Testimony of
Commissioner Jeanne M. Lambrew, Ph.D.
Department of Health and Human Services

Before the Joint Standing Government Oversight Committee

OPEGA Information Brief on Frontline Workers in the State Child Protective System

Hearing Date: March 8, 2019

Good Morning Senator Chenette, Representative Mastraccio, and esteemed members of the Government Oversight Committee.

I am Jeanne Lambrew, Commissioner of the Department of Health and Human Services. I want to begin by thanking you for the opportunity to testify before you today. I also want to thank Danielle Fox and the staff of the Office of Program Evaluation and Government Accountability (OPEGA) for the hard work, dedication, and professionalism that they have exhibited in their work regarding the Office of Child and Family Services (OCFS). Their efforts to review specific cases and study the perspective of frontline workers has been invaluable to the Department of Health and Human Services (DHHS) as we identify areas in need of improvement, prioritize resources, and implement change.

I also want to thank OCFS staff who have been spearheading our work discussed today: Acting Director Elissa Wynne and Associate Director of Child Welfare Services Bobbi Johnson among others.

The Office of Child and Family Services' primary goal is to provide services and support to enable Maine's children and their families to lead safe, healthy, and fulfilling lives. Specifically, child welfare services workers seek safety, well-being, and permanency for children. Child welfare staff partner with families and the community in their work to prioritize child safety and well-being, while also considering the rights and responsibilities of parents. This is difficult work. I commend frontline caseworkers, supervisors, and other District staff for their dedication and commitment to the families they serve.

As you all know, over the past year, OCFS has been the subject of intense scrutiny as the result of the tragic deaths of two Maine children. A significant amount of evaluation has occurred since these deaths, both internally and externally. But the concerns regarding child welfare services' ability to adequately address the safety of Maine's children predate the deaths of Marissa Kennedy and Kendall Chick. A number of these concerns are unrelated to those tragic events.

I can tell you that the Governor, my entire Department, and I are committed to systemic improvements to ensure the safety and well-being of all Maine children. The Governor has announced that she will convene a Children's Cabinet so our work revolves around a child's needs rather than siloed programs and Departments. Similarly, at DHHS, the work we have undertaken to evaluate, plan, and implement improvements aims to consider the entirety of the child welfare system, which includes OCFS, as well as other programs and organizations whose work impacts child welfare. We are taking special care to ensure that our work incorporates the specific needs of Maine's children and families. And, here and throughout the Department, we aim to do so with transparency. Our reports are posted online and, earlier this week, we added the first of what will be regular OCFS updates to let the public know about our progress.

And thanks to the work of OCFS, advocates, other partners, and the Legislature, we are not beginning from scratch. The child welfare system is already benefiting from some of the early work done over the

past year. In particular, the Department has undertaken improvements as a result of LD 1923, passed in a special session of the 128th Legislature last fall. Because of this legislation, OCFS has:

- Hired 39 staff, including 2 regional associate directors, 16 supervisors, 16 caseworkers, and 5 case aides, and is in the hiring process for an additional 3 case aides.

- Since last September, paid a $5 per hour stipend to caseworkers, supervisors, assistant program administrators, and program administrators. We expect to fully implement the additional $1 per hour stipend for staff who hold a relevant master's degree by May of 2019.

- Increased the reimbursement rates for foster families starting last September.

- Worked with the Office of Information Technology to start work on an upgraded information technology system to document and track the child welfare's work. The current system, Maine Automated Child Welfare Information System (MACWIS) is nearly twenty years old. Clearly, a new system is needed. This new technology will streamline documentation and recordkeeping, which will create efficiencies that will allow OCFS staff to spend more time working directly with families to address child safety and family wellbeing. A new system will also improve our ability to conduct continuous quality improvement and quality assurance activities to ensure that cases are proceeding as expeditiously as possible. Timely permanency for children is a high priority for OCFS, and a new computer system will play an important role in ensuring children do not linger in our system. We expect to publish a request for proposals (RFP) this summer.

- Lastly, we are in the planning process for LD 1923's pilot of a new model for family visitation. This model includes coaching and parent education within the visits which is intended to improve the parent's ability to safely care for their children. The goal is for the pilot to become operational during the summer of 2019. OCFS will closely review and evaluate the effectiveness of this program as it considers whether to expand the model Statewide.

These changes represent an important first step towards long-term improvements in Maine's child welfare system, but much work remains. To that end, the Department has been reviewing the reports and findings of other organizations tasked with evaluating the child welfare system as well as completing an extensive internal review.

OCFS has benefitted immensely from the work of OPEGA. The February 2019 report provides a comprehensive review of the perspectives of frontline staff. The information contained in this report is particularly valuable because of the manner in which it was gathered, via surveys and interviews conducted by OPEGA staff (not by OCFS staff, Department staff, or the staff of a contracted entity). Since this report was released, we have been reviewing the wealth of unique information it contains and planning how best to address the concerns of our staff.

The Child Welfare Services Ombudsman has also been a resource for the Department as we have undertaken systemic change. The Ombudsman has a unique perspective of reviewing individual cases at the request of members of the public. This vantage point provides an extraordinary perspective on the day-to-day operations of the child welfare system and, as a result, the Ombudsman has considerable knowledge of the strengths and weaknesses of the system. OCFS is dedicated not just to reviewing and responding to the Ombudsman's yearly report, but also to working with the Ombudsman on a regular basis to address case-specific and general concerns.

Internally we have undertaken a child welfare evaluation and business process redesign with the assistance of Public Consulting Group (PCG). The evaluation began in October of 2018 and is slated to continue through March of 2020. The goal is to evaluate the current system to identify changes needed to improve the safety, permanency, and well-being for children and families who are served by OCFS and to develop a plan to both implement and sustain the needed change. Both OCFS and PCG are dedicated to utilizing a variety of qualitative and quantitative research methods, with a particular focus on the experience and needs of the frontline staff. The final report from the first phase of this project was released on February 8th. It focuses primarily on identifying areas for improvement in child welfare policy and practice and contains fifty-one specific recommendations which touch on all areas of child welfare, from technology, to caseload standards, to court involvement.

