Maine's Child Protection System

Areas for Concern or Improvement Identified for GOC Consideration

June 28, 2018

From OPEGA Information Brief

A. Guidance and training for mandated reporters, including expectations of what constitutes "reasonable cause to suspect" for those in various roles

Potential Next Steps

1. Assess content of DHHS-approved training, training delivery avenues, frequency of training, training roles and responsibilities, and communication regarding required training to identify potential improvements taking into consideration:
    - scope of what constitutes child abuse and neglect in Maine statute;
    - "best practices" / evidence-based practices;
    - other states' approaches to training; and
    - roles, perspectives and environments of various categories of mandated reporters.

    Note that OPEGA currently has not gathered any information on the extent to which "best practice" and expert advice has already been considered in developing the current Department-approved mandated reporter training or how recently training content has been re-assessed for needed updates.

2. Determine extent to which current mandated reporters are obtaining Department-approved training and factors impacting whether they are complying with statutory training mandate.

    Note that this would likely involve gathering input from various mandated reporters and/or comparing training records maintained by DHHS to lists of licensed professionals or those associated with various organizations.

3. Define "reasonable cause to suspect" or otherwise establish expectations or situational criteria of what constitutes "reasonable cause to suspect" - perhaps framed around known high risk factors for child abuse and neglect (possible statutory change and/or inclusion in mandated reporter training).

    Note that:

    a. Mark Moran, LCSW and Chair of the Maine Child Death and Serious Injury Review Panel, provided three study reports and an article on the topic of "reasonable suspicion" as it pertains to child abuse and neglect. The three studies, taken together, found that among pediatricians, pediatric residents, and experts on child abuse, there was no consensus on how "reasonable suspicion" (or a similar term) is interpreted, defined, and applied or how likely abuse must be before reasonable suspicion can be said to exist. The article provided identified that all states have similar statutory language and that interpreting what constitutes reasonable suspicion and determining when suspected child abuse should be reported will remain difficult until steps are taken to specify estimated probability that constitutes reasonable suspicion and to create systematic and effective strategies for training mandated reporters about reasonable suspicion.

    b. OPEGA did not observe any meaningful guidance on what constitutes "reasonable cause to suspect" in the DHHS-approved mandated reporter training currently posted on the web.

B. Timeliness of OCFS Intake in answering calls coming into the statewide, toll-free number for reporting child abuse and neglect.

Potential Next Steps

1. Determine extent to which calls to Intake are being answered in a timely manner and understand factors impacting timely answering of calls.

2. Determine extent to which Intake is receiving child abuse/neglect reports via avenues other than the statewide, toll-free number, how timely Intake is responding to those reports and understand factors impacting timely response to those reports.

3. Assess status and effectiveness of DHHS' recent initiatives in improving timeliness of Intake response to calls and reports via other avenues.

Note that the potential next steps likely involve obtaining and analyzing data. OPEGA has not explored to what extent DHHS is already producing relevant statistics that might be used.

C. Timeliness and comprehensiveness of OCFS (Intake and Assessment) 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.

Potential Next Steps

1. Determine timeliness and comprehensiveness of risk assessments conducted by Intake upon receipt of reports of potential child abuse/neglect and understand factors impacting timeliness and comprehensiveness of Intake assessments.

2. Determine timeliness and comprehensiveness of child protective assessments conducted by District offices and understand factors impacting timeless and comprehensiveness of these assessments.

3. Determine timeliness and comprehensiveness of assessments conducted by ARP providers and understand factors impacting timeliness and comprehensiveness of ARP assessments.

4. Assess status and effectiveness of DHHS' recent initiatives in improving timeliness and comprehensiveness of child and family assessments.

Note that all of these potential next steps likely involve review of records for a sample of reports/assessments and/or obtaining and analyzing relevant data. OPEGA has not explored to what extent DHHS is already producing relevant statistics that might be used.

D. Appropriateness of caseloads and adequacy of supervision and training for OCFS and ARP staff.

Potential Next Steps

1. Determine appropriateness of caseloads/workloads for OCFS caseworkers and supervisors in OCFS Intake, Assessment, Permanency and Adoption and understand factors impacting workload.

   Note that caseload and workload are different concepts. There are many factors that impact the workload associated with individual cases that would need to be considered. An analysis of just caseloads (# of cases/# of workers) may not be meaningful. The factors that impact workload would need to be considered in any comparison of Maine caseloads to national standards.

2. Determine adequacy of training for OCFS caseworkers and supervisors and understand factors impacting training.

3. Determine adequacy of supervision of OCFS caseworkers and understand factors impacting supervision.

4. Determine appropriateness of caseloads/workloads for ARP caseworkers and supervisors and understand factors impacting ARP workload.

5. Determine adequacy of training for ARP caseworkers and supervisors and understand factors impacting training.

6. Determine adequacy of supervision of ARP caseworkers and understand factors impacting supervision.

7. Assess status and effectiveness of DHHS' recent initiatives in addressing OCFS caseload/workload concerns.

8. Assess status and effectiveness of DHHS' recent initiatives in improving training for OCFS caseworkers and supervisors.

9. Assess status and effectiveness of DHHS' recent initiatives in improving supervision of OCFS caseworkers and supervisors.

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Note that determining adequacy of training may involve review of training content against best practice/evidence-based practice and/or DHHS policy and procedures. Also potentially would involve review of training records for individual caseworkers and supervisors. OPEGA has not yet gathered any information on the extent to which DHHS training curriculum for caseworkers and supervisors already includes consideration of best practices and/or expert input.

Note that determining adequacy of supervision may involve review of case records.

