of the definitions of success, activities thought to be linked to that success, and then developing the key metrics with which to measure whether the activities chosen by the experts in the Department are working or not.
     - Once key metrics are decided, the GOC requests these updated measures be included in either the quarterly reports to the HHS Committee or a periodic (to be determined) update to the GOC.

   With this concerted effort, the GOC believes its Members, as well as those of the HHS Committee, will be in a better position to promote legislative changes or secure funding for pilot projects that could aid the Department and the State in achieving greater safety, well-being and permanency for children either involved with the child welfare system, or at risk of becoming involved.

2. **Require outcomes data.**
(Unanimous Support of those Members Present) (See LD 50)

- Among those supporting this recommendation it was expressed that obtaining answers on Department performance has been difficult and that better and more presentations of data readily accessible to the Legislature is desired.
- Also, see narrative under E.1, above.

3. **Require specific public reporting on any hospital, hotel, or Department office stays (age of child, length of stay, district).**
(Unanimous Support of those Members Present)

- Please see the narrative under D.1., above.

4. **Improve culture and job satisfaction.**
(Unanimous Support of those Members Present)

- The Committee views this as an indispensable element of a management plan for addressing those areas in crisis, and to build a more stable and sustainable model for child protection.

5. **Review and assess informal policies and practices.**
(10 Members Support)

- Among those Members supporting this recommendation, it was expressed that an appropriate "Department culture" transformation would logically include an assessment of formal and informal practices, and eliminating those which may be identified as unhelpful. It was also noted here that a recent reply from the Department confirmed a lack of formal policy on whether and when confidential information may be shared with others. To the extent this results in the Department defaulting to less sharing with critical stakeholders in the varying systems of child protection than might be appropriate, that should be carefully assessed and reconsidered.

## F. The Courts

1. **Improve Access to Courts for Children and Families.**
(Unanimous Support of those Members Present)

- The Committee is mindful that it has not yet had an opportunity to obtain the perspectives of Judiciary leadership, itself, during the Committee work sessions held in recent months, but that some feedback was received from others working in child protection. In this vein, the Committee looks forward to further discussions and initiatives by responsible parties.

2. **Improve Child and Family Access to Legal Services.**
(Unanimous Support of those Members Present)

    - Please see the narrative under F.1., above.

## G. Statute

1. **Initiate a Review of Statutes Relevant to Child Protection.**
(Unanimous Support of those Members Present)

    - Among those supporting this recommendation, it was recognized that this effort may not be feasible in the immediate term, but is nevertheless very important to pursue at some point.

## H. Technology

1. **Fix issues with critical Department technology (Katahdin).**
(Unanimous Support of those Members Present)

    - Quite a number of case workers and others, including the Child Welfare Ombudsman, expressed strong concerns about the Katahdin system's user interface, general ease of use, and/or effectiveness of data merges from the prior system. Some Committee Members also expressed reservations regarding the extent to which additional funds would be sought to fix a system that was not performing as expected, and that further processes would need to be engaged, including whether the contract with the vendor warranted any renegotiation or pursuit of other remedies.

## I. Child Safety

1. **Support the current child abuse pediatricians and hire more child abuse pediatricians through appropriate financial support[7] from the state in addition to the pre-existing contract with the Department.**
   (10 Members Support)

   - The Committee heard from two medical professionals who have served as forensic experts in child abuse evaluation. It was clear that this is a vital role in helping to establish, at the earliest possible interval, whether a child is in danger.

2. **Make consultation with child abuse pediatricians more routine in the child protective intake process and investigations.**
   (11 Members Support)

   Please see narrative under I.1., above.

3. **Address Department struggles to determine the safety of children 1) at the beginning of involvement during child protective services investigations and 2) when deciding whether or not to reunify children with their parents.**
   (Unanimous Support of those Members Present)

   - The Committee has heard consistently from the Child Welfare Ombudsman that Department performance in these regards requires significant improvement.

4. **Share Safety Science recommendations with stakeholders and implement systemic recommendations.**
   (Unanimous Support of those Members Present)

   - Please see narrative under I.3., above.

5. **Join the National Center for Fatality Review and Prevention's Case Reporting System.**
   (11 Members Support)

   - Please see [Our Role – The National Center for Fatality Review and Prevention (ncfrp.org)]

[7] What constitutes "appropriate financial support" will require further exploration through Department and legislative processes including possible MaineCare rate reform.

## Summary of Committee Work Sessions[8]

## January 5, 2024: Committee Members - Individual Priorities for Reform[9]

The following captures the number of Committee Members who provisionally indicated they were inclined to prioritize a particular reform, followed by their individual priorities as stated at the January 5, 2024, Committee Meeting.

**Category Counts**

| | |
|---|---|
| 9 | Improve recruitment, retention, and support for front line staff |
| 6 | Invest more in services for families |
| 5 | Separate OCFS from DHHS (or study this idea) |
| 4 | Improve support for resource (foster) families |
| 3 | Management review of OCFS |
| 3 | Improve culture of OCFS |
| 3 | Improve / invest more in court system |
| 3 | Prioritize best interest of children in family reunification |
| 3 | Ensure residential placement options vs. hoteling & ER placements |
| 2 | Statute review |
| 2 | Review Katahdin |

Senator Timberlake

1. Separate OCFS from DHHS and change the leadership
2. Revise Caseworker job description
3. Change OCFS culture/attitude
4. Establish family court system (Kentucky and Virginia examples)

Senator Bennett

1. Separate OCFS from DHHS
2. Fund more Case Aides and make the job more attractive
3. Address OCFS culture and improve communication
4. Family reunification: Address bias favoring mothers

[8] The Committee also met on November 1, 2023 to plan the approach to the subsequent sessions. The recording of that meeting may be found here: November 1, 2023 Committee Meeting.

[9] The recording of the January 5th meeting may be found at the following link: January 5, 2023 Committee Meeting.

Representative Blier
1. Residential options for children otherwise placed in hotels or hospitals
2. Improve caseworker retention, address job dissatisfaction

Representative Mastraccio
1. Review & assess OCFS policy changes; improve practice & address district office variation
2. Promote retention of Caseworkers and Case Aides
3. Residential housing to eliminate hoteling and ER stays
4. Improve prevention services. Use opioid settlement funds for family intervention services pilot
5. Family court system
6. Put child safety first in family reunification [Later endorsed foster family rights statute review]

Representative Keim
1. Case Aide pilot program (emergency measure bill)
2. Market research on foster family needs, pay rates, etc.
3. Separate OCFS from DHHS, revise organizational structure, analyze administration needs to eliminate redundancy (Lean Six Sigma)
4. Invest upstream in family services, use opioid settlement funds

Representative Millett
1. Support Caseworkers with better training, hiring & retention. Career ladder. Team approach.
2. Improve support for foster families
3. Reunification: make safety of children top priority
4. Address workplace culture at OCFS
5. Put more resources into investigations
6. Further implement Safety Science and learning from tragedies
7. Consider a separate OCFS
8. IT review of Katahdin

Representative O'Neil
1. Invest in more prevention services, address Mental Health and Substance Use service needs
2. Court system investments
3. Support Caseworkers: vehicles, technology, Case Aides, coaching and mentoring
4. Specialization for complex cases

Senator Duson
1. Request that OCFS leadership create a management improvement plan with metrics (with input from Caseworkers and families); GOC to review periodically

Senator Tipping
1. Staffing: improve recruitment and retention

2. Reform Mental Health, Behavioral Health & Substance Use Disorder services systems and education to support families and foster prevention
3. Improve performance at handoff points

Representative Arata

1. Support Caseworkers' quality of life. More case aides.
2. Support residential options, transitional housing
3. Katahdin [OPEGA should look at state software procurement]
4. Study commission about removing OCFS from DHHS, explore administrative bottlenecks
5. Study impact of cannabis on child welfare

Representative Fay

1. Improve Caseworker job quality (training, pay, workload, team approach)
2. Support families with services before there's immediate risk of harm
3. More respect for Caseworkers and casework

Senator Hickman

1. Improve support for foster families
2. Review child welfare statutes, including for foster parent rights and child's best interest

## December 13, 2023: The Committee heard from a range of frontline professionals, individual biological parents, and resource (foster) families[10]

Professionals

Mark Moran, LCSW, Chair of Maine Child Death and Serious Injury Review Panel

Opportunities to Improve Child Welfare Communication

1. Continue Family Team Meetings (FTMs) that include extended family members and service providers consistently throughout cases.
2. OCFS should proactively share information about children with education personnel (administrators, counselors, teachers) who are best positioned to monitor and support a child's safety.
3. Maine should join the National Center for Fatality Review and Prevention's Case Reporting System.

Recommended changes from the medical system perspective

1. Develop residential Behavioral Health Services for minors in emergency departments whose parents are unable or unwilling to care for them at home (but are not in OCFS custody).
2. Maine needs more child abuse pediatricians to accurately diagnose or exclude child maltreatment.
3. Maine should implement the Nurse Family Partnership model of public health nursing to prevent child maltreatment.

Top recommendations:

1. Address culture, workload, and staff turnover issues with OCFS frontline staff. Biggest issue is lack of work-life balance.
2. Improve consistency and quality of child safety investigations. Acknowledge that prevention is not always possible, and it is sometimes necessary to remove children from their parents.
3. Support case-specific and systemic child welfare reviews by various multidisciplinary groups in various settings to identify opportunities for improvement.

Dr. Amanda Brownell, Child Abuse Pediatrician and Medical Director at Spurwink Center for Safe & Healthy Families

1. Support the current child abuse pediatricians and hire more child abuse pediatricians through appropriate financial support from the state in addition to the pre-existing contract with DHHS.

[10] Written testimony may be found at the following link: December 13, 2023 Written Testimony. The recording of this meeting may be reviewed here: December 13, 2023 Committee Meeting.

2. Make consultation with child abuse pediatricians more routine in the child protective intake process and investigations.
3. Increase payment rates for child abuse evaluations.

Christine Alberi, Child Welfare Ombudsman

1. Address OCFS struggles to determine the safety of children 1) at the beginning of involvement during child protective investigations and 2) when deciding whether or not to reunify children with their parents.
2. Improve the availability of mental health services, substance abuse treatment, trauma informed services, domestic violence services, housing, and transportation.
3. Share Safety Science recommendations with all stakeholders and implement systemic recommendations.
4. Address Katahdin, the new child welfare database, which is difficult and time-consuming to use, especially for looking up family history.
5. Prioritize recruitment and retention of foster homes, both relative and non-relative resource homes.

Melissa Hackett, Maine Child Welfare Action Network

1. Strengthen and support the child protective workforce. Embed strategic consultation within the administration. Increase specialized office support staff, including dedicated positions for coaching and mentoring, legal secretaries, family team meeting facilitation, kinship and foster family support, visitation and transportation, and community services.
2. Expand low-barrier supportive services for families. Cash assistance, home visiting/public health nursing, aftercare services to prevent recurrence, behavioral health services, domestic violence services, substance use disorder treatment, peer support and flex funds.
3. Develop alternatives to hoteling and stays in offices. Identify kinship and resource families to provide respite for children coming into care.
4. Create a special unit in each district to review and manage complex cases with an interdisciplinary team approach.

Andrea Mancuso, Co-Chair of Maine Child Welfare Advisory Panel

1. Create an Office of Parent Counsel to strengthen the quality of representation appointed to parents in child welfare cases and ensure these legal professionals have the tools and resources they need to help their clients be successful and safe parents.
2. Offer the "Child Welfare Law Specialist" training and certification for attorneys, judicial officers and Guardians Ad Litem from the National Association of Counsel for Children and provide scholarships to interested attorneys.
3. Amend Title 22 to require the assignment of client directed attorneys to children age 10 and above in addition to Guardians Ad Litem (GALs).
4. OCFS should report quarterly on the number of children in custody who have stayed in hotels and in DHHS offices for more than six hours (age, length of stay, district).

5. Review the implementation of the Home Builders Program.
6. Align economic supports for parents, foster placements, and uncompensated visit supervisors. Update formal and informal policies and practices.
7. Conduct an outside evaluation of Maine's Family Team Meeting model and create a structure for ongoing quality assurance monitoring.

Ariel Piers-Gamble, Assistant Attorney General and Chief, Child Protection Division (did not make recommendations in her role)

1. Provided an overview of her office's structure and role in providing legal services in the realm of child protective services in Maine.
2. Noted that per statute, reunification efforts are mandatory for the Department but "cease reunification" decisions are discretionary for the Courts.
3. Described her office's representation on relevant panels, availability to provide relevant trainings, and participation in stakeholder groups in the context of policy development.
4. Observed the balances struck in current statute between the interests of children and parents.
5. Provided additional context to the Ombudsman's recent observation on the rate of judicial denial of preliminary protection orders, specifically, the lack of data on the extent to which any are amended or dismissed after a summary preliminary hearing, or how many requests are contemplated and not brought to Court.
6. Shared the challenges, found in other realms but also those distinct to this type of work, in maintaining necessary legal staffing, and that this extends to a range of court personnel and resources (e.g., trial time), as well.
7. Generally described her office's role in advising the Department on potential disclosures of child protection information to authorized recipients.