Across all of the evaluations, we have seen some common themes emerge. In these areas, we are striving to develop and implement change quickly, while also ensuring that this work is done thoughtfully so the changes are sustainable into the future. Here are four examples of actions taken in response to clear needs.

- The child welfare intake unit was identified as an area in need of improvement. The work done within this unit is vitally important. It is where the decision is made to screen-in or screen-out reports of abuse and/or neglect. We recently added 7 new positions to the intake unit and we are working towards fully staffing these positions. We are collaborating with the Office of Information Technology to identify areas that need improvement within the phone system and have developed a plan to modernize this system over the next three months – with the goal of improving call routing, call-back functionality, data collection and reporting, and management tools to support staff in continuous quality improvement.

- Child welfare staff have continually emphasized their need for additional information as they make decisions about child safety. Of particular concern was our staff's limited access to criminal history information. As a result of LD 1921, in late 2018, OCFS was able to partner with the Office of the Attorney General, the Department of Public Safety, and the Federal Bureau of Investigation to quickly create a background check unit within child welfare that has access to an expanded array of criminal background information, including national criminal history. The program has been in operation for several months providing national criminal history information on all new matters in York and Cumberland counties and to other areas on an as needed or emergency basis, and is expected to grow to cover the entire State. In January alone, the unit conducted over 1,100 checks. The Access Integrity Unit within the Department of Public Safety recently performed an initial audit of OCFS' background check unit and praised the unit's accuracy and documentation. We are working on plans to build on the early success of this pilot.

- We've also heard clearly from staff that they are concerned about the workload balance for frontline workers. PCG is finalizing a Workload Analysis Tool which incorporates the specific duties and activities required of OCFS' frontline staff and the time needed to complete these activities in a way that has a meaningful impact on children and families. While we await the completion of that tool, we have been working to fill all current staff vacancies within child welfare to reduce the caseload.

- Another issue identified in the early evaluations was the need for the increased availability of clinical consultation services. These services were envisioned to encompass both case-specific consultation regarding the clinical aspects of a particular assessment or case, as well as clinical support for staff. OCFS has been developing an RFP for this service which we expect to release by summer.

I want to emphasize: we are relying on the OCFS frontline staff not to just identify problems, as they did in the OPEGA and PCG reports. We want their input as we prioritize solutions. Their perspective on ideas for improvement are vital to ensuring that the recommendations we implement are grounded in the day-to-day realities of this challenging work. This is of particular importance to me because one of my priorities as Commissioner has been to ensure that staff in all of our Offices and Divisions have the opportunity to help shape the direction of the Department. To that end, we are currently in the process of surveying OCFS staff regarding their perspective on the prioritization of the 84 recommendations made by PCG, the Ombudsman, and others. We expect to have that work completed by the end of the month so we can begin to incorporate the staff's priorities into our plan for short-term and longer-term improvements. We are authorizing 30 minutes of overtime pay to hourly staff who complete the survey to demonstrate the value we place on their input.

One of my primary goals for the Department is to ensure that we are doing everything possible to provide services and supports which improve the health, safety, and wellbeing of Maine's people. That goal has been reflected in a number of early initiatives of the Mills Administration, including the Medicaid or MaineCare expansion, measures to address the opioid crisis, and work to reinvigorate the public health nursing program. It is no coincidence that these initiatives all have a direct impact on the child welfare system. These improvements in the supportive services for those who are most vulnerable in our State have both direct and indirect impacts on child welfare services. Parents who are struggling to safely care for their children due to substance use disorders will have greater access to treatment. Public health nurses can work with families to ensure infants born affected by substances have access to services which will improve long-term outcomes. Access to MaineCare ensures that parents can afford medical and behavioral health care which has a direct impact on their ability to safely parent their children. Our work to improve child welfare services is part of the larger effort to advance the Department's mission. And it is consistent with the Governor's goal for Maine people of hope: advancing our health, opportunities, prosperity, and education.

I am confident we can do so. As I have become familiar with Maine child welfare system, I have learned that its greatest asset is the people who work within it. This includes the staff of OCFS, the Attorney General's Office, the courts, and the multitude of providers whose work intersects with child welfare services. Every individual is dedicated to the safety and well-being of children and families. It is this dedication and resolve that grounds my belief that the improvements we implement will have a real and lasting impact on the safety and wellbeing of Maine's children and families.

I thank you for the opportunity to testify today.

Testimony of Chris Bicknell
Speaking about the OPEGA Information Brief of February 2019 as it pertains to the lack of temporary placement options for youth in OCFS custody awaiting foster placement
Before The Joint Government Oversight Committee
Friday, March 8, 2019

Sen. Chenette, Rep. Mastraccio and members of the Joint Government Oversight Committee my name is Chris Bicknell and I am the Executive Director of New Beginnings the only agency in Maine focused solely on serving runaway and homeless youth in the state.

I am speaking today about the lack of temporary medium to long-term placement options for older youth in OCFS custody who are awaiting foster placements. This has been completely overlooked in the OPEGA Information Brief. Currently there are only three options available for older youth in OCFS custody who can't be placed immediately; kinship placement, hotels and emergency shelters for youth.

All of the evidence shows that placing youth in hotels with revolving staffing is not in the best interest of the children being placed, it is actually a traumatizing experience that compounds the trauma of being separated from their family. This practice has also proven to be excessively burdensome to the staff supervising them. These factors do not even take into account that placing children in hotels is not cost effective for the taxpayers of this state as a result of staff overtime expenses and hotel fees. For these reasons I would recommend that the practice of placing children awaiting foster placements in hotels be stopped imediately.

The use of licensed 24-hour emergency youth shelters for temporary placement has historically been a safe option for children awaiting foster placement. They can stay for up to three months during the vetting process of a foster family. Children are able to continue their education, have access to safe supportive adults, receive medical care and a host of other supportive services including family mediation when it is safe and appropriate to do so.

However in the past three years older youth in OCFS custody have been placed in emergency shelters indefinitely, some for as long as 20 months. This is unhealthy for those youth for a number of reasons. First among those is that emergency shelters are not designed for long term care they are defined under statute as short term. As such they are not equipped programmatically to provide for the long term care of youth.