E. Compliance with policies and procedures, and consistency and appropriateness of decisions made, by caseworkers and supervisors in OCFS Intake and District Offices.

<u>Potential Next Steps</u>

1. Determine extent to which OCFS caseworkers and supervisors and complying with established policies, procedures, laws and regulations in the handling of child abuse/neglect reports, assessments and cases.

2. Determine extent to which decisions made and actions taken by OCFS case workers and supervisors are appropriate and consistent across reports, assessments and cases.

3. Assess status and effectiveness of DHHS' recent initiatives in improving compliance with policies and procedures among OCFS caseworkers and supervisors.

4. Assess status and effectiveness of DHHS' recent initiatives in improving consistency and appropriateness of decisions among OCFS caseworkers and supervisors.

Note that these potential next steps would likely involve review of records on reports, assessments and cases.

Note that assessing appropriateness would require establishing criteria for appropriateness to compare to. Also that assessing appropriateness and consistency could be focused on specific OCFS units, i.e. Assessment. It would also involve assessing across all District offices.

F. Compliance with contractual obligations, and consistency and appropriateness of decisions made, by ARP caseworkers and supervisors.

Potential Next Steps

1. Similar steps to Item E above.

G. 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.

Potential Next Steps

1. Understand factors impacting OCFS decision-making in assessing risk and determining actions to take in response.
2. Understand factors impacting ARP decision-making in assessing risk and determining actions to take in response.

Note that it may be useful to have this understanding to inform decisions on what particular aspects of the Child Protection System should receive further review or consideration. Potential avenues for gaining this understanding include conducting surveys of, or focus groups or interviews with, caseworkers and supervisors.

H. Extent to which OCFS and ARP monitor whether families are participating in voluntary services intended to reduce risk of child abuse and neglect and take action when they are not.

Potential Next Steps

1. Determine extent to which families referred for voluntary services are receiving them and extent to which there are resulting improvements in risk of child abuse/neglect. Understand factors impacting whether families are participating in services.
2. Determine extent to which OCFS is monitoring whether family is cooperating/receiving voluntary services and what actions are being taken when a family is not receiving services.
3. Determine extent to which ARP is monitoring whether family is cooperating/receiving voluntary services and what actions are being taken when a family is not receiving services.

Note that these potential next steps would likely involve review of case records.

I. Extent to which mandated reporters, OCFS and ARP seek to verify, and can verify, information reported by a child's parents.

Potential Next Steps

1. Establish expectations/requirements for when schools should require parents/guardians to provide documentation supporting reasons for frequent or extended absences from school whether excused or unexcused and regardless of age. (possible statutory change)

2. Explore possible options for facilitating a school's ability to independently verify, directly with health care providers, health care information on a student provided by a parent/guardian.

3. Understand how home schooling impacts effectiveness of child protection system.

J. Effectiveness of 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.

Potential Next Steps

1. TBD

K. 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.

Potential Next Steps

1. Establish expectation/requirement that schools share information on observed risks for child abuse/neglect, including reports and involvements with DHHS, for students transferring to another school.

2. Explore barriers/challenges and options for facilitating/requiring sharing of information on potential or actual abuse/neglect risks and actions for a child among key mandated reporters including:

    - DHHS to reporters on actions taken on reports they made;
    - DHHS notification to schools, law enforcement and health care providers when assessments/cases are opened and closed; and
    - Between and among law enforcement, schools, health care providers and DHHS.

From Public Comment

L. Strengthen Maine's mandated reporter laws and establish means to hold mandated reporters accountable for meeting reporting and training requirements.

Potential Next Steps

1. Determine whether other states mandated reporter laws have aspects that Maine should consider adopting.

2. Establish expectation/requirement that mandated reporters who are licensed or certified professionals must have obtained statutorily required training before obtaining licenses or certifications.(possibly statute change

   Note this has been considered in two past bills but not enacted. Proponents cite potential issues with implementation and monitoring of compliance with such a requirement.

3. Establish criminal penalty for mandated reporters who fail to report.

   Note that this has been considered in a past bill and was not enacted. Current statute currently has a civil penalty. Public commenters at the GOC meeting on May 31st expressed concern about how this would be meaningfully implemented/operationalized. OPEGA observes that it would seem necessary to specify/define "reasonable cause to suspect" before establishing a criminal penalty.

M. Ensure that child's best interest is primary consideration in all child protection actions and decisions.

Potential Next Steps

1. Assess impact of recent statute change from LD 1187 that defines child's best interest in child protection statutes and whether additional statutory changes may be useful for clarifying child's best interest is primary for DHHS and courts.

2. Understand how federal laws and regulations are impacting DHHS and court decisions/actions with regard to child's best interest and family rehabilitation and reunification.

3. Understand what factors are impacting decisions and actions by OCFS caseworker and supervisors – see Item G.

N. Address barriers/challenges impacting OCFS caseworkers' and supervisors' effectiveness in performing assigned functions.

Potential Next Steps

1. Understand factors impacting OCFS caseworkers' and supervisors' effectiveness in performing assigned functions.

Note that this understanding may be gained from work done in addressing other potential areas for concern and improvement as noted by OPEGA. Other potential avenues for gaining this understanding include conducting surveys of, or focus groups or interviews with, caseworkers and supervisors.

O. Address challenges/factors impacting retention of OCFS caseworkers and supervisors.

1. Understand factors impacting retention of OCFS caseworkers' and supervisors'.

Note that this understanding may be gained from work done in addressing other potential areas for concern and improvement as noted by OPEGA. Other potential avenues for gaining this understanding include conducting surveys of, or focus groups or interviews with, caseworkers and supervisors.