Biological Parents

Jamie Brooks

Shared her history:

Undiagnosed mental health issues.
Untreated substance use disorders.
Power and control dynamics.
Multi-generational conditions.

Suggested breaking the cycle is done with adequate services and support.
Stressed the importance of well-trained case workers to be "clear and kind".

Karen Tompkins

Karen Tompkins described her experiences as a parent who had received services in the past, and her role subsequently as a peer support for other parents. In addition to highlighting the challenges

associated with mental health and substance use disorders, she cited involvement with the child protective services system itself as a source of stress for families. She also read a letter on behalf of other parents which included the following:

> We collectively had a variety of experiences with child protective staff. Although not the norm, when we experienced positive relationships with caseworkers, there were common practices that made this possible. Most significantly, these caseworkers worked closely with our Family Teams (groups of our service providers and family/friend supports). They listened to the perspectives of other team members, and took those perspectives into consideration when making case decisions. The Family Team members who made the positive impact regularly told us that they wanted us to succeed in bringing our children back home.
>
> Resource parents who shared similar messages of hope also played an important role in successful reunification with our children. Some resource parents went out of their way to encourage and support our own growth and change, as well as caring for our children. A few of our relationships with resource parents were long lasting as they became true extended family. Peer support from other parents who had personally experienced the child protective system was a source of hope for those of us who had this service; those of us who did not have this support recognize it would have been helpful. Collectively, we agree that it is essential that parents are connected to somebody who provides unconditional positive support throughout the process.
>
> Many of the experiences that we did not find helpful were related to communication. Most of us did not understand what would happen next during our case, and when we asked, it was not explained in a way that made it easier to understand. It was hard not knowing what was going to happen, and this made it easier to imagine the worst-case scenario of losing custody of our children forever. While case workers are asked to give all parents a few documents when they first meet them that explains parents' rights and responsibilities, many parents aren't able [to] process what is being said after they are told their children are being removed. This information needs to be reviewed in subsequent visits when there may be more time for a conversation. Caseworkers get seven weeks of training to understand how the system works, but the vast majority of parents don't get any formal training, and they need their rights and responsibilities reviewed as many times as necessary. Expecting parents to learn how the system works on their own can make many issues more challenging, and make reunification less likely. Every parent should have access to training that explains their rights and responsibilities. Investing in peer support and educational services for parents can make a big difference.
>
> We preferred when our family teams were able to have hard conversations, sharing all the information they had with us, and telling the truth even when they thought there might be a strong reaction. We recommend that caseworkers and supervisors take the time to share whatever they can with families, tell them what they will be doing during the time it takes for a decision to be made, and help parents understand what they should be doing. Parents need transparency and to know what is going to happen, and it's important to help them understand the process and their responsibilities.
>
> Collectively, we had a variety of stressors in our lives that brought our families into contact with child protection. These included mental health issues, untreated substance use disorders (SUD), relationships with people who used violence to control us, and generational poverty. Each of our situations was unique and overwhelming, and getting services and support for the stressors in our

lives was critical. We needed care for our physical and mental health, and support to face old traumas from our own childhoods with honesty and courage. Some of us had Family Team members who helped us get resources for our children, addressed our housing situations with vouchers, and supported us as we juggled appointments and made life changes.

Some of the most important resources we received were not just formal services but opportunities: we first needed reliable income to meet our needs, and then a pathway to financial independence. Poverty is often mistaken for neglect, and it takes skill to know the difference. Many states have updated their definitions of neglect to clarify it as withholding a resource parents already have, not one that is absent in their household. We recommend investing in policies and programs that relieve immediate financial stress for families, while helping them build a path forward to new economic opportunities. We also recommend updating statute to clarify neglect as willful withholding, not a lack of financial resources.

It was equally important that everyone working with our families understood the other issues we were facing. Some of us experienced child protective staff or other providers who did not understand depression, and the deep mental obstacles that needed to be overcome in order to do the work. For some of us, our substance use increased initially when our children were removed, as a way to cope with the pain and grief we were experiencing. Some of us worried about how to pay for treatment, or didn't know about Medication Assisted Treatment (MAT). Substance use disorder touches many people, and relapse is not unusual. Things sometimes get worse before they got better, but people can and do change. A study by the U.S. Centers for Disease Control and Prevention showed that 75% of people with a substance use disorder find recovery.

Many parents want help, they just don't know how to ask, or they are fearful or feel shame. Access to mental health and recovery services are essential both during a crisis, and in order to maintain health over a lifetime. The current reality of long waitlists for services is not aligned with federal timelines for family reunification. We recommend developing more SUD and mental health recovery and treatment resources in every community, including more peer support services, and more opportunities to keep families safely together while parents are seeking treatment and making changes. Instead of expecting caseworkers to be experts in all of these topics, we also recommend establishing access for each district office to people who understand the issues of mental health, SUD recovery, domestic violence, and poverty.

Child removal causes lifelong trauma that affects the whole family, including parents, kids grandparents, and extended family, and can last for generations. Families don't have to stay in difficult places in their lives. We didn't stay there. The right support can help more parents make the changes needed to be the parents they want to be.

Thank you for your time and attention.

Resource (Foster) Families

Melanie Blair (See also "Unsupported", presented by Walk A Mile In Their Shoes, December 2023)

Communication – needs to be complete and honest to meet child needs and find correct

placement. This has not been satisfactory in her experience. Had a placement that resulted in violence by the placement toward one of her other children.
Negative Consequences for Challenging the Department.
High caseworker turnover – delays case resolution.
Reunification pursued at all costs.
Ombudsman does a fantastic job, but more ongoing oversight is needed.

Jessica Creedon

High caseworker turnover – who were bullied and mistreated for advocating.
Preservation of biological family is prioritized above foster family always.
More is needed from state above and beyond MaineCare for high needs children.
Adoption means less state support from State.
But if they do not adopt, the Department may place the child in a nursing home.

Deborah Hibbard Brito

Was adopted herself. Has a kinship placement.
Three main issues:

1. Re-traumatization from not following guidelines for parental rights termination.
2. Caseworker works for the parent, not the child. System should be child-centric.
3. Foster parents excluded from family team meetings. Need real information sharing.

Hannah Pelletier

Therapeutically licensed foster parent for 13 years.
Hoteling from the experience of a child and its negative impact.
There should be public data on numbers hoteling.
Lack of services.
Placement disruptions on top of removal from home and the negative consequences.
Not making good placement matches and supporting the available resource parents.
Kids with higher needs qualifying for higher rates and services, yet the home does not qualify for a therapeutic license, if home already has four kids under 16.
"Leveling" challenges. What care level is appropriate and lack of information about true level.
Parent's rights protected at expense of children's rights.
Ombudsman process takes longer than timeline when negative event takes its toll.
Nowhere else to go to challenge Department decisions, as a foster parent.

Ashley Pesek

Most of her kids have reactive attachment disorder.
Kids with dual system involvement (child protective and juvenile criminal)
Real change requires looking through all stakeholders' lenses.
Need to avoid unintended consequences in reform.
A totally overburdened system or series of systems.

Cited a case in which jeopardy was found by court on same day as reunification (trial home placement).
Cited other cases in which there were procedural and substantive shortcomings.
Hoteling children has many negative implications. Wildly inappropriate for child development and caseworker can no longer have neutrality with foster family who had to seek another placement.
Not all kids are prepared immediately to live with a family.
Placement waitlists and refusals.
Services not available in time needed to make a difference.
Cited one case in which there were thirteen placements in approximately as many months.
Need a place outside of a family at times. Understands the difficulties with group homes, but with hoteling and mismatched placements, trauma result.
Believes it is clinically inappropriate to have a child forced to be placed in a home at a time when that is what "sets their brain on fire."
Suggests some other kind of "supportive living."
She exceeds the number of placements to have a therapeutic license. But if children need the therapy, that needs to follow them to wherever they may be.
Permanency not being established timely. Cited one child in placements for nine years.
Caseloads too high.
Foster family attrition when feeling undervalued.
Waiting for court dates. Courts with inadequate trial time directing parties to make more agreements. May not be best outcome.
Systems beyond child welfare need reform.
Need plan for care gaps for foster parents.
More trauma training.

Deborah DeJulio

Foster parent for 23 years.
Has a therapeutic license.
"I'm done."
There is no support for foster families.
"We don't listen to foster parents—you are all biased."
Waiting too long to get into court.
Trauma to children during forced visits with biological parents.
"We know what they need. Can't get the services."
Biological parents need to work with the foster families, but most do not.
Foster Parent Bill of Rights does not really mean anything.
Travel restrictions create difficulties. Cannot take a child to Disney if parent vetoes it.

Stephanie Millette

Provides respite for teens who are in foster placements.
Shortage of foster homes for teenagers.
Uncertainty in placement makes for fragile placement. Child not knowing what is next.
There should be a "market" study of foster needs and foster placements before making a recommendation on what to do.
Resort to emergency rooms where services and placements lacking.

Dayna Pittiglio

Gave up foster license due to adopting child with complex medical needs.
Parents have all the rights and foster parents are seen as having an improper agenda.
Felt coerced and manipulated by the Department which made it hard to obtain services on child's behalf.
If a parent is unable to be safe around animals, they are not fit to be around children.
DHHS and Police information sharing needs improvement.

Ashley Collins

No longer accepting placements.
One placement remains unresolved four years later.
Case worker turnover in this case nine times.
Year long waitlist for services.
Not invited to family team meetings or provided information for first year.
Insufficient GAL visits.
Biological family rights are impacting child's needs and do not adequately consider foster perspectives.

Coreen Jurson

Children leaving system more traumatized than when entering.
Asked for help for a long time, but result was change in placement after 3 ½ years, which felt punitive. Given one hour, supervised "goodbye" visit (not even told it was "goodbye" at that time).
This was followed by an investigation of her.
She did clear her name.
Not sure what needs to change, but changes are needed.

Mary Jean Rumery

Feels she was lied to and abused by the Department.
Eventually was able to adopt children, but it was an ugly and too lengthy a process.
Feared for current placement.
Described differing treatment based on District.
Asserted that top leadership does/did not value foster parents (at least in one district).

Kelly Collins

Certified emergency room nurse.
Struggled to obtain services for foster placements.
Reunification process taking too long—increasing attachment disorder syndrome.
Foster parents need answers.

## December 6, 2023: The Committee heard from Commissioner Lambrew and Then-Acting Director Bobbi Johnson[11]

Acting Office of Child and Family Services Director Johnson

Shared her work and personal history.
Intends to prioritize the well-being and empowerment of staff.
Looks forward to continuing to work with community partners and the Committee.

Department of Health and Human Services Commissioner Lambrew

Shares frustration that performance on some key measures has worsened; staff vacancies have increased. Caseworker concerns are being looked into.
There is no place in Department for a supervisor to pressure a worker to work without pay.
Changes in recent years are not keeping pace with new dynamics, including substance use disorder epidemic and high cost of living.
Believes the change in OCFS leadership offers opportunity for a re-set. Will seek empathy and listening skills, in addition to technical capability.
Commits to improving the culture, including to make caseworkers feel valued and supported.
Looks forward to reviewing the recommendations of the Committee.

[11] The recording of this meeting may be found at the following link: [December 6, 2023 Committee Meeting.]()

## November 29, 2023: The Committee heard from Former DHHS Child Protection Leader Peter Walsh[12]

Vision: Eliminate child abuse and neglect in three years

Double the resources including federal, state, private, and other sources.

Prioritize child welfare in all other human services agencies.

Greatly increase support to frontline staff.

Develop a new category of service provider called Child Safety Specialist.

Send an immediate response person on all calls that come into the hotline.

Double the salaries of frontline staff.

Strengthen the caseworker advisory committee.

Rename DHHS to the Department of Child and Family Services.

Transfer unrelated services to other departments.

Use existing state surplus: whatever is necessary to eliminate child abuse and neglect.

[12] A recording of this meeting may be found here: November 29, 2023 Committee Meeting. Mr. Walsh testified in the afternoon.

## November 15, 2023: The Committee heard additional frontline perspectives[13]

Bethany Fournier – Resource Parent, Occupational Therapist and Executive Director of the Nonprofit Nanna's House

Ms. Fournier shared with the Committee her experiences working within a school district, and as a foster parent. She shared information on her nonprofit, Nanna's House, that aims to help ease the transition for children being placed into Foster Care. She hoped to create a home-style environment that a caseworker could bring a child to, and stated the nonprofit has a house ready to go but the Department responded by saying they did not think the idea was something that was needed or valuable.

Marsha Rogers – Retired CASA Guardian Ad Litem

Ms. Rogers shared her experiences with working with families as a Guardian Ad Litem (GAL) and as a Foster Parent. She noted times when a child who was not treated for the trauma of Foster Care had bad behaviors come out years later that affected their schooling abilities. She hoped that there could be plans for these children in the future to give them tools before the change of behavior happens to help prevent a negative outcome.

Sandra Hodge – Founding member of the Child Death and Serious Injury Review Panel, past Program Specialist for the Child Protective Services central office.