What ends up happening with these youth is that they become discouraged as they see others come and go while they languish in the shelter without any hope of a long-term placement. Many give up hope and act out, some get dropped from care by OCFS for refusing to "participate" in their care plan some get transferred to less structured programs that are less expensive.

The reality is that older youth in care often wait longer for placements than young children and infants or bounce in and out of placements and from foster family to foster family. These older youth need safe supportive environments in order too not only survive these long waits but to potentially thrive despite them. I strongly believe that Maine has a severe lack of medium to

long-term residential placements that are designed to meet the needs of these older sometimes difficult to place youth.

There is however one other option. Eight years ago OCFS closed all of the residential programs for foster youth. This was an overreaction that resulted in there being no residential options for youth who were difficult to place, older, or who refused to be placed in families that were not their own. Maine needs to create three or four congregate care facilities for older youth in different regions of the state. This would allow those older more difficult to place youth to stay closer to their communities of origin and natural supports and be in safe supervised programs designed specifically to meet their needs.

Thank you for taking the time to hear my concerns and if you have any questions I would be happy to answer them.

Sincerely,

Chris Bicknell

Amy K. Cobb, Ed. M, LSW
Waterville, ME 04901
Contact information available upon request

March 1, 2019

Government Oversight Committee
82 State House Station
Augusta, ME 04333-0082

Dear Senator Justin Chenette, Representative Anne-Marie Mastraccio, and other members of the Government Oversight Committee,

My name is Amy Cobb and I live in Waterville. I am currently a child protective caseworker at the Central Intake Unit within DHHS/OCFS. I have worked in this position since March 2013, answering calls and processing reports of child abuse and neglect on the 24/7 hotline. From 2004 to 2011, I worked as a child protective permanency worker in the Augusta District Office. My comments in this letter are my own and in no way speak for the department, office, or unit for which I work.

First, I want to express my appreciation for the actions of the 128th legislature on Sept 7, 2018 in passing the emergency legislation which included funding for a $5-6 hourly stipend, an updated computer system, and additional staff. I am also grateful for the actions of this committee as well as the diligent work of OPEGA in looking to examine our child protective system in Maine. In my opinion, the information brief issued on February 22, 2019 was an extremely accurate depiction of the perspectives of those of us doing the work every day.

During the legislative meeting on February 22, there were a number of questions raised about whether child welfare functioning has improved since the fall. In my opinion there is no "yes" or "no" answer. I would encourage the committee to recognize the myriad contributing factors that brought our child welfare system to what I can only hope is the nadir of its functioning. Some issues have been longstanding while others occurred over the past year. Some things have certainly begun to improve (staffing); others remain unchanged (shifting procedures/policy communicated via memo). We have been told the target timeline for a new computer system is about two years. We have only had a new commissioner and a new acting director for a short period of time. The changes that are needed are substantial. They should be done in a thoughtful, studied manner—a departure from the reactive method of the past year. I will note that the communication coming from our new leadership has been refreshing in its message of intent to engage with front-line staff and provide thoughtful, lasting change that will benefit the children and families of Maine.

An issue that I wish to highlight for the committee is what happens with "appropriate" reports.[1] As you have learned, appropriate reports are sent to the local office from Central Intake, where they are either assigned for an OCFS assessment or an ARP[2] assessment. It is important to recognize the distinctions between an OCFS assessment and an ARP assessment. Findings of child abuse and neglect, petitions for court action, and removal of a child due to safety concerns can only occur in an OCFS assessment. For years, staffing levels have prohibited our agency from assigning all appropriate reports to an OCFS worker. The local office reviews appropriate reports with low/moderate severity allegations and assigns

[1] Reports that contain an allegation of child abuse/neglect as defined by OCFS policy.
[2] Alternative Response Program (Contracts held by local agencies who employee staff to conduct assessments.)

some of them for ARP assessment. ARP is a voluntary program where parents must sign paperwork to participate.

The practice of sending reports with allegations of abuse/neglect to ARP has long been the subject of debate. Because the decision is based both on staffing availability as well as the nature of the report, reports of a similar nature may have different outcomes. One family may be asked if they voluntarily want to work with ARP while another family is not given that option, exposing the caregiver to potential findings and court action. For years, if a family declined ARP, the report was closed with no further action. One of the positive changes that occurred in March 2018 was that an OCFS assessment was automatically begun if a family declined ARP. However, also in March 2018, ARP services abruptly ended for families residing in four counties. As stated in the OPEGA report, these actions contributed to the incredible increase in caseworker workload.[3]

One of the difficulties at intake is that reports either get "all" or "nothing." Our only choice is to recommend no intervention at all or assessment. Some of us have long advocated for a tiered system. One example (my personal preference) would be three tiers: 1) clear cut incidents of abuse/neglect always assigned for OCFS assessment, 2) circumstances that have risk factors for abuse/neglect but no clear allegation sent to ARP, and 3) reports that contain information that suggest one or more family members could benefit from engaging in social services (case management, counseling, Public Health Nursing, Maine Families, etc) referred to someone who could assist in linking the family to services. We do not have those choices. Rather than a tiered system, reports are either screened in with allegations of child abuse/neglect, or screened out with no follow up.[4]

In 2016, OCFS began the development of Structured Decision Making (SDM) at intake. The idea of SDM was to formalize and tighten the criteria that determines if a report is appropriate for intervention (aka "screened in"). We were told that other states who implemented SDM found that they screened in less reports overall, which led to less assessments, which ultimately led to less cases. This was a strategy that upper management was very interested in, as the caseloads were known to be overwhelming. Additionally, we were told that intake staff as a whole (workers, supervisors, manager) were "risk averse," screening in reports that did not warrant assessment.

We were encouraged when the SDM intake tool was initially being developed because it clearly stated that assessments should only be conducted by OCFS staff to ensure all families are receiving the same intervention. Reports that did not meet criteria for allegations would be reviewed for the presence of risk factors (substance use, mental health issues, domestic violence, criminal activity, etc). If one or more of these risk factors were present, the report could be sent to ARP (which would change names to CIP[5]). A family's involvement with CIP would be voluntary and would not expose a family to a possible finding of child abuse/neglect.

In May 2017, intake began using the SDM tool to process every report of suspected child abuse and neglect. As expected, the numbers of appropriate reports decreased. However, we were told that there would be no change to the existing process of the local office assigning some appropriate reports to ARP and some to OCFS. Additionally, we were instructed that nothing would be happening at that time with

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[3] OPEGA information brief, February 22, 2019, page 8

[4] Prior to Sept 2017, there were various initiatives that allowed for a very small number of referrals on screened out reports to be made to CPPC and other prevention programs. We were notified via email in Sept 2017 that these would no longer be an option because CPPC was being discontinued. There remains one mechanism to refer certain reports involving newborns/expectant parents to Public Health Nursing and Maine Families.

[5] "Community Intervention Program." This is essentially synonymous with Alternative Response Program.

the screened out reports containing risk factors because the infrastructure did not exist to handle the referrals. By September 2017, we continued to be told that the CIP referral protocol was a work in progress. As of this writing, referrals are still not being made to ARP on screened out reports with risk factors.

The OPEGA brief already described the additional concerns about SDM missing serious cases of physical abuse and drug abuse because of how the tool requires "impact" to be shown to children, yet very young children are unable to express if or how they have been impacted.[6] If we at least had the CIP referral process, we would not be faced with the "all" or "nothing" dilemma. We have continually provided feedback to upper management with ideas for edits and improvements to SDM as well as requesting a timeline for change. As of this writing, we are still using the exact SDM tool that we began using in May 2017. Rather than addressing the core issues, in March 2018, upper management directed us to screen in every 3rd report received within six months on the same family.[7] This caused OCFS assessment workers to be assigned child custody disputes and repeated neighbor conflicts—circumstances that diverted our scant resources away from legitimate child safety concerns.

As a licensed social worker, I have a professional obligation to adhere to the core values of social work: service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. In the last several years, I have found my capacity to uphold these core values strained on an almost daily basis while working for a child welfare system in chaos. My colleagues across the state and I are capable, committed professionals who are eager to be part of improving our system. We must do better for the children and families of Maine.

Sincerely,

Amy Cobb

[6] OPEGA information brief, February 22, 2019, pages 9, 15 and 18

[7] OPEGA information brief, February 22, 2019, page 8

Testimony of Pamela Day
Speaking Before The Joint Standing Committee on Government Oversight
Friday, March 8, 2019

Senator Chennette, Representative Mastraccio, and members of the joint standing committee on Government Oversight: My name is Pamela Day, and I am representing a network of organizations invested in child welfare reform. These organizations include The Opportunity Alliance, the Maine Children's Alliance, Sweetser, Volunteers of America Northern New England, Community Concepts, Spurwink, KidsPeace New England, and Adoptive and Foster Families of Maine (AFFM).

As noted in the OPEGA Frontline Workers report, multiple issues impact staff capacity including workload, supervision, training, turnover, overtime, and placement resources. I am speaking today to urge Maine's leaders to act on the findings in the OPEGA report by establishing caseload limits in order to lower caseload burdens for front-line child welfare workers, and to provide them with the opportunity to work effectively with children and families.

Child welfare caseworkers in Maine are currently required to serve too many children and families. This negatively impacts both caseworkers in the Department, and the children and families they are meant to serve. The Child Welfare League of America[i] and the Maine State Employees Association[ii] have developed recommendations for child welfare caseload standards. We urge our state's leaders to develop and codify a formula for child welfare caseload limits, and to increase the number of workers as needed to ensure caseload limits are met.

In order to fill new and existing positions with well trained workers we also urge the Department, with the support of the legislature, to establish a working relationship with schools of social work and other educational institutions, as needed, to prepare students for the demanding work of child welfare. Our recently published white paper[iii] provides additional recommendations on the important partnerships that are needed to develop a solid and effective workforce.

In addition to establishing caseload limits and building a competent workforce, there must be a mechanism in our state law that ensures the necessary funding to meet caseload requirements. Our current statute links state action in situations of child abuse and neglect to the availability of funds: "*The department may take appropriate action, **consistent with available funding,** that will help prevent child abuse and neglect and achieve the goals of section 4003 and subchapter XI-A.*"[iv]

This element of our statute has resulted in budgeting decisions that have left our current system without the necessary resources to keep children safe. We believe all children are entitled to protection from harm and that providing this protection requires adequately resourcing our child welfare system. We urge our legislative and executive leaders to revise this statute to ensure that our commitment to protecting children from abuse and neglect not be impacted by shifting budget priorities in the future.

We appreciate the efforts already underway by the Department to address these important issues and we look forward to answering your questions.

Sincerely,

Pamela Day

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[i] Child Welfare League of America Direct Service Workers Recommendations for Child Welfare Financing and System Reform, p. 5 https://www.cwla.org/wp-content/uploads/2014/05/DirectServiceWEB.pdf

[ii] Maine State Employees Association, Our Vision for Child and Family Services

[iii] Maine Child Welfare Priority Reform Recommendations https://drive.google.com/open?id=1LvHDQW-ZOQKkdwVj3vFget7EtqjeHw_U

[iv] MRSTitle22 Chapter 1071 Section 4003-4004, http://legislature.maine.gov/legis/statutes/22/title22sec4003.html

My name is Brian Houston. My wife, Lia, and I are resource parents living in Gardiner. We have been foster licensed since 2015. I am very uncomfortable testifying today because I am worried about the repercussions, however I am more afraid for the children in state custody and those who may soon be. Over the last year, we have met with many parents and families who have come to us and shared the following stories:

- One parent was threatened to sign a termination of parental rights on their youngest child or face losing their older children
- A sibling group was left multiple times by a case worker with an intoxicated parent
- Foster parents reported physical abuse on a child that went ignored
- Allegations of inappropriate sexual contact were dismissed without investigation by the department
- A mother who had been clean for two years has yet to again see her three children
- A child who is being reunified with a sex offender
- A child who was raped after her grandmother begged the department not to send the child back to her mother's house

I am here to ask you for help for all of these children and families. Maine needs to do 100% better. Since 2015, my wife and I have gone up the chain of command, all the way to the former acting commissioner, raising red flags about the system, saying that children would die if something wasn't done about the practices and actions in the OCFS. Unfortunately, our worst nightmare was realized. Two girls died. We know of one unreported child death in which the department was involved in 2015, and have been told of two others in 2018. You, the legislature, need to demand transparency from the department. OPEGA and the Public Consulting Group need to expand their investigations to include biological parents, foster parents, grandparents,

guardian ad litems and others. These public hearings are not going to give you the full truth about how to fix the system because anyone with a child they love in state custody will never step foot in a public setting to testify about their experiences because they are afraid of losing that child.