Ms. Hodge explained that the Child Death and Serious Injury Review Panel started as a mission to bring together the communities and resources within the state to bear on the issue of Child Abuse and Neglect. She added that there was a wonderful reservoir of information and experience that needs to be tapped.

Kerry Hewson – CASA Guardian Ad Litem and School Nurse

Ms. Hewson shared her experiences as a CASA GAL and a School Nurse. She shared disappointment in Maine for not asking for more grants to fund more resources for children within the schools. She suggested implementing a less complicated system so that it is easier for staff to collect data and easier for people to receive more resources.

[13] The recording of this meeting may be found here: November 15, 2023 Committee Meeting. The additional frontline perspectives were heard in the afternoon.

MaryAnne Spearin – Superintendent of Schools, Washington County

Ms. Spearin shared her experiences with children as a middle and high school principal for 10 years. She stated that the system's inadequate support of the health and wellness of the students and families makes educating those children more difficult when the basic needs of those kids are not being met. She noted families being on wait lists for services for over a years' time. She added that another area of concern would be the lack of communication between the Department and the school systems as it is a disjointed system of services for the greatest at-risk students. She stated that calling the report line sometimes does not bring fast enough results when a child is fearful of going home from school, so the school has started resorting to directly calling known caseworkers to ask for someone to come help. She strongly felt that the Department and the schools should work together in a collaborative way to figure out solutions for these students. She mentioned having responses while reporting stating that the children were too old to be helped and she thought it was wrong to suggest that kids of legal dropout age are past the cutoff for help.

Stacey Henson-Drake – Caseworker

Ms. Henson-Drake shared some statistics on her district being high in numbers of cases, crime and child deaths or serious injuries. She noted that there were multiple children within her district that have been housed in hotels for months requiring tons of mandatory overtime to staff the overnight hours. Ms. Henson-Drake stated that the starting pay for case aides is less than that of Burger King and that it was hard to find a qualified workforce at such an abysmal hourly rate. She stated that the pay of the caseworkers is okay but that it is the work life balance that makes it hard to keep the job. Ms. Henson-Drake stated that her local office communication was good, but that she had only met the then-Director Todd Landry twice. She noted there was no communication about what the state planned to alleviate some of the burden. Ms. Henson-Drake answered that she has been in this role since 2021, which makes her a veteran staffer.

Priscilla Girard – Guardian Ad Litem and LCSW

Ms. Girard shared her experiences as a GAL and her expertise of providing clinical assessments and serving as an expert witness for the Department, in processing the trauma that children have gone through.

## November 8, 2023: The Committee heard frontline perspectives from a number of caseworkers, and others[14]

Maureen Cote, Caseworker

1. Workloads have continually increased, are not sustainable, and do not allow for adequate service to children and families.
2. Required overtime, especially overnight shifts caring for children in hotels or hospitals, are negatively affecting morale, well-being, and staff retention.
3. Compensation is not adequate to address increases in the cost of living, and staff are currently working without a contract.
4. Field training for new caseworkers is inadequate.

Diane McGonagle, Caseworker

1. Establish field training units in each district office. New caseworkers are guided by supervisors for only their first two investigations, which is not adequate.
2. Develop residential options for high-need children to put an end to hoteling.
3. Reduce mandatory and short-notice overtime.

Mandy Baird, Caseworker

1. Required overtime and hoteling children is a barrier to staff retention.
2. Caseworker workloads are too high.
3. Add staff to assist with administrative and legal tasks.

Sarah Ament, Caseworker

1. Heavy workload is unmanageable.
2. Wait times for services for parents in reunification are counterproductive to the process. Invest in more mental health and substance abuse treatment clinicians.
3. Court delays have a negative impact on ability to meet reunification timelines.
4. Staff should be paid more for mandatory overtime.

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[14] The recording of this meeting may be found here: November 8, 2023 Committee Meeting. The written versions of testimony may be found at the following link: November 8, 2023 Written Testimony.

Rochelle Kadema, Caseworker

1. Overtime hoteling shifts are not voluntary.
2. Legal documentation expectations are burdensome; workers need more support.
3. Documenting case work in Katahdin is clunky, disorganized, and inconsistent across workers.

Dean Staffieri, President, Maine Service Employees Association. 28 Year Tenure in OCFS

1. Mandatory overtime expectations are unreasonable.
2. Katahdin, the child welfare information system, does not allow information to be efficiently saved and retrieved.
3. Constant shifting of policies and priorities makes it difficult for caseworkers and supervisors to develop expertise and hinders continuity and efficiency.
4. Lack of reliable transportation services, parent-child visitation supervisors, and residential treatment options for the most vulnerable children are significant obstacles.
5. There are not enough mental health clinicians to meet families' needs.
6. Inadequate staff recruitment and retention contribute to unmanageable workloads.

Former Senator Mike Carpenter (current and longtime Guardian ad Litem)

1. 22 M.R.S. § 4002(10)(B) ("Serious mental or emotional injury or impairment now *or in the future…")* – the "drip drip drip" of harm over time
2. Problems with Katahdin system
3. Whether lack of pre-filing cooperation could be grounds for keeping an investigation open
4. Could a GAL be empowered to check in on a family post-case-closure or other resolution, at some interval in the future, as an added safeguard

## Other Perspectives: Summary of representative frontline perspectives shared ith the OPEGA Director confidentially and without attribution[15]

The perspectives provided directly to the OPEGA Director were generally consistent with those provided directly to the Committee, and centered on:

- Hoteling and Emergency Room Coverage
- Availability of Resource (Foster) Family Placements
- Availability of Services (Mental and Behavioral Health, Substance Use, Other)
- Other residential options for some children hard to place or in immediate need following removal
- Case worker burnout, turnover, and vacancies
- Mandatory overtime; pressure to work uncompensated
- New case worker training (more job shadowing desired)
- Katahdin (IT system) functionality, user interface, and data merge from MACWIS
- Leadership support and understanding and consideration of frontline conditions and perspectives
- Support and resources ($) for foster families, reasonable expectations, and a greater voice in a child "best interest"-centered process
- Need for better data on outcomes, not just outputs
- Learn from negative events and share lessons learned with frontline
- Ability of OCFS to meet mission
- Structured Decision Making and whether case workers still have room for discretion and judgment
- More support for transportation, legal paperwork, and other matters freeing case workers to focus on investigation and social work
- After hours (night shift staffing) not yet realized
- Whether foster families may have greater access to information about case plans and statuses
- Better early intervention/prevention

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[15] In an effort to facilitate the Committee's direct review of these matters, the OPEGA Director assisted in identifying and interviewing frontline professionals who later spoke on the record to the Committee or privately with the OPEGA Director. The OPEGA Director provided other facilitation in his role as lead support for the Committee, including in tracking and helping assemble the elements of this report. This report is not the product of any OPEGA analysis or evaluation. The views expressed are those of the Committee, individual Members, or individuals offering perspectives in connection with the Committee's review. Relevant work performed by OPEGA at the direction of the Committee is summarized in Appendix C of this report.

- Better risk assessment
- There are different types of case workers, and at times there are equity concerns over pay incentives for some and not others; there are also times when the Department is competing with itself when case workers are incentivized to take jobs elsewhere in the Department (e.g., Adult Protective).
- Older youth "aging out" without adequate support.
- Ever growing impact of drugs
- More and better coordination with other elements involved in child protection, and interdisciplinary teams
- Court schedules
- Compensation

## Some additional observations from those sharing with the OPEGA Director ("Food for Thought")

From a Guardian ad Litem: Beware the false dichotomy that it is "parent's rights versus children's rights." The system needs to protect both. Some of these are Constitutional rights.

From a case worker: No plan of reform will succeed unless and until burnout, turnover, and vacancies are addressed. Hoteling and Emergency Room stays as they are occurring are not fair to kids and not fair to case workers.

From a parent's attorney who has also served as a GAL: The system is built on the false premise that there are services available, including available timely, and this is not the case, especially in more rural areas of the state.

From a number of case workers: Job shadowing is seen as key to better training of new case workers, including to provide realistic expectations about actual conditions to be faced.

From a community service provider: We must be clear about what outcome metrics define success for our child welfare system and the children and families engaged in services. For me, I would like to see a dashboard that outlines outcomes for core goals and operational functions:

- o Safety of children referred to OCFS and those already in state custody.

- Wellbeing of children under OCFS custody – especially focused on educational progress, health care access, and psycho-social well-being and sense of safety and belonging for children.
- Permanency – not only the percentage of children that achieve permanency, but the placement history and speed to which permanency is achieved.
- Operational management outcomes for OCFS – metrics related to the structure, financing, management, and personnel outcomes from the Department. It would be helpful to be shown more early information about the financing and expenses, organizational charts, service spectrum and utilization, strategic priorities, and personnel recruitment and retention of staffing outcomes for OCFS.

Data and information should be presented and routinely discussed by the Administration, Legislature, and community stakeholders that allows for identification of system deficits and opportunities for improvements. Reforming a child welfare system cannot be solely based on the most horrific child death cases and should also not accept summaries not backed by specific evaluation metrics.

## **Appendix A:** Legislation of interest as of 2/1/2024

| LD # | Title | Summary | Sponsor | Committee Public Hearing/ Work Session |
|---|---|---|---|---|
| | | **CPS** | | |
| LD 50 | An Act to Prevent Child Abuse and Neglect by Developing a System to Ensure Child and Family Well-being | This bill is a concept draft pursuant to Joint Rule 208. This bill, as emergency legislation, proposes to ensure that a forthcoming statewide child abuse and neglect prevention plan is developed and funded in order to provide access to services, develop resources for family stabilization and require outcomes data on the provision of services and resources. | Rep Meyer | HHS<br>Carried Over |
| LD 500 | An Act to Improve the Office of the Child Welfare Services Ombudsman | This bill is a concept draft pursuant to Joint Rule 208. This bill would make changes to the program established to provide ombudsman services to the children and families of the State regarding child welfare services provided by the Department of Health and Human Services. | Sen Keim | HHS<br>Carried Over<br>Public Hearing<br>**1/31/24 ONTP** |
| LD 779 | An Act to Create a Separate Department of Child and Family Services | This bill creates a new Department of Child and Family Services and transfers the functions of the Department of Health and Human Services that relate to child and family services and child welfare to the new department. The Department of Child and Family Services will have a commissioner appointed by the Governor and confirmed by the Legislature as is the current Commissioner of Health and Human Services. The bill also establishes provisions for transferring functions to the new department. | Sen Timberlake | HHS<br>Carried Over<br>Public Hearing<br>1/11/24 |
| LD 857 | An Act to Improve Family Team Meetings in Child Welfare Cases to Ensure Better Outcomes for Children by Providing Adequate Funding | This bill is a concept draft pursuant to Joint Rule 208. This bill proposes to enact measures to improve family team meetings in child welfare cases to ensure better outcomes for children by providing adequate funding to support the full implementation of family team meetings, including neutral facilitation at critical case points and training and coaching for all staff. | Sen Bailey | HHS<br>Carried Over<br>Public Hearing<br>1/16/24 |
| LD 878 | An Act to Improve Child Welfare | This bill is a concept draft pursuant to Joint Rule 208. This bill would improve child welfare by making changes to the child welfare system. | Sen Keim | HHS<br>Carried Over |
| LD 1725 | An Act to Strengthen Legislative Oversight of Government Agencies and Programs by Providing the GOC Access to Confidential Records. | This bill provides that the Government Oversight Committee may receive information and records that are privileged and confidential and that that information and those records are exempt from public disclosure. | Sen Hickman | State and Local<br>Carried Over |
| LD 1788 | An Act to Establish the Office of the Inspector General of Maine Child Protection | This bill establishes the Office of the Inspector General to investigate cases of death, serious injury and abuse or neglect of children in state custody or receiving child welfare or juvenile justice services. | Sen Baldacci | HHS<br>Carried Over<br>Public Hearing<br>1/11/24 |
| | | | | |
| LD 2049 | An Act to Increase Safety for Child Welfare Services Workers | This bill exempts certain motor vehicles used regularly for work protecting the welfare of children from the requirement that state-owned vehicles display special registration plates. | Rep Stover | Transportation<br>Public Hearing<br>2/1/24 |
| LD 2095 | An Act to Require Reporting of Child Abuse and Neglect to Military Family Advocacy | If an allegation of abuse or neglect of a child against a parent or legal guardian of a child is investigated, this bill requires the Department of Health and Human Services to | Sen Jackson | HHS<br>Public Hearing<br>**1/31/24 OTP-AM** |