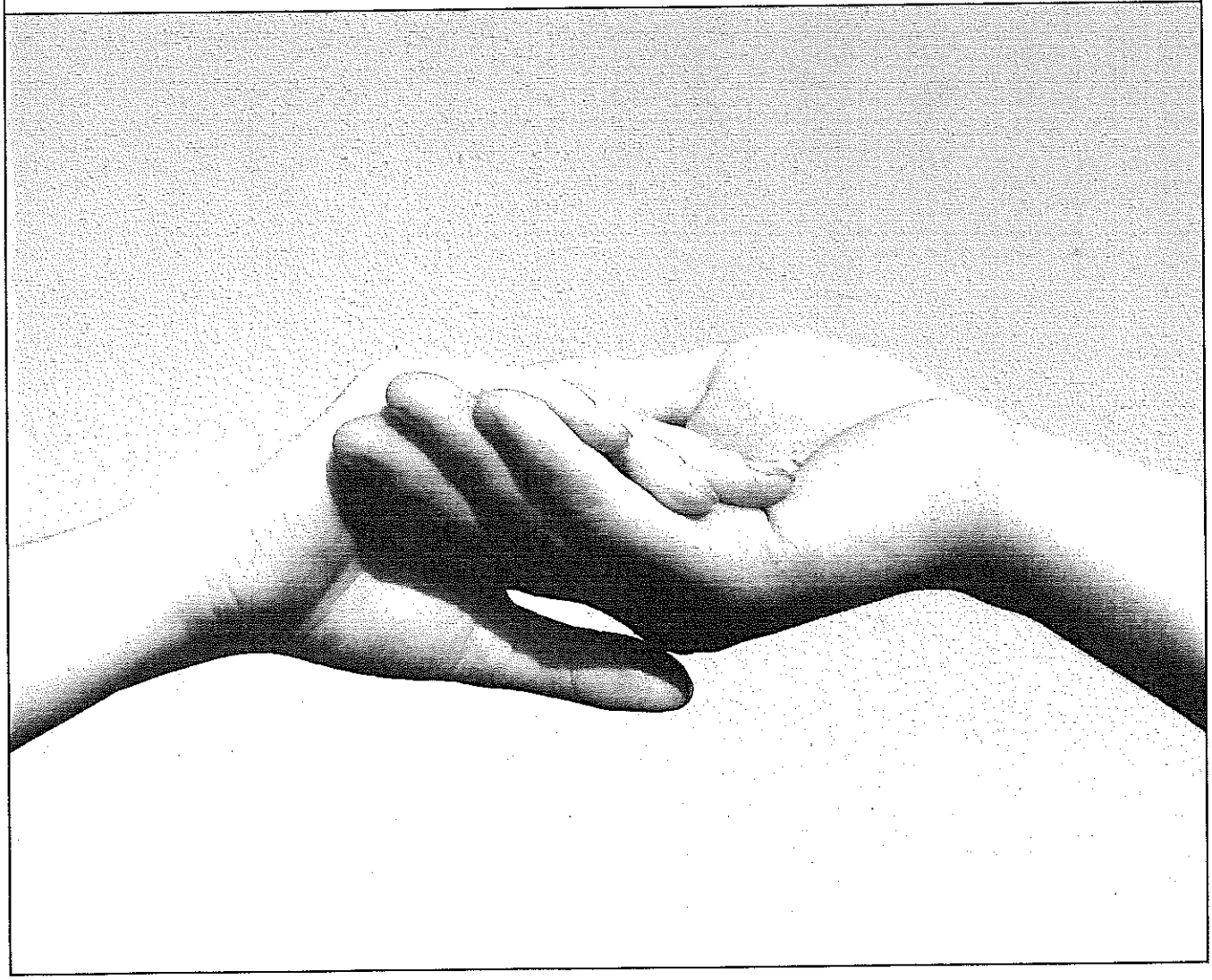
Furthermore, there is a lot of talk about caseworkers staying in hotels with children. The department is not utilizing their resources. After our foster child was reunified, we put ourselves back on the active fostering list for placements of newborns to children age two. The first month back on the list, we received two calls that were for large sibling groups inappropriate for our two-bedroom home and then we received no calls for 15 months. During that quiet spell we called to see what was going on and were twice told that there were no infants or small children entering the system. Seven months ago, our former foster child re-entered state custody, we unsuccessfully sought involvement in that case, and since then, have received two calls for sibling groups. In addition, our home study report states that the department found that we "did not understand that reunification was the top priority." When my wife asked the then deputy director of OCFS about this and explained that we had advocated for our foster child's safety, as well as for the parent's rights, Lia was told that "advocating for child safety is sometimes interpreted by a caseworker as interfering with reunification."

Lia and I have been told by many people in both government and child development that the child welfare system has been broken for decades. We have fought for 4 years to make the system better for children and their families and we can say from recent personal experience that nothing has changed in the execution of these cases by the department or the courts. If the emphasis is never placed on child safety and wellbeing, why would you ever expect the results to be any different?

Maine

CHILD WELFARE SERVICES OMBUDSMAN

16TH ANNUAL REPORT • 2018



CHILDREN'S OMBUDSMAN

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The 2018 Maine Child Welfare Ombudsman Annual Report was written and prepared by:

CHRISTINE E. ALBERI, Esq.
Executive Director, Ombudsman

I am honored to present the sixteenth annual report of the Maine Child Welfare Ombudsman. Maine Child Welfare Ombudsman, Inc. is an independent non-profit solely dedicated to fulfilling the duties and responsibilities promulgated in 22 M.R.S.A. § 4087-A. The Child Welfare Ombudsman provides neutral investigations of complaints brought forth against the Maine Department of Health and Human services, Office of Child and Family Services ("the Department"). The Ombudsman also provides information about child welfare services to the public.