| LD # | Title | Summary | Sponsor | Committee Public Hearing/ Work Session |
|---|---|---|---|---|
| | Programs | collect information concerning the military status of the parent or legal guardian and share information about the allegation with the appropriate military authorities. It also directs the department to negotiate a memorandum of understanding with family advocacy programs at military installations. | | |
| LD 2097 | Resolve, to Establish a Pilot Project to Alleviate the Staffing Crisis in the Child Protective Services System | This resolve directs the Department of Health and Human Services to increase staffing in the department's Office of Child and Family Services by developing and implementing a pilot project in the office for the recruitment and employment of case aides in the child protective services system for those areas of the child protective services system where there is the greatest need for assistance, as determined by the department. The pilot project must include a public recruitment campaign that targets retirees and other persons not in the workforce. The department is directed to submit a report addressing the implementation and effectiveness of the pilot project and making recommendations regarding further recruitment and employment efforts to the joint standing committee of the Legislature having jurisdiction over health and human services matters, which may submit legislation to the 132nd Legislature in 2025 to continue or expand the pilot project. | Sen Keim | HHS<br>Public Hearing<br>1/31/24 |
| | | **CPS Related** | | |
| LD 353 | An Act Concerning Substance Use Disorder, Treatment, Recovery, Prevention and Education | This bill is a concept draft pursuant to Joint Rule 208. This bill would improve and expand treatment and recovery services for persons with substance use disorder, strengthen prevention efforts and modernize education requirements for clinicians. | Sen Farrin | HHS<br>Carried Over<br>Public Hearing<br>1/24/24 |
| LD 653 | An Act to Support Constitutionally Required Public Defense by Creating the Maine Office of Public Defense Services | This bill creates under the supervision of the Maine Commission on Indigent Legal Services the Maine Office of Public Defense Services, transfers the duties relating to the provision of legal services from the commission to the office and changes references to the executive director of the commission to the director of the office. | Sen Keim | Judiciary<br>Carried Over |
| LD 907 | An Act to Meet the Needs of Individuals with Severe Behavioral Health Diagnoses | This bill is a concept draft pursuant to Joint Rule 208.<br>C-A (H-496): This amendment replaces the bill, which is a concept draft. It requires DHHS to establish a contingency fund to provide supplemental assistance for children and adults with severe behavioral health diagnoses when those needs are not otherwise met by existing state or federal programs. The fund is a nonlapsing fund, and expenditures are capped at $100,000 per fiscal year. The funds may be used to support additional staffing, enhanced reimbursement rates, physical accommodations or other identified needs. Expenditures from the fund must be used to supplement, not supplant, other departmental expenditures. | Rep Stover | HHS<br>Carried Over |
| LD 1236 | An Act to Increase the Provision of Children's Behavioral Health Services in Rural Areas and to Provide Support for Families of Children | This bill requires the Department of Health and Human Services to expand children's behavioral health services for children in families involved in the child welfare system in rural areas.<br>C-A (H-495): This amendment changes the bill to a resolve. It removes requirements related to faculty team meetings | Rep Medigan | HHS<br>Carried Over<br>Work Session |

| LD # | Title | Summary | Sponsor | Committee Public Hearing/ Work Session |
|---|---|---|---|---|
| | Receiving Services | and reimbursement rates for Chapter 101: MaineCare Benefits Manual, Chapter III, Sections 28 and 65 services. It requires the Department of Health and Human Services to offer grants and incentives to providers to expand into rural areas to provide services to children and adults in families involved in the child welfare system. It provides an appropriation of $500,000 in each year of the biennium for this purpose. | | |
| LD 1494 | An Act to Help Address the Worker Shortage in Behavioral Health Care Services by Allowing Provisional Licensure and Providing for Reimbursement for Out-of-state Licensees | This bill requires the Board of Counseling Professionals Licensure to grant a provisional license for up to 90 days to a counseling professional licensed in another state or an applicant who has completed the requirements for licensure in this State upon receipt of an application for licensure. | Rep Crafts | HCIFS<br>Carried Over<br>**1/16/24 ONTP** |
| LD 1506 | Resolve, Directing the Department of Health and Human Services to Study the Scarcity of Licensed Clinical Behavioral Health Professionals Across the State | This resolve requires the Department of Health and Human Services to convene a stakeholder group to review issues related to the training and recruitment of clinical behavioral health care professionals. The resolve requires the department to submit a report related to the study to the Joint Standing Committee on Health and Human Services and authorizes the committee to report out a bill relating to the report.<br>C-A (H-209): It adds representatives of the Consumer Council System of Maine, the Department of Labor and the Department of Professional and Financial Regulation as members of the stakeholder group. It authorizes DHHS to contract for services to convene, facilitate and provide research for the stakeholder group. + other changes.<br>S-A (S-185): This amendment removes the emergency preamble and emergency clause. | Rep Sargent | Health Coverage, Insurance & Financial Services<br>Carried Over |
| | | | | |
| LD 1877 | An Act to Reduce the Number of Children Living in Deep Poverty by Adjusting Assistance for Low-income Families | This bill changes the policy goal of the provision of assistance to low-income families to allow those families to live with economic stability and secure access to health care, based on reliable market data. The bill adjusts the standard of need for assistance and the maximum amount of monthly assistance to a standard and amount based on the federal poverty level. The bill increases the pass-throughs of child support collections. The bill provides for a clothing allowance and payment for certain transportation support services and sets a lower limit on the amount of the special housing allowance for families receiving assistance under the Temporary Assistance for Needy Families program. The bill prohibits DHHS from requiring verification of the use of payments for support services. | Rep Meyer | HHS<br>Carried Over<br>Public Hearing<br>2/1/24 |
| LD 1975 | An Act to Implement a Statewide Public Health Response to Substance Use and Amend the Laws | This bill establishes the Substance Use, Health and Safety Fund in the Department of Health and Human Services. Money deposited in the fund must be used by the | Rep Crafts | HHS<br>Carried Over<br>Public Hearing |

| LD # | Title | Summary | Sponsor | Committee Public Hearing/ Work Session |
|---|---|---|---|---|
| | Governing Scheduled Drugs | department to oversee, approve and provide grants and funding to agencies, organizations and service providers, including the federally recognized Indian tribes in this State and service providers that are affiliated with federally recognized Indian tribes in this State, to increase voluntary access to community care for persons who need services related to substance use, as set forth in the bill. By June 30, 2024, and annually thereafter, the Legislature must appropriate to the fund an amount sufficient to fully fund the services as set forth in the bill. The bill repeals the laws that make possession of a schedule W, X, Y or Z drug and use of drug paraphernalia a crime. It also repeals the laws governing the civil violation of use of drug paraphernalia and possession with intent to use drug paraphernalia. | | 1/17/24 |
| LD 2009 | An Act to Prevent Abandonment of Children and Adults with Disabilities in Hospitals | This bill requires a hospital to discharge a minor or an adult with a disability who is under guardianship to the care of a parent or guardian no later than 48 hours after the attending physician has determined the minor or the adult with disabilities is safe for discharge, and if a parent or guardian does not take custody of the discharged minor or the discharged adult with a disability within that period, the hospital is required to notify child protective services or adult protective services, as appropriate, which must then take custody of the minor or the adult with a disability. | Rep Stewart | HHS<br>Carried Over<br>Public Hearing<br>1/16/24<br>Work Session<br>**1/25/24 OTP-AM** |
| | | | | |
| LD 2050 | An Act to Expand Accreditation Options for Laboratories That Conduct Blood-alcohol or Drug Testing | Under current law, a laboratory certified under the federal Clinical Laboratory 14 Improvement Amendments of 1988 may test blood samples to determine blood-alcohol 15 level or the presence of a drug or drug metabolite. This bill adds an additional accreditation 16 option for laboratories | Rep Meyer | HHS<br>Work Session<br>**1/18/24 OTP** |
| LD 2082 | An Act to Ensure the Financial Stability of Behavioral Health Services Providers and Housing Assistance Providers | This bill requires the Department of Health and Human Services to pay administrative expenses and interest charged on lines of credit or loans accessed by behavioral health services providers and housing assistance providers when a delay in department contract award, finalization or payments requires the provider to access the line of credit or loan. | Sen Bennett | HHS<br>Public Hearing<br>1/24/24<br>Work Session<br>2/6/24 |
| LD 2105 | Resolve, to Protect and Enhance Access to Behavioral Health Services in Androscoggin County and Surrounding Communities | This resolve directs the Department of Health and Human Services to provide emergency funding to cover operating losses associated with providing acute behavioral health care services provided by St. Mary's Regional Medical Center in Lewiston to ensure that those services can be continued and expanded to meet urgent needs in Androscoggin County and surrounding communities while avoiding curtailment of other critically important health care services in the region. The resolve appropriates $10,000,000 in fiscal year 2024-25 for that purpose. The resolve provides that funds must be disbursed by July 1, 2024. | Sen Rotundo | HHS<br>Public Hearing<br>1/24/24<br>Work Session<br>2/6/24 |

## **Appendix B:** Supporting Documents

Nov 9, 2023 – Letter from OPEGA Director on behalf of the GOC to Commissioner Lambrew of DHHS on:

- Vehicles;
- Staffing;
- Exit interviews;
- Katahdin database management system; and
- Payments to resource families.
  https://legislature.maine.gov/doc/10753

Dec 6, 2023 – Response from Commissioner Lambrew: https://legislature.maine.gov/doc/10481

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Dec 15, 2023 – Letter from OPEGA Director on behalf of the GOC to Acting Director Johnson of OCFS regarding:

- Children in Emergency Departments;
- Standards of information sharing with medical and educational personnel;
- MaineCare's Section 23 relating to child abuse assessment;
- Numbers of resource families;
- Remote work policies and data for OCFS; and
- Children in Hotels.
  https://legislature.maine.gov/doc/10754

Jan 26, 2024 – Response from now Director Johnson: https://legislature.maine.gov/doc/10703

Hotels Placements by Child, Month, and District. https://legislature.maine.gov/doc/10704

Emergency Department Stays by Month based on data required by LD 118.
https://legislature.maine.gov/doc/10705

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January 26th Testimony of Direct Johnson: https://legislature.maine.gov/doc/10758

January 26th Testimony of Commissioner Lambrew: https://legislature.maine.gov/doc/10759

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Jan 31, 2024 Letter from OPEGA Director on behalf of the GOC to OCFS Director Johnson asking for further detail regarding hospital and hotel stays by children.
https://legislature.maine.gov/doc/10755

Feb 8, 2024 – Response to Jan 31 letter from Commissioner Lambrew
https://legislature.maine.gov/doc/10756

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Feb 8, 2024 – Letter from Commissioner Lambrew to Sen Hickman regarding reorganization of the Office of Child and Family Services: https://legislature.maine.gov/doc/10757

# **Appendix C:** A Compendium: Oversight of Child Protection Services, 2018 – Present Conducted at the Direction of the Government Oversight Committee by the Office of Program Evaluation and Government Accountability

Since 2018, at the direction of GOC, OPEGA has undertaken a number of reviews and reported on a broad range of matters in the field of child protection services in Maine. The following pages present a list of OPEGA publications on child protectives services from 2018 – 2023, and include OPEGA's findings, recommendations, and other considerations for OCFS and the GOC. GOC meetings and public hearings to discuss these issues are detailed after each report summary.

| **2018** | **Report regarding the cases of Marissa Kennedy and Kendall Chick** |
|---|---|
| Information Brief: Maine's Child Protection System – A Study of How the System Functioned in Two Cases of Child Death by Abuse in the Home | |

OPEGA reviewed and analyzed records of entities involved with the cases of Marissa Kennedy and Kendall Chick. We also reviewed statutes, rules, policies and procedures, and obtained additional information through interviews.

OPEGA identified a number of potential areas of concern or improvement in the child protection system with the expectation that these observations will help inform the GOC and OPEGA in consideration of potential areas of focus for a broader review of Maine's Child Protection System. The potential areas OPEGA identified in no particular order of priority include:

- guidance and training for mandated reporters, including expectations for what constitutes "reason for suspicion" for those in various roles;
- timeliness of answering phone calls regarding potential child abuse and neglect by OCFS Intake workers via the statewide, toll-free number;
- timeliness and comprehensiveness of OCFS and ARP assessments of risk for a child or family and junctures at which a comprehensive re-assessment of risk could be or should be conducted;
- appropriateness of caseloads and adequacy of supervision and training of OCFS and ARP staff;
- compliance with policies and procedures, and consistency and appropriateness of decisions made, by caseworkers and supervisors in OCFS Central Intake and District Offices;
- compliance with contractual obligations, and consistency and appropriateness of decisions made, by ARP caseworkers and supervisors;
- factors that impact OCFS or ARP decision-making on appropriate action to take in response to assessed risk levels, and information received or situations observed with a child or family;
- extent to which OCFS and ARP monitor whether families are participating in voluntary services intended to reduce the risk of child abuse and neglect and take action when they are not;
- extent to which mandated reporters, OCFS and ARP seek to verify, and can verify, information reported by a child's parents;

- effectiveness of the child protection system in identifying and responding to child abuse/neglect risks that are not considered to be imminent physical safety risk, i.e. emotional maltreatment, neglect, truancy; and
- extent and manner of communication and information exchange among the various key entities that are part of the child protection system including schools, law enforcement, health care providers, counselors and therapists, community service providers; OCFS Intake, OCFS Field Offices and ARP providers.