This year was marked by the heartbreaking deaths of two young girls, Marissa Kennedy and Kendall Chick. These deaths brought into sharp focus the realities of the child welfare system, and highlighted difficulties and trends that have been at issue for many years. While the details of these deaths have not been made public, the resulting attention and reforms have been necessary for the safety and well-being of thousands of other anonymous children who are at risk of harm or who have been harmed by their parents or caregivers.

In August of this year, a package of reform bills was passed by the legislature and signed into law by Governor LePage in September, increasing staffing and adding other resources to help support front line staff and foster parents. These newly enacted laws were a substantial step in the right direction, but further reforms are necessary:

- Caseworkers and supervisors must receive rigorous and ongoing training in investigative techniques so that the two most important decisions in the life of a case can be made correctly: 1) whether the home is unsafe and 2) whether a child should be safely returned to a parent. All other considerations are secondary in importance to this. Staffing must be sufficient to give caseworkers and supervisors time to complete training, support new staff, and handle a reasonable caseload.
- The Office of Program Evaluation and Government Accountability ("OPEGA") is completing a survey of child welfare employees in the Department, as well as assessing the effectiveness of reforms implemented internally by the Department. OPEGA's forthcoming report, as well as the previous report issued after reviewing the deaths of Marissa Kennedy and Kendall Chick should be used by the Governor, Legislature and the Department to inform continued reforms that are effective and discontinue those that are not.
- The Child Welfare Ombudsman has a unique vantage point from which to view the child welfare system throughout the state. The considerable knowledge gained from reviewing hundreds of confidential case records is invaluable in identifying primary problems within the complex system of child welfare. The Ombudsman's office is a resource that has been underutilized by the Department and lawmakers, partly due to a lack of resources within the Ombudsman's office. Strengthening the ability of the Ombudsman to advocate for necessary case specific and systemic change would be a clear way to strengthen the system as a whole. Redefining the structure of the office, increasing staff to adequately respond to requests and improving visibility of the office are recommendations made by the Ombudsman Board of Directors.

In Maine there is now momentum to support much needed changes in Child Welfare. The urgency that exists now cannot be lost or the Department will not have the support and resources necessary to protect children in both the long and short term. I would like to thank both Governor LePage and the Maine Legislature for continuing to support the Maine Child Welfare Ombudsman and I look forward to working with the Governor, Legislature and the Department to continue to improve practice, policy and law in a joint effort to keep children safe.

Sincerely,

Christine E Alberi

Christine Alberi, Child Welfare Services 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.

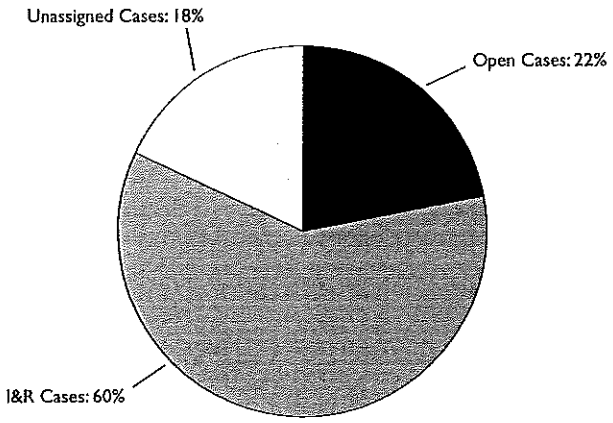
More information about the Ombudsman Program may be found at http://www.cwombudsman.org

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, 2017, through September 30, 2018.

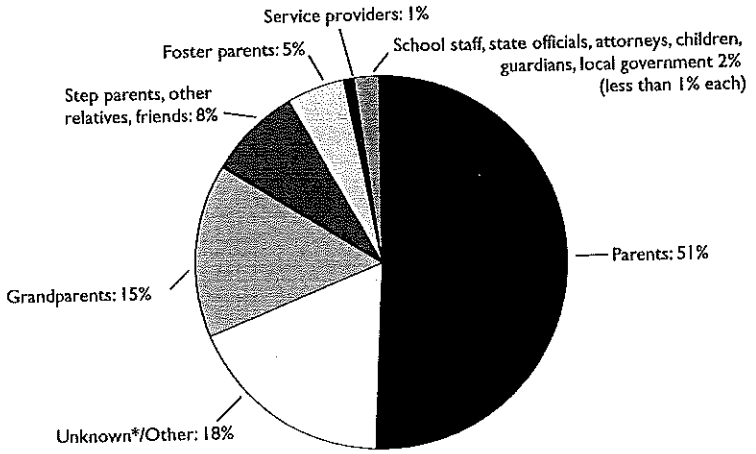
In Fiscal Year 2018, 605 inquiries were made to the Ombudsman Program, an increase of 101 inquiries from the previous fiscal year. As a result of these inquiries, 110 cases were opened for review (22%), 364 cases were given information or referred for services elsewhere (60%), and 131 cases were unassigned (18%). 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?



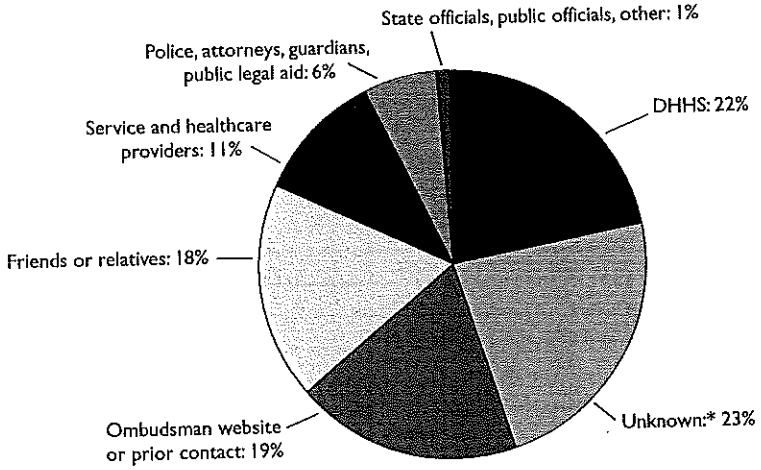
WHO CONTACTED THE OMBUDSMAN PROGRAM?