**Discussion and GOC Actions:**

- GOC Meeting 05-24-2018
  - GOC discussion of Information Brief Presented by OPEGA. https://legislature.maine.gov/doc/2335
- GOC Meeting 05-31-2018.
  - Public Comment on OPEGA Report: Gov LePage, Senators & Representatives from HHS Committee, various experts and members of the public. https://legislature.maine.gov/doc/2352
- GOC Meeting 06-14-2018.
  - Committee Discussion of Information Desired for June 28th Work Session https://legislature.maine.gov/doc/2364
- GOC Work Session 06-28-2018.
  - **GOC Passed motion to subpoena Commissioner of DHHS to appear before GOC. Passed motion to direct OPEGA to add a project to its workplan regarding perspectives of front-line CPS workers.** https://legislature.maine.gov/doc/2381
  - OPEGA's Areas of Concern & Potential Next Steps Document for 06-28-2018 GOC Work Session https://legislature.maine.gov/doc/2354
  - Additional Information Requested by GOC for their 6-28-2018 Work Session https://legislature.maine.gov/doc/2355
- GOC Meeting 07-10-2018.
  - Questioning of Commissioner Hamilton of DHHS appearing due to subpoena. https://legislature.maine.gov/doc/2382
- GOC Meeting 09-27-2018.
  - Review of Summary of legislation enacted during Second Special Session of the 128th Legislation related to child protective services. https://legislature.maine.gov/doc/2517

**CPS-Related Legislation Enacted during the 2nd Special Session of the 128th Legislature:**

- **LD 1920 – An Act to Modify the Expungement Requirements for Records under the Child and Family Services and Child Protection Act – P.L. 2017, c.472**
  - Current law governing records held by DHHS in connection with the department's child protective activities requires the department to maintain unsubstantiated child protective case records for no more than 18 months (except some unsubstantiated records related to certain persons eligible for Medicaid Services under the federal Social Security Act Title XIX which are retained for 5 years). Public Law 2017, chapter 472 increases that retention period to 5 years.
- **LD 1921 – An Act to Grant the Department of Health and Human Services Access to criminal History Information to Achieve the Purposes of the Child and Family Services and Child Protection Act – P.L. 2017, c.473**

- Current law authorizes DHHS to take appropriate actions to help prevent child abuse and protect the health and safety of children (22 MRSA §§4003 and 4004). Public Law 2017, chapter 473 adds to the list of those appropriate actions, the authority to request and receive certain confidential criminal history record information (and public criminal history information) from the Department of Public Safety as defined under the Criminal History Record Information Act (17 MRSA c. 7).

- **LD 1922 – An Act to Amend the Child and Family Services and Child Protection Act – P.L. 2017 c. 470**
  - Current law lists as a purpose of the Child Protection Act making family rehabilitation and reunification a priority as a means for protecting the welfare of children. Public Law 2017, chapter 470 amends this purpose statement to require DHHS to make reasonable efforts to rehabilitate and reunify families.
- **LD 1923 – An Act to Improve the Child Welfare System – P.L. 2017, c.471**
  - Provides funding to increase the daily reimbursement rates for the various categories of foster homes; 2. Provides funding to create a new Child Welfare Investigator position; 16 Human Services Casework Supervisor positions;
  - Regional Associate Director for Child Welfare positions; 16 Human Services Caseworker positions; and 8 Customer Representative Associate II positions within the Department of Health and Human Services, Office of Child and Family Services;
  - Provides funding for a $5 per wage-hour stipend payment for Caseworkers, Caseworker Supervisors, Assistant Program Administrators and Program Administrator positions;
  - Provides funding for a $1 per wage-hour stipend payment for Caseworkers, Caseworker Supervisors, Services Assistant Program Administrators and Program Administrator positions for those holding or obtaining a relevant master's degree;
  - Provides funding for the procurement of a pilot program to provide supportive visitation, including supervision of court-ordered visitation with the child's relatives and evaluation of parental capacity;
  - Provides funding for the procurement of clinical support and guidance of caseworker practice, including direct consultation with a clinician, training, staff functioning and debriefing;
  - Provides one-time funding for the development of a new comprehensive child welfare information system and directs the Department of Health and Human Services to conduct a needs analysis for its comprehensive child welfare information system, review possible solutions to meet those needs and purchase or develop a new system;
  - Requires the Department of Health and Human Services to contract for a 3rdparty independent rate study to develop a separate rate for MaineCare reimbursement for trauma-focused cognitive behavioral therapy to be billed under rule Chapter 101: MaineCare Benefits Manual, Section 65; and
  - Requires the department to report on the progress of the department in implementing the provisions of the legislation to the joint standing committee of the Legislature having jurisdiction over health and human services matters by January 31, 2019.

| 2019 | Report Regarding OCFS Frontline Worker Perspectives |
|---|---|

Information Brief: Frontline Workers in the State Child Protective System – Perspectives on Factors That Impact Effectiveness and Efficiency of Child Protective Work

OPEGA was assigned a special project by the GOC which aimed to understand the perspectives of frontline workers in the Office of Child and Family Services (OCFS). OPEGA obtained workers' perspectives in two ways. An online survey was sent to all assessment, permanency and intake caseworkers and supervisors. OPEGA received a total of 191 responses from the survey. After reviewing the responses, OPEGA created follow-up interview questions and interviewed 44 child protective staff. Those interviewed represented each of the eight OCFS districts and involved caseworkers, supervisors, program administrators and assistant program administrators.

The information brief was not designed to contain conclusions or recommendations, but described the perspectives of frontline workers in the following areas:

- The Nature of the Job
    - Off-hours Demands;
    - Work/Life Balance;
    - Secondary Trauma and Health Effects;
    - Worker Safety;
    - Training & Preparedness;
    - Additional Work Components such as Documentation, MACWIS, Court Preparation, Travel, and Administrative Tasks.
- State of Workload for Intake and the Districts
    - External Factors Related to Increased Workload;
    - Internal Factors Related to Increased Workload;
        - Reports previously assigned to ARP
        - Automatic assessments after three inappropriate reports
        - Add-on Reports
        - Structured Decision-Making (SDM) Tools
    - Changes in Practice
        - Out-of-Home Safety Planning no longer permitted
        - Team Decision-Making
        - Changes in the Family Plan / Child Plan
        - Recently implemented Supervisory Tool Kit
        - Supervisors in the Field Requirement
    - Implementation of Changes by the Organization
- Systemic Barriers
    - Lack of Placements for Children
    - Lack of Services
    - The Role of the Courts
- Impacts on the Quality of Work
    - Impact of High Workloads
    - Ability to Do the Work
    - Places for Children in Care (including "hoteling")
    - Policy and Practice Changes
    - Confidence in Decision-making
- Impacts on Frontline Workers
    - Workers Seeking Outside Employment

- Worker-Described Period of High Turnover in 2018
- What Could Help
- What Workers Want Legislators to Know

**Discussion and GOC Actions:**

- GOC Meeting 02-22-2019.
  - Discussion of Information Brief by OPEGA on Front-Line Worker Perspectives. https://legislature.maine.gov/doc/2870
- GOC Meeting 03-08-2019.
  - Public Comment on OPEGA Report 03-08-2019. Commissioner Lambrew, Charles Bicknell, Amy Cobb – OCFS Caseworker, Pamela Day, Brian Houston, Maine Children's Alliance, Jan Strout. https://legislature.maine.gov/doc/2909
- GOC Meeting 03-22-2019.
  - Potential Next Steps for CPS work: (Options included:
    1) Periodic updates from DHHS to GOC;
    2) Follow-up survey of OCFS Workers after implementation of changes described by DHHS;
    3) OPEGA's project on the workplan to Assess the status of current DHHS initiatives and their impact on previously noted areas of concern or improvement;
    4) OPEGA to review Out-of-Home Placements.)

  **GOC passed a motion to put option 3 on hold.**
  **GOC passed a motion to put option 2 on OPEGA's workplan.**
  **GOC passed a motion to put option 4 on OPEGA's workplan.**
  https://legislature.maine.gov/doc/2940
- GOC meeting 05-10-2019.
  - Minutes: https://legislature.maine.gov/doc/3098
  - Testimony from Commissioner Lambrew and Director Landry regarding OCFS' efforts to address concerns raised during system evaluations completed by OPEGA, the Ombudsman, and PCG's (Public Consulting Group) C.A.R.E. Project. https://legislature.maine.gov/doc/2954
  - C.A.R.E. Project recommendations: https://legislature.maine.gov/doc/2955
- GOC Meeting 08-14-2019.
  - Update on Child Protection Legislation from 129th Legislature:
    - **LD 192 – An Act to Require an Annual Report on the Activities of the Maine Child Welfare Advisory Panel – P.L. 2019, c.28**
      - The bill requires DHHS to submit an annual report to the HHS Committee on the activities of the Child Welfare Advisory Panel. The amendment removed a deadline for the annual report.
    - **LD 821 – An Act to Set Case Load Standards for the OCFS – P.L. 2019, c.34**
      - The bill requires DHHS to ensure caseworkers are not assigned cases exceeding a number established by department rule; the number must be recommended by a national organization with expertise in maximum caseloads; the number of caseworkers assigned to support staff must not exceed 8. The amendment replaces the bill and requires DHHS to review case load standards and develop recommendations with input from caseworkers and PCG. Requires

the department to submit a report by October 1, 2019 with findings and recommendations and submit an annual report on staffing in child welfare in relation to the case load recommendations; the reports are submitted to HHS Committee and GOC.

- GOC Meeting 09-23-2019.
    - Minutes: https://legislature.maine.gov/doc/3335
    - Testimony for Director Landry: Includes discussion of OCFS turnover improvement between 2018 and 2019, but at the same time caseloads are not decreasing due to increases in cases. Also includes an update on children in hotels and emergency rooms due to lack of placements. https://legislature.maine.gov/doc/3228
    - Presentation Slides from Director Landry: https://legislature.maine.gov/doc/3229
- GOC Meeting 10-15-2019.
    - Minutes: GOC discussed OPEGA Tracking Document for use in handing off the Child Protection work to the next GOC. **GOC passed a motion to remove from the OPEGA workplan, the project they put on hold on 03-22-2019.** https://legislature.maine.gov/doc/3613
    - OPEGA developed a child protection system improvements - oversight coordination/tracking document. https://legislature.maine.gov/doc/3333
    - OCFS produced a Child Welfare Caseload and Workload Analysis. https://legislature.maine.gov/doc/3332
- GOC Meeting 03-13-2020.
    - Minutes: Committee questions regarding Director Landry's testimony. https://legislature.maine.gov/doc/4630
    - Director Landry Testimony 03-13-2020: Presented recent statistics for New Assessments, Children in Care, Percent Exiting to Some Form of Permanency, Hotel and Emergency Department Stays. https://legislature.maine.gov/doc/4018
    - Presentation Slides from Director Landry: https://legislature.maine.gov/doc/4019

The Committee did not meet until November 2020 due to COVID-19 pandemic.

- GOC Meeting 03-26-2021
    - Minutes: Discussion of OPEGA memo recommending avenues by which the GOC could continue its oversight of CPS should they decide to. https://legislature.maine.gov/doc/6535
        - **GOC passed a motion to direct OPEGA to perform a follow-up survey of frontline child protective service workers, with the understanding the results of that survey may trigger future work related to out-of-home placements or other matters.**
        - OPEGA memo to GOC detailing prior history of CPS work and recommendation of possible avenues to continue oversight. https://legislature.maine.gov/doc/6380
- GOC Meeting 04-23-2021
    - Minutes: Questions for Director Landry after his presentation regarding the status of initiatives and the effect of the pandemic. https://legislature.maine.gov/doc/6707
    - Presentation by Director Landry: https://legislature.maine.gov/doc/6663
- GOC Meeting 07-14-2021
    - OPEGA Compendium of GOC and OPEGA Activities regarding the Child Protective System. https://legislature.maine.gov/doc/6918

- OPEGA Summary of Media reports regarding recent child deaths. https://legislature.maine.gov/doc/6923
- Minutes: https://legislature.maine.gov/doc/6958
  - Director Landry appeared before the Committee and answered questions regarding OCFS processes of assessment, the use of SDM tools, the workload analytic tool from PCG, and the upcoming Casey Family Programs methodology for case review. (Testimony attached to minutes)
  - Assistant Attorney General Lisa Marchese appeared before the Committee and discussed reasons associated with the confidentiality of case files during the adjudication and possible sentencing of prosecuted individuals.
  - Child Welfare Ombudsman Christine Alberi presented testimony to the Committee. (Testimony attached to minutes)
  - Both Senator Curry https://legislature.maine.gov/doc/6921 and Senator Diamond https://legislature.maine.gov/doc/6919 requested reviews of aspects of the Child Protection System. (Testimony attached to minutes)
  - **GOC passed a motion to add an immediate review to OPEGA's workplan for which OPEGA will provide a draft scope to be considered at their next meeting.**