In Fiscal Year 2018, the highest number of contacts were from parents, followed by grandparents, then other relatives/friends, and foster parents.



HOW DID INDIVIDUALS LEARN ABOUT THE OMBUDSMAN PROGRAM?

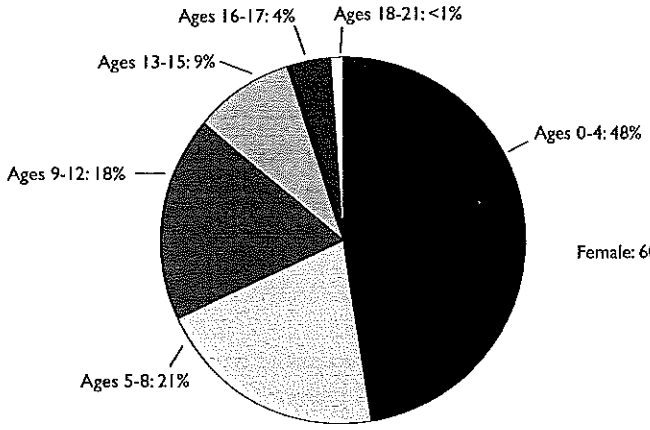
In 2018, nineteen percent of contacts learned about the program through the Ombudsman website or prior contact with the office. Twenty-two percent of contacts learned about the Ombudsman Program through the Department of Health and Human Services.

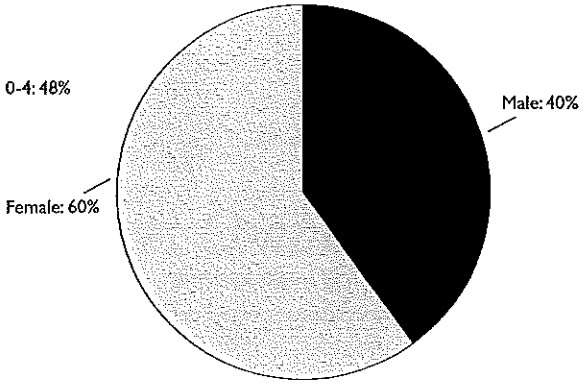


* *Unknown* represents those individuals who initiated contact with the Ombudsman, but who then did not complete the intake process for receiving services, or who were unsure where they obtained the telephone number.

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 186 children represented in the 110 cases opened for review: 40 percent were male and 60 percent were female. During the reporting period, 69 percent of these children were age 8 and under.





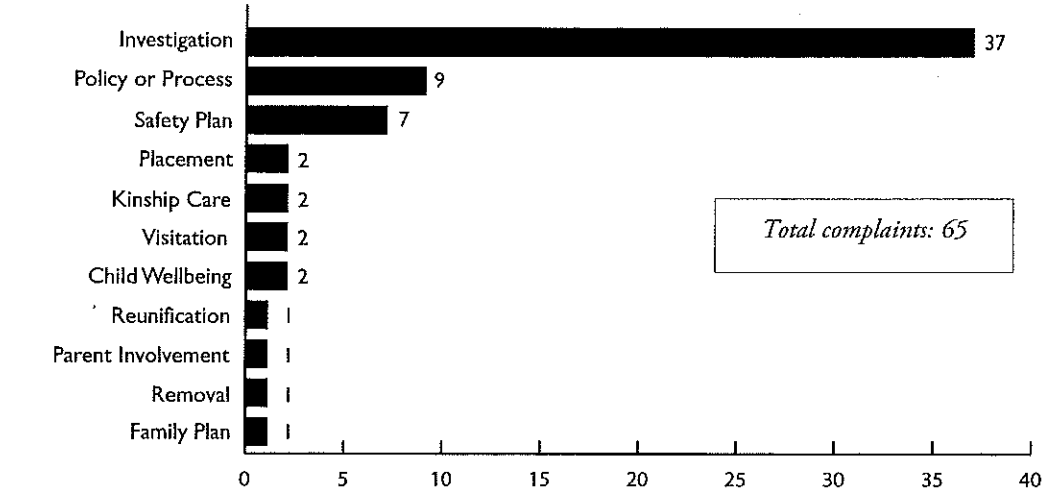
HOW MANY CASES WERE OPENED IN EACH OF THE DEPARTMENT'S DISTRICTS?

			DISTRICT	CHILDREN	
DISTRICT #	OFFICE	CASES	% OF TOTAL	NUMBER	% OF TOTAL
0	Intake	2	2%	4	2%
1	Biddeford	18	16%	29	16%
2	Portland	9	8%	17	9%
3	Lewiston	13	12%	25	13%
4	Rockland	8	7%	8	4%
5	Augusta	27	25%	49	26%
6	Bangor	17	15%	29	16%
7	Ellsworth	12	11%	18	10%
8	Houlton	4	4%	7	4%
TOTAL		**110**	**100%**	**186**	**100%**