- GOC Meeting 08-11-2021 Minutes: https://legislature.maine.gov/doc/7016
  - OPEGA presented a Proposed Scope of Work for evaluation of OCFS practices regarding investigations, reunification and an overview of the oversight of child protective services within the State. https://legislature.maine.gov/doc/6952
  - **The GOC passed a motion to approve OPEGA's scope with the following adjustments to Reporting items 3 and 4 (See page 3, Table 1,"Reporting):**
    - **3. Information Brief on Scope Area 3 by January 15, 2022,**
    - **4. Initial Evaluation Report on Scope Area 1 by March 15, 2022, and**
    - **5. Final Evaluation Report on, including Scope Area 2, by September 30, 2022.**
    - **The GOC directs OPEGA to prioritize the use of staff and adjust staff assignments to complete the work on the timeline the GOC has laid out.**
- GOC Meeting 09-08-2021 Minutes: https://legislature.maine.gov/doc/7421
  - Citizen Review Panels Bobbi Johnson https://legislature.maine.gov/doc/7024
  - MCWAP Presentation – Debra Dunlap https://legislature.maine.gov/doc/7025
  - CDSIRP Presentation – Mark Moran https://legislature.maine.gov/doc/7023
  - JCTF Presentation – Betsey Boardman (no copy)
- GOC Meeting 11-10-2021 Minutes: https://legislature.maine.gov/doc/7913
  - Presentation – Collaborative Safety, Casey Family Programs and the Office of Child and Family Services
    - Casey Family Programs / Collaborative Safety Report to OCFS https://legislature.maine.gov/doc/7420
    - Collaborative Safety Presentation to GOC https://legislature.maine.gov/doc/7429
    - Director Landry takes questions from the Committee
    - Child Welfare Ombudsman testimony to Committee https://legislature.maine.gov/doc/7425

| 2022 | Report Regarding the System of Oversight of Maine's Child Protective Services |
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Information Brief: Oversight of Maine's Child Protective Services

OPEGA presented facts and background information to describe state and federal oversight of child protective services. There were 10 key lessons and observations highlighted in 5 categories:

1. **Current structure of oversight of DHHS/OCFS and child protective services broadly:**
    a. Child protective services as administered by DHHS/OCFS are subject to in-depth regulatory oversight by the federal government as well as advisory oversight from a network of state-level entities.
    b. Federal oversight is comprehensive and outcomes-oriented with financial penalties for nonconformity.
    c. State-level advisory oversight engages all three branches of government and both public and private sector stakeholders.
2. **Roles and responsibilities of the entities involved in child protective services oversight:**
    a. The roles and responsibilities of the different entities address both macro-level oversight of the system and micro-level review and oversight of specific CPS cases, including cases of death and serious injury.
    b. The four state-level panels and the Ombudsman have distinct missions, but there is a degree of overlap as well as nuanced differences in the scope of their activities.
3. **Information sharing between entities, including barriers or gaps:**
    a. Information is routinely and regularly shared among the state-oversight entities and DHHS/OCFS. This routine information sharing among the panels is often the result of individual panel members and DHHS/OCFS staff being members of more than one oversight entity.
    b. Work is currently being done by several of the state oversight entities to formalize and institutionalize information sharing practices to ensure continuity in information sharing over time.
4. **Best practices and models of oversight of child protective services:**
    a. The state-oversight entities, including the four panels and the Ombudsman, are structured in a manner, and are practicing in a manner, that generally conform to published best practices for entities overseeing child protective services.
    b. Several of the entities have recently made or are in the process of implementing changes to improve alignment with published best practices.
5. **Effectiveness of the structure of child protective services oversight. Without the benefit of a full evaluation, we cannot draw evaluative conclusions about effectiveness. However, based on the limited research for the Information Brief, we can say:**
    a. The oversight structure includes many opportunities for DHHS/OCFS to obtain multiple points of view and draw on the expertise of several professional disciplines engaged in child protection across the private sector and multiple levels and branches of government.

**Discussion and GOC Actions:**

- GOC Meeting 01-21-2022
    - Presentation Slides – Oversight Info Brief https://legislature.maine.gov/doc/7925
    - Minutes – Questions from the Committee https://legislature.maine.gov/doc/8133
- GOC Meeting 02-11-2022

- Minutes – https://legislature.maine.gov/doc/8371
- Public Comment on OPEGA Info Brief regarding CPS oversight – Betsey Grant, Bill Diamond, Victoria Vose, Christine Alberi, Molly Bogart https://legislature.maine.gov/doc/8139
- OPEGA provided an update on CPS bills in the HHS Committee https://legislature.maine.gov/doc/8137

- GOC Meeting 03-11-2022
  - Minutes https://legislature.maine.gov/doc/8491
  - Memo provided to GOC regarding summary of OPEGA Info Brief and relevant public comment https://legislature.maine.gov/doc/8372
    - Additional CFSR information requested by the Committee https://legislature.maine.gov/doc/8388
    - GOC work session on confidentiality statutes among various CPS oversight organizations https://legislature.maine.gov/doc/8375
  - Update to GOC on HHS Committee timeline from Senator Claxton, Senate Chair https://legislature.maine.gov/doc/8376

## 2022 | Report Regarding Investigations in Child Protection Services

OPEGA Evaluation: Child Protective Services Investigations

OPEGA performed an evaluation of the processes for child welfare investigations at the Office of Child and Family Services with a focus of protecting child safety. Related below are the key takeaways followed by specific issues and recommendations for the agency and policy considerations for the Government Oversight Committee.

**Common Misconceptions about Child Welfare**

- There are a number of common misconceptions that limit individual and collective understanding of the realities of child welfare, which may lead to unreasonable expectations and missed opportunities for improvement. These misconceptions include the role and authority of OCFS and other key parties; the availability of timely, accurate, and complete information; and the causes and preventability of adverse outcomes. (See page 11.)

**Child Welfare Philosophy and the "Pendulum Swing"**

- There is a continuum of child welfare philosophies that emphasize child safety and family preservation to varying degrees. Child welfare practice at any given time may vary in response to the prevailing philosophy. Federal and state laws and policies have reflected both family-oriented and child safety principles, and have not substantially changed in several decades. In recent years, demands on the child welfare system have changed periodically as a result of elevated concerns caused by events like high-profile child deaths or unusually high numbers of children in state custody. Regardless of the prevailing child welfare philosophy at any one time, the initial investigation provides the basis for critical child safety decisions. (See page 14.)

**Investigation Process Design**

- Child abuse and neglect investigations are designed by OCFS to be comprehensive, employing structured tools to guide workers and supervisors to make decisions about child safety at several points throughout the course of the investigation. It is the goal of investigations that all threats to child safety be addressed, planned for, and/or resolved within a 35-day timeframe. The process, however, is lacking in guidance for sufficiency of investigation thoroughness and how to triage multiple cases and priorities. (See page 18.)

**Training and Supervision of Caseworkers**

- There is wide agreement that the training offered to new caseworkers has been insufficient to prepare them for investigations work. Over the past two years, OCFS has collaborated with the Cutler Institute of the Muskie School of Public Service to restructure the training, and a new course of training took effect in January 2022. (See page 28.)
- Supervisors have significant involvement in the training of new caseworkers, and they support a relatively inexperienced staff of caseworkers in the midst of relatively high turnover. (See page 33.)
- Supervisors are key to the investigations process. Supervisors assign investigations to caseworkers and monitor the whereabouts of caseworkers for safety purposes. They are involved in critical safety decisions at various points, and they provide support, mentoring, and oversight of investigations caseworkers throughout the investigations process. (See page 33.)

**Quality Assurance Case Reviews**

- OCFS's Quality Assurance Program performs ongoing case reviews. The reviews are conducted based on the federal Child and Family Services Review (CSFR) protocol. OCFS uses case reviews both during the federal CSFR period and on an ongoing basis as a tool for understanding and monitoring the quality of investigations of reported and alleged child abuse or neglect. The standards and expectations of the case review system are very high, and meeting them requires exceptionally thorough and comprehensive work to evaluate risks. (See page 34.)
- The QA case review results indicate a lack of overall thoroughness and completeness in investigations. However, we observed that caseworkers do generally appear to be thorough and complete in the assessment of the most critical and relevant risk and safety concerns, and the most critical and relevant individuals, with respect to the reported allegations. We attribute the lack of thorough and complete investigations to issues related to workload. (See page 36.)
- While infrequent, we observed several practice issues in the conduct of investigations that do not appear to be a function of workload challenges, but rather departures from expected practice. (See page 40.)

**Perspectives on Elements Impacting Investigations**

- OCFS staff reported that their workloads are unreasonable and that they do not have adequate time to understand risks to the child or the needs of the family. (See page 41.)
- Caseworkers reported that families are usually willing to engage with CPS during investigations, though they are sometimes unwilling to participate in services offered. (See page 45.)
- The sharing of medical and treatment information with OCFS appears to be a barrier to completing thorough and timely investigations. (See page 46.)

**Family Perspectives and Service Needs**

- Parents and children may experience a variety of reactions during a CPS investigation, including fear and confusion. Organizations that advocate for parents indicate that support for parents to assist in understanding and navigating a CPS investigation would be beneficial. (See page 49.)
- Access, availability, and engagement in services for families were concerns that emerged through interviews with OCFS management and other stakeholders, as well as in our surveys of caseworkers and supervisors, and in the results of the federal oversight of OCFS. (See page 51.)

## Issues and Recommendations

OPEGA makes three recommendations for OCFS management's consideration. OPEGA recommends that OCFS:

1) Take steps to address the workload issue to ensure that caseworkers and supervisors have the time necessary to conduct thorough investigations and more effectively assess the safety risks to children and the needs of families; (Specifics on page 52.)
2) Evaluate the nature and extent of after-hours work requirements and expectations currently placed on caseworkers, and the risks to caseworker effectiveness and burnout; design and implement policy and program changes to address identified issues and risks; and consider restructuring the delivery of Children's Emergency Services to decreases or even eliminate required overnight shifts for caseworkers and supervisors; (Specifics on page 55.)

3) Build on the foundation of its existing QA system of case reviews to better identify specific practice concerns in a timely manner, within all OCFS districts, and link those concerns to opportunities for supervisor feedback, mentoring, and potentially additional training for individual caseworkers and other district staff. (Specifics on page 56.)

**Policy Considerations**

OPEGA recommends that OCFS, and the GOC as appropriate, consider the following additional areas noted, but not fully evaluated, in this review:

- **Training of new caseworkers and their transition into the field.** (See page 57.)
- **Caseworker access to medical records and treatment information.** Reluctance of parents' substance use and mental health providers to speak with caseworkers or share medical records can be a barrier to investigations. (See page 58.)
- **Services for children and families in the CPS system.** Mental health, substance use disorder treatment, in-home behavioral health services, and case management services appear to be inadequate in comparison to their need. (See page 59.)
- **Prevention of child abuse and neglect.** Child welfare practitioners describe three levels of prevention: (1) primary prevention, which is directed to the whole population, (2) secondary prevention, which is targeted to families experiencing risk factors, and (3) tertiary prevention, for families in which child abuse or neglect has already occurred. OCFS is primarily engaged at the level of tertiary prevention. Federal and state child welfare experts recommend that states invest in and coordinate efforts at all three levels of prevention. According to the U.S. Centers for Disease Control, the prevention of child abuse and neglect requires a comprehensive focus that crosscuts key sectors of society (for example, public health, education, social services, and the judicial system). (See page 59.)

**Discussion and GOC Actions:**

- GOC Meeting 03-25-2022
  - Minutes GOC questions regarding the report answered by OPEGA and additional questions to OCFS answered by Director Landry and Bobbi Johnson https://legislature.maine.gov/doc/8530
  - Investigations Report Slides – https://legislature.maine.gov/doc/8494
- GOC Meeting 04-08-2022
  - Public Comment CPS – Investigations: Senator Bill Diamond; Molly Bogart, DHHS; Laura Tomascik, resource parent; Melanie Blair, resource parent; Melissa Hackett Maine Children's Alliance & Maine Child Welfare Action Network; Richard Wexler, National Coalition for Child Protection Reform; Richard Hooks Wayman, resource parent and Volunteers of America Northern New England ; Tonya DiMillo. https://legislature.maine.gov/doc/8536
  - OPEGA summary of report recommendations and related legislation currently proposed. https://legislature.maine.gov/doc/8533
  - LD 960 130th 2nd Regular Session – An Act To Make Changes to the Laws Governing the Child Welfare Services Ombudsman Program P.L. 2021 c.550 https://legislature.maine.gov/doc/8532
  - DHHS/OCFS Responses to Questions posed by the GOC and HHS Committee on 03/25/22 https://legislature.maine.gov/doc/8535

- GOC Meeting 04-13-2022
    - Minutes https://legislature.maine.gov/doc/8631
    - OPEGA summary of Actions Suggested at 04-08-2022 Public Hearing https://legislature.maine.gov/doc/8548
    - USM / OCFS Caseworker Foundations Training document https://legislature.maine.gov/doc/8547
    - DHHS/OCFS Responses to Questions posed by the GOC and HHS Committee on 04/08/22 https://legislature.maine.gov/doc/8546
    - OPEGA update of CPS bills in the 130th Legislature https://legislature.maine.gov/doc/8545
    - Letter from HHS Committee to Director Landry requesting updates to specific questions raised as a result of OPEGA's evaluation of Investigations. https://legislature.maine.gov/doc/8544
    - OPEGA memo to GOC restating report conclusions and providing options to the Committee to address or further define CPS issues. https://legislature.maine.gov/doc/8543
- GOC Meeting 05-18-2022
    - Minutes https://legislature.maine.gov/doc/8632 includes conversation with AAG Chris Taub regarding "what ability the GOC has to meet in executive session to discuss otherwise confidential matters or documents that are not presently available to the committee as public elected officials." The Joint rules and statutes referred to in this discussion are in: https://legislature.maine.gov/doc/8597 .
    - GOC letter to OCFS relaying questions for the Office https://legislature.maine.gov/doc/8595
    - OCFS Response to GOC regarding specific questions (discussion with Bobbi Johnsons and Molly Bogart - in minutes) https://legislature.maine.gov/doc/8598
    - OPEGA provided legislative update on CPS issues to GOC https://legislature.maine.gov/doc/8596
- GOC Meeting 06-15-2022
    - Minutes. The discussion involving CPS was a continuation of the conversation with Bobbi Johnson and Molly Bogart answering GOC questions for OCFS. https://legislature.maine.gov/doc/8679
- GOC Meeting 07-20-2022
    - Minutes https://legislature.maine.gov/doc/9049
    - Second Public Comment Period on OPEGA's CPS – Investigations Evaluation: Melanie Blair; Rachel Grubb; Arleen Sue Carter; Bill Diamond; Jennifer Pieces; Jessica Beck; John and Johnna Morton; Les Cook; Kristine; Mary-Gene Rumery; Stephanie Gaddar; Marcia Rogers; Sarah Sue Wood; Melissa Hackett. Others are recorded in minutes. https://legislature.maine.gov/doc/8689
    - Update to GOC on OPEGA's work regarding "Reunification" Phase 3 of the scope approved in August of 2021. https://legislature.maine.gov/doc/8685
    - After discussion with OCFS, OPEGA provided the GOC with the type of information available in the confidential casefiles from OCFS. https://legislature.maine.gov/doc/8684
    - Memo to GOC from OPEGA providing more detailed information regarding media-reported child deaths where OCFS was involved. https://legislature.maine.gov/doc/8683

- Letter from AAG Gannon to Director Landry stating the opinion that confidential CPS records can be provided to OPEGA as the GOC's investigative arm, but not to the Committee directly. https://legislature.maine.gov/doc/8682
  - Letter from OCFS – responses to questions from GOC at 06/15/2022 meeting https://legislature.maine.gov/doc/8681
  - Presentation of SDM tools by Evident Change https://legislature.maine.gov/doc/8680
  - **GOC passed a motion to have OPEGA continue it evaluation of phase 3 of the CPS scope: Reunification.**
  - **GOC passed a motion to request casefiles to review in executive session**
- GOC Meeting 09-21-2022
  - Minutes. Discussion of Current Reunification work. Discussion of potential phase 4 projects. Discussion of OPEGA review of confidential casefiles. Discussion with counsel in executive session regarding response to DHHS refusal to provide confidential records directly to GOC. https://legislature.maine.gov/doc/9143
    - OPEGA future project recommendations in the realm of CPS https://legislature.maine.gov/doc/8940
    - Letter from DHHS Commissioner refusing request for confidential records https://legislature.maine.gov/doc/8939
  - **GOC passed a motion to direct OPEGA to do a "rapid review" of CPS casefiles with respect to 4 specific children's deaths. This put the Reunification work on hold.**
  - **GOC passed a motion to Subpoena the DHHS/CPS records – the casefiles (previously requested and denied) of the 4 children fatalities for the Government Oversight Committee to review in an Executive Session on October 19, 2022.**
  - Subpoena issued by GOC for confidential DHHS records to review in executive session https://legislature.maine.gov/doc/9121
  - DHHS subpoena response https://legislature.maine.gov/doc/9132
- GOC Meeting 01-13-2023
  - Minutes https://legislature.maine.gov/doc/9555
  - Superior Court denied GOC's motion to Compel https://legislature.maine.gov/doc/9464
  - GOC in executive session with counsel to discuss response.
  - **GOC passed a motion to move forward with an appeal of the Superior Court's decision.**
  - **GOC passed a motion to allow chairs and leads to be the liaison to Mr. Taub (counsel for GOC) for the appeal process.**

| 2023 | Report Regarding Case of Hailey Goding |
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[OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Hailey Goding]

The Government Oversight Committee of the 130th Maine State Legislature directed OPEGA to review certain records generated by the Maine Department of Health and Human Services (DHHS or the Department), Office of Child and Family Services (OCFS) to better understand the safety decisions and actions taken by the Department during its involvement in the lives of four Maine children who died in 2021. This is the first of those four reports.

**OPEGA's Overall Conclusion on OCFS Safety Decisions for Hailey Goding**
OPEGA did not conclude that any OCFS safety decisions regarding Hailey Goding were unsound within the framework of the records we reviewed, interviews we conducted, agency policy and practice, and legal authority.

**Potential Opportunities for Improvement**
OPEGA identified two potential opportunities for improvement in the child protection system during our review of this case. The potential areas OPEGA identified, in no particular order of priority, include:

**Establish a Central Resource for Substance-related Questions**
During our review, we noted a lack of clarity regarding the resources, if any, child protective services workers might consult in an effort to validate or refute the likelihood that exposure to fentanyl in the manners asserted by Ms. Goding in May 2020 on behalf of herself and Hailey were scientifically possible. We believe that establishing such a resource would be beneficial to caseworkers in the future as they encounter various drug-related scenarios and may have questions about certain exposures, interactions, and presentations that may ultimately impact safety decisions.

**Improve Service Availability and Enhance OCFS's Ability to Ensure Recommended Services Are Provided**
In the wake of Hailey's May 2020 substance ingestion, the Department worked to improve Hailey's safety in the custody of her mother by making a series of initial referrals for mental health and substance use treatment and drug screens for Ms. Goding. Later, additional referrals were made for trauma counseling and case management services. Despite the efforts of the Department, ARP, a case manager, and even Ms. Goding herself, who had demonstrated a willingness to participate in such services, we observed that trauma counseling services were never established nor provided. From our work on this case and other child protective services reviews, we understand that there is a pronounced lack of available services that may vary based on the geographic location or the specific type of service sought.

**Discussion and GOC Actions:**

- GOC Meeting 02-10-2023
    - Minutes – Questions regarding the report answered by OPEGA. Additional questions to Director Landry of OCFS. https://legislature.maine.gov/doc/9876
    - "Reunification" project is paused. https://legislature.maine.gov/doc/9714
    - 2022 Child Welfare Ombudsman's Report https://legislature.maine.gov/doc/9711
    - OCFS provided its published response letter to the most recent Ombudsman's Report https://legislature.maine.gov/doc/9712

- GOC Meeting 03-10-2023
    - Minutes https://legislature.maine.gov/doc/9938
    - Public Testimony Regarding OPEGA Report: Michelle Ortega; Melanie Blair; Melissa Hackett; Letter from DHHS/OCFS in response to OPEGA report. https://legislature.maine.gov/doc/9929 Additional non-written testimony provided by Betsey Grant; Victoria Vose; Allison Porter; Brian Picciano; and Mark Moran (see minutes above).

| 2023 | Report Regarding Case of Maddox Williams |
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OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Maddox Williams

The Government Oversight Committee of the 130th Maine State Legislature directed OPEGA to review certain records generated by the Maine Department of Health and Human Services (DHHS or the Department), Office of Child and Family Services (OCFS) to better understand the safety decisions and actions taken by the Department during its involvement in the lives of four Maine children who died in 2021. This is the second of those four reports.

**OPEGA's Overall Conclusion on OCFS Safety Decisions for Maddox Williams**

Overall, OPEGA concluded that OCFS safety decisions regarding Maddox Williams were not unsound within the legal, policy, and practice frameworks through which the Department must process its information.

OPEGA identified one Legal Issue, one Practice Issue, and one Resource Issue, all with corresponding recommendations; one Public Policy Consideration; and two Potential Opportunities for Improvement.

**Legal Issue: Existing Process May Not Adequately Ensure Robust Documentation of Legal Justifications for Not Filing an Otherwise Statutorily Mandated TPR Petition**

Recommendation:

OCFS should look to better formalize and more robustly document this specific decision in its process and system to prompt staff to make this decision according to the timeframe specified in statute in an effort to promote permanency for children in foster care.

**Practice Issue: Custodial Arrangements Were Not Explored for All Children in the Home**

Recommendation:

OCFS should provide guidance to supervisors and caseworkers on the practice of exploring custodial arrangements of the identified children in the household. Understanding the composition of the household, including any out of home parents and the corresponding custodial arrangements (such as when the child will be residing with the other parent), may be a means of obtaining information about the family and the potential risk and safety concerns. It also may be a means of gaining permission to interview or observe children during the course of an investigation, who are otherwise being prevented from being accessed by another parent. OCFS should reinforce this practice through communication and training of staff and amend the investigations policy and pursue any related forms, if necessary, to ensure this investigative task is always completed by caseworkers.

**Resource Issue: Staff Vacancies May Impact Casework**

Recommendation:

OCFS should conduct a comprehensive examination of CPS caseworker vacancies to identify and propose new strategies to recruit and retain staff. Resulting strategies should be specifically targeted and focused on child protective caseworker positions to address the staffing vacancies within this area of social work. This examination should include the following:

- continue to determine the underlying reasons for CPS caseworker vacancies through exit and stay interviews and how concerns of child protection caseworkers specifically may be alleviated;
- examine the fundamental structure of caseworker and supervisor jobs, and assess whether any restructuring would promote staff retention;
- explore changes to the retirement system and other incentives specific to child protective services casework to promote staff retention and longevity (The Department notes that the

work of OCFS field staff is substantially analogous to that of other first responders, including law enforcement, but these staff do not benefit from the same treatment in statute and policies.);

- examine the Department's current requirement that caseworkers be licensed social workers;
- work with the State Board of Social Worker Licensure to develop a means of getting otherwise qualified applicants the requirements they need to become licensed; and
- report back to the Legislature on the status of these efforts and the current number of vacancies.

**Potential Opportunities for Improvement:**

1) **Continue OCFS Research into Identifying Risk Factors Related to Targeted Children**
2) **Increase Availability of CODE Resources**

**Public Policy Consideration: Persistent Disconnect Between Public Expectations for the CPS System and the Current Legal and Policy Framework and Capabilities of OCFS**

**Discussion and GOC Actions:**

- GOC Meeting 04-14-2023
  - Minutes including questions to OPEGA and to Director Landry of OCFS https://legislature.maine.gov/doc/10043
  - DHHS revised memo regarding the timeline of the Maddox Williams Case https://legislature.maine.gov/doc/10032 Original memo is Appendix A of OPEGA Report (linked above).
- GOC Meeting 05-26-2023
  - Minutes https://legislature.maine.gov/doc/10192
  - Caseworker Table associated with Maddox Williams case: https://legislature.maine.gov/doc/10138
  - Maddox Williams case Visual Timeline: https://legislature.maine.gov/doc/10137
  - Public Comment on OPEGA Report: https://legislature.maine.gov/doc/10132 Christine Alberi; Betsey Grant; Bill Diamond; Melissa Hackett; Melanie Blair. Additional unwritten testimony by Victoria Vose, Maddox Williams' grandmother; and Mark Moran noted in Minutes (above)
- GOC Meeting 07-07-2023
  - Minutes including questions regarding the report to OPEGA and to Director Landry of OCFS https://legislature.maine.gov/doc/10217.
- GOC Meeting 10-18-2023
  - Minutes including discussions with Molly Bogart and Todd Landry regarding Customer Wait Times in DHHS and OCFS (pages 4-8) and further discussion of a media news report regarding Maine's most recent Annual Service & Progress Report (ASPR) and the GOC's desire to intensify their meeting schedule to provide recommendations for the full legislature by January. (pages 8-9) https://legislature.maine.gov/doc/10407 .
- GOC Meeting 11-01-2023
  - Discussion of strategies for the Committee to accomplish its work.
    The discussion revolved around a goal for the GOC to provide recommendations to the full Legislature regarding how to make the system of child protection better. The prevailing view was to hear from frontline workers of the system and use that information to inform further investigation. Prior work regarding frontline perspectives can be found in (Information Brief: Frontline Workers in the State Child

Protective System – Perspectives on Factors That Impact Effectiveness and Efficiency of Child Protective Work and OPEGA Evaluation: Child Protective Services Investigations). (See 11-08-2023 GOC meeting, below, for testimony from frontline workers.) Viewpoints from the courts were also desired by members of the Committee. Discussion continued regarding how to obtain testimony from front-line workers while ensuring their job security and protecting confidential information.

Approaching the problem from two perspectives was suggested: aspects to prevent families from entering the system in the first place along with improving the performance of the system once in it.

There were questions regarding how mandated reporters are responded to by the department. (See OPEGA Evaluation: Child Protective Services Investigations page 43 for survey results of mandated reporters.)

Another topic of conversation included questions regarding how often caseworkers and AAGs disagree on or don't align their opinions in CPS court cases. [OPEGA note: OPEGA interviews with caseworkers and supervisors reveal that CPS cases have numerous decision points which may move the trajectory of the case in one direction or another. Disagreements are common in certain cases but typically move to consensus as the jeopardy petition or TPR is prepared.]

It was noted that drug use is common in the cases studied. Members expressed concerns about the variability and adequacy of testing in the State. Why can some facilities test for fentanyl and others cannot?

There were questions regarding whether parents should be able to keep a caseworker from coming into their home to inspect their children once a parent has been found to have children that are at risk.

The meeting continued with a discussion of the most recent Annual Progress and Services Report (APSR) highlighted in a recent media report. OPEGA produced a compilation of historical APSRs. https://legislature.maine.gov/doc/10377 .

**The GOC passed a motion to allow OPEGA to interview CPS staff about their experiences in the department.** Minutes: https://legislature.maine.gov/doc/10456

- OPEGA staffing the Committee, provided a discussion power point: https://legislature.maine.gov/doc/10376 .
- OPEGA staffing the Committee, provided an APSR trend report https://legislature.maine.gov/doc/10377 .

- GOC Meeting 11-08-2023
  - Testimony from front-line CPS workers: https://legislature.maine.gov/doc/10439

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| | Maureen Cote, Diane McGonagle, Mindy Bard, Sara Ament, Sen. Michael Carpenter, Rochelle Kadema plus written testimony from Dean Staffieri (including testimony to HHS Committee 01/25/2022.) |

| 2023 | Report Regarding Case of Jaden Harding |
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OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Jaden Harding

Through our review of the larger history of CPS involvement, OPEGA identified:

- two unsound safety decisions in which we conclude that the facts of the case—as known at the time—warranted additional Departmental intervention to ensure the safety of the children in the home prior to Jaden's birth;
    - **Unsound Safety Decision 1:** No Additional Interventions or Safety Planning to Ensure the Safety of the Children (Prior to Jaden's Birth) from the Man Living in Ms. Hartley's Home (February 2020)
    - **Unsound Safety Decision 2:** No Additional Interventions or Safety Planning when Ms. Hartley's Out-of-State Relatives Leave Her Home (June 2020)

- two overarching practice issues that spanned multiple investigations and ultimately prevented the Department from making other necessary and appropriate safety decisions and taking related actions to ensure the safety of the children in the home prior to Jaden's birth;
    - **Overarching Practice Issue 1:** Important Connections Missed by OCFS Across Multiple Investigations Regarding the Risks Posed by Ms. Hartley's Relative (And Alleged Abuser of Her Children)
        - **Recommendation:** OCFS should develop a process and standard for identifying which families' CPS histories should be subject to a more comprehensive review. Additionally, OCFS should ensure that any staff assigned this work have the time and resources needed to conduct them.
    - **Overarching Practice Issue 2:** No Comprehensive Review of the Family's Prior CPS Involvement That Would Have Shown a Pattern of Ms. Hartley Allowing Unsafe Individuals Around Her Children

- eight practice issues that occurred during specific investigations that were both prior to and following the announcement of Ms. Hartley's pregnancy with Jaden;
    - **Practice Issue 1:** Extremely Overdue Investigation with Periods of No Investigative Activity (April 2018)
        - **Recommendation:** Although we did not review data that would enable us to quantify the impact of the 2018 policy changes on workloads, we would still recommend that the Department take a thoughtful, measured approach to future policy changes with a focus on potential workload impacts to avoid similar risks—especially as the Department experiences difficulties in the recruitment and retention of caseworkers
    - **Practice Issue 2:** Inadequate Efforts to Locate the Family (April 2018)
        - **Recommendation:** As the Department continues to update its investigations policy and any related documents, we recommend that the "Activities to Locate" tool continue to be used and caseworkers continue to be trained in its application.
    - **Practice Issue 3:** Incorrect Identification of Alleged Abuser by Intake (March 2019)
        - **Recommendation:** While we do not know the extent to which intake screening errors such as this occur, we do recommend that OCFS consider

implementing a mechanism into their existing process to denote instances in which intake—and not the referent—has identified a critical case member. In denoting these individuals, caseworkers may be more cognizant of the need to verify the accuracy of the identities provided solely by intake.

- **Practice Issue 4:** Reported Allegations and Safety Threats Unexplored by Caseworkers (April 2018, March 2019, and March 2020)
  - **Recommendation:** OCFS should clarify and communicate its expectations for what caseworkers should do when an "FYI report" that would otherwise be screened out is added to an open investigation. For other screened-in reports containing multiple allegations, supervisors should ensure that caseworkers, at a minimum, discuss all allegations with the parents/caregivers.
- **Practice Issue 5:** Inconsistent and Sometimes False Information Unexplored by Caseworker (February 2020 and March 2020)
  - **Recommendation:** OCFS should make efforts to communicate and reinforce its expectation that caseworkers identify and challenge inconsistencies in the information provided to them by families.
- **Practice Issue 6:** Status of Bangor Police Department Investigation Unexplored by Caseworker (February 2020 and March 2020)
  - **Recommendation:** Although we are unsure of the extent to which a scenario like this occurs, we believe that following up on the results and status of earlier criminal investigations can provide valuable information to caseworkers. As such, OCFS should consider developing guidance for closing summaries specifying how caseworkers are to document that there are ongoing criminal investigations at the time the investigation closes, and, also, establish expectations for what subsequent caseworkers are to do when they review that documentation in the future.
- **Practice Issue 7:** Installation of Child Safety Locks Not Verified by Caseworker (March 2020)
  - **Recommendation:** OCFS should consider the development of a process to ensure that any tasks identified as next steps to complete the investigation as part of the preliminary safety decision are revisited by the caseworker and supervisor prior to the closure of the investigation. Any steps that are determined to still be relevant, but not yet performed should be performed before the investigation is closed.
- **Practice Issue 8:** Mr. Harding's Safety Never Assessed (June 2020)
  - Recommendation: OCFS should consider revising its investigations process and related checklists to require caseworkers to confirm a family's living arrangements and all household members have been identified when nearing the end of an investigation to ensure that the safety of all individuals residing in the home with access to the family's children is assessed before the investigation is closed. This is particularly relevant as it appears the living arrangements and household compositions of the families that the Department works with can change often and sporadically.

- one systems issue that contributed to the Department not fully understanding the risk that Ms. Hartley's relative/alleged abuser of her children posed to the children (other than Jaden) at a later point in the timeline;
  - **Systems Issue 1:** Multiple Profiles for the Same Individual

        - **Recommendation:** Even with the improvements offered through the use of Katahdin, OCFS should establish appropriate search guidance to be used by caseworkers to mitigate the risks associated with multiple profiles. This guidance could include more thorough search criteria, such as adding a date of birth or social security number. The Department should also review its current guidance related to screening people into the Department's various systems to ensure that guidance outlines a process that appropriately addresses the risks associated with entering multiple profiles for a single individual.
- three potential opportunities for improvement.
    - Identify and Provide Appropriate Levels of Services for Families
    - Improve Information Sharing Between OCFS, Law Enforcement, and the Courts
    - Improve Feedback and Management Expectations

- GOC Meeting 11/15/2023
    - Presentation of OPEGA Report on the Case of Jaden Harding followed by continued testimony from Bobbi Johnson and Molly Bogart and then select front-line workers: Bethany Fournier – Resource Parent, Occupational Therapist and Executive Director of the Nonprofit Nanna's House; Masha Rogers – Retired CASA Guardian Ad Litem, District 7 + Foster Parent; Sandra Hodge – Founding member of the Child Death and Serious Injury Review Panel, past Program Specialist for the Child Protective Services central office; Kerry Hewson – CASA Guardian Ad Litem + School Nurse; MaryAnne Spearin – Superintendent of Schools, Washington County; Stacey Henson-Drake – Investigations Caseworker, District 3 OCFS; Priscilla Girard – Guardian Ad Litem + LCSW; https://legislature.maine.gov/doc/10479.
    - November 9th Letter from Committee to Commissioner of DHHS https://legislature.maine.gov/doc/10753 .
- GOC Meeting 11/29/2023
    - Public Testimony regarding OPEGA's report on Jaden Harding: Melanie Blair, Shawn Yardley, Mark Moran, Christine Alberi, Melissa Hackett https://legislature.maine.gov/doc/10462 .
    - OPEGA Document: House Composition over time – Mother of Jaden Harding https://legislature.maine.gov/doc/10452 .
    - Sen Hickman invited former child protection services leader, Peter Walsh to address the Committee.
    - Meeting Minutes https://legislature.maine.gov/doc/10748.
- GOC Meeting 12/06/2023
    - DHHS Commissioner's Response to Nov 9th Questions from the Government Oversight Committee: https://legislature.maine.gov/doc/10481 .
    - Discussion with Commissioner Lambrew and Acting Director Bobbi Johnson.
    - Meeting Minutes: https://legislature.maine.gov/doc/10749
- GOC Meeting 12/13/2023
    - The Committee heard from a range of frontline professionals, individual biological parents, and resource (foster) families. Written Testimony: https://legislature.maine.gov/doc/10505 .
    - Meeting Minutes: https://legislature.maine.gov/doc/10750 .
- GOC Meeting 01/05/2024 (Cancelled due to weather)

- GOC Meeting 01/12/2024
  - December 15th Letter from OPEGA Director on behalf of Committee to Acting Director Johnson of OCFS https://legislature.maine.gov/doc/10754 .
  - Handout on LD 779 from Sen Timberlake https://legislature.maine.gov/doc/10629
  - Meeting Minutes unavailable as yet.
- GOC Meeting 01/26/2024
  - OCFS Response to GOC letter from December 15th https://legislature.maine.gov/doc/10703 .
  - Testimony from Commissioner Lambrew https://legislature.maine.gov/doc/10759
  - Testimony from OCFS Director Johnson https://legislature.maine.gov/doc/10758
  - CPS Hotel Placement Info https://legislature.maine.gov/doc/10704
  - Emergency Dept Data required by LD 188 https://legislature.maine.gov/doc/10705
  - Meeting Minutes unavailable as yet.
- GOC Meeting 02/09/2024
  - January 31 Letter to Director Johnson of OCFS https://legislature.maine.gov/doc/10755
  - Memo to Sen Hickman from Commissioner Lambrew on February 8, 2024 https://legislature.maine.gov/doc/10757
  - Follow up information on hospital stays and “hoteling” from Commissioner Lambrew https://legislature.maine.gov/doc/10756 .
  - Meeting Minutes unavailable as yet.

| 2024 | Report Regarding Reunification in Child Protection Services |
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[Information Brief: Child Protective Services Reunification]

For this report, OPEGA: (1) examined relevant Maine statutes, federal law, agency rules, and OCFS policies; (2) conducted a total of 58 interviews with OCFS staff members, stakeholders in the court process, biological and resource parent representatives, and others; and (3) assessed OCFS reunification work by analyzing existing quality assurance data. OPEGA examined the 235 case reviews conducted from April 2017 to March 2023 that had reunification as the child's permanency goal.

OPEGA identified four cross-cutting challenges that are prevalent in reunification casework.

1. **Caseworker practices concerns:**
   - Assessment of parent's substance use: Many cases did not meet the federal standard for regularly assessing parents' substance use. OCFS staff named caseworker inexperience and issues with drug screening as challenges contributing to this concern.
   - Caseworker engagement with family: Casework tended to fall short of expectations on assessments of caseworker conversations with parents about their needs and case planning goals, as well as facilitation of family team meetings. Staff said that inadequate training and job shadowing contribute to this deficiency.

2. **High workloads impacting safety, permanency, and well-being outcomes:**
   - Permanency caseworker vacancies: OCFS has struggled with high staff turnover and inability to fill vacant positions, with some district offices experiencing especially high vacancy rates. This causes high workloads and means that staff are relatively inexperienced, which contribute to many of the identified challenges.
   - Lack of support staff: Frontline staff reported that inadequate support with administrative and legal tasks exacerbates the challenge of high workloads and has a negative impact on casework quality.
   - Lack of visitation supervisors and transportation for families: OCFS contracts with agencies to provide supervision for parent and child visits, as well as transportation for families. Staff and parent representatives reported high demand and lack of availability of these crucial services.

3. **Waitlists for evaluations and treatment:**
   Case reviews and staff interviews suggest that progress toward reunification is often hindered by long waitlists for parents' required mental health evaluations, mental health treatment, and for substance use disorder treatment.

4. **Timeliness of termination of parental filings and other legal concerns:**
   Case reviews identified challenges with timeliness of filing termination of parental rights, leading to delays in permanency for children. Several factors may contribute to delays,

including caseworker workload and the backlog of cases in the judicial system delaying hearings necessary for timely reunification.

- GOC Meeting 02/23/2024
    - Committee received the presentation of OPEGA's Information Brief on Child Protective Services – Reunification.
    - Committee finalized their Report : Frontline Perspectives in Child Protection as Catalysts for Reform.