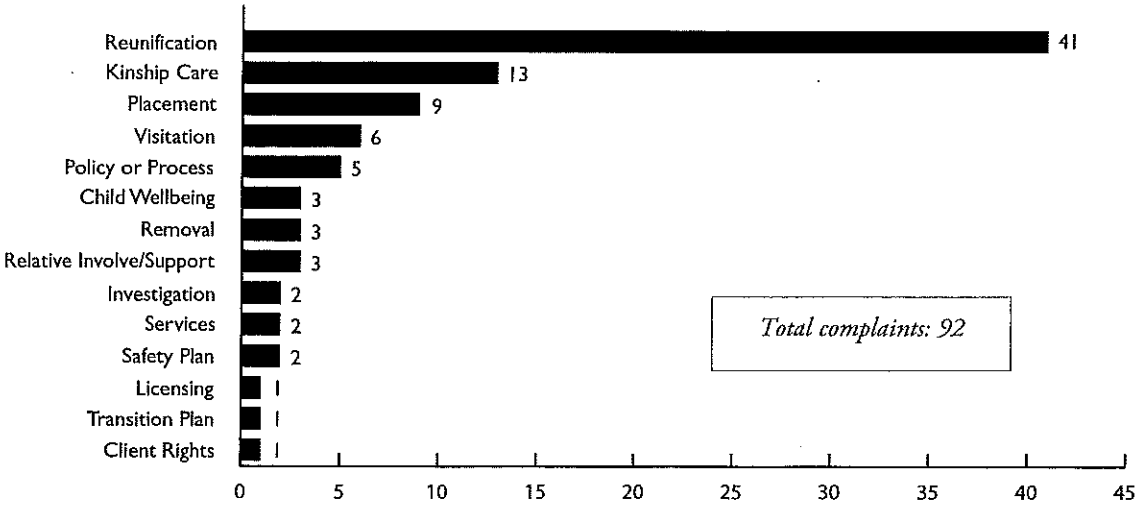
WHAT ARE THE MOST FREQUENTLY IDENTIFIED COMPLAINTS?

During the reporting period, 110 cases were opened with a total of 158 complaints. Each case typically involved more than one complaint. There were 65 complaints regarding Child Protective Services Units or Intakes, 92 complaints regarding Children's Services Units, most during the reunification phase.

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



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 108 cases that had been opened for review. These cases included 163 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	6	7
Valid/Not Resolved*	14	13	27
1. Action cannot be undone	14	11	
2. Dept. disagrees with Ombudsman	0	0	
3. Lack of Resources	0	2	
Not Valid	57	76	133
TOTAL	**74**	**89**	**163**

* Total of numbers 1, 2, 3

During reviews of the 108 closed cases, the Ombudsman identified 26 additional complaint areas that were not identified by the original complainant. The 26 complaints were found to be valid in the following categories: 8 investigation, 6 reunification, 3 child-wellbeing, 2 services, 2 policy or process, 2 safety plan, 1 relative involvement,1 parent involvement, 1 removal.

POLICY AND PRACTICE
Findings and Recommendations

During the past fiscal year, the Ombudsman and the Department of Health and Human Services, Office of Child and Family Services ("the Department") have worked together in partnership on over one hundred individual cases. The Department has continued to sustain improved practice in the area of kinship placements and involvement of kin in child protective cases. The Department has continued to struggle in initial assessments of child safety. Case specific reviews in 2018 have also shown a heightened number of issues with reunification practice.

This has been a difficult and tragic year, marred by the deaths of Kendall Chick and Marissa Kennedy. Many changes in the practice of child welfare have occurred, but more work is needed.

- Caseworkers and supervisors must have increased and consistent training in investigative techniques to improve the assessment of child safety and ongoing assessment of the progress of parents working towards reunification with their children. As detailed below, these two practice areas continue to be a concern in the Department's caseworker practice.
- Caseworkers and supervisors must have sufficient resources, time, and support to complete ongoing training and manage a reasonable number of cases, including additional staff as necessary.
- The Office of Program Evaluation and Government Accountability ("OPEGA") is working to evaluate internal reforms made by the Department and surveying Department front line staff in order to make more recommendations for reform. The recommendations from the forthcoming report should be taken into full consideration to inform and implement further changes as necessary.

The Ombudsman has reviewed the Department's involvement around the deaths of Marissa Kennedy and Kendall Chick, but these cases are not specifically referenced in the sections below due to existing confidentiality law.

1. REUNIFICATION

For the first time in Fiscal year 2018 the Ombudsman has seen significant issues with reunification practice. After a child enters state custody, the Department is required to provide a reunification plan and reunification services to parents and permanency to children. Reunification services for parents must be tailored to the circumstances of each case and could include scheduled supervised or unsupervised visits with children, mental health and substance abuse evaluations and services, domestic violence counseling, family team meetings, and transportation. The Department is financially responsible for required reunification services if parents do not have insurance or other resources.

The brief synopses of individual cases below give examples of a variety of practice issues that most often involve lack of ongoing assessment of a case. The decision that the Department must make towards the end of the reunification period, whether a child will be safe with his parent going forward, is often difficult due to the complexity of the issues. This decision is made particularly difficult when the impact of a parent's mental health diagnosis is not understood or the mental health issue is not treated using evidence based therapy. If the correct services are not initiated or the parents' progress in services is not adequately assessed on an ongoing basis, this can result two undesirable outcomes: 1) children are reunified with parents when

the situation is not safe, or 2) there are unnecessary delays in reunification when children could have been sent home to parents sooner.

There were changes in reunification practices implemented by the Department in the beginning of 2017 and it is not clear whether some of these observed issues are as a result of these changes or due to other factors.

Cases included:

- a child entered state custody due to inflicted physical abuse and trial placement was started despite the fact that both parents had multiple serious issues that had not been evaluated or addressed through services;
- during trial placement DHHS received clear evidence that the original danger to the children continued and closed the case despite this;
- a child was reunified with a parent and a case closed leaving a child unsafe and the parent subsequently left the state with the child during a new assessment;
- a non-evidence based decision to start a trial placement before the parent was a safe caregiver that showed a lack of understanding of the parents' mental health issues;
- an unnecessary delay in starting trial placement for a family causing the children had to be in state custody for too long;
- a trial placement failure after the ongoing assessment of the parent's progress in reunification was inadequate;
- a trial placement that occurred too quickly due to Department miscommunication;
- a parent's progress in reunification was not adequately assessed and then the trial placement was not sufficiently monitored;
- parents did not receive good faith reunification services including face to face visits, family team meetings, contact with providers and sufficient visits with the children;
- trial placement began without consulting the team and without considering the parent's lack of progress in mental health services;
- ongoing assessment of a case was not conducted, including contact with providers and regular contact with a parent which resulted in children moving back in with a parent without the Department's knowledge;
- there was little face to face or other contact with parents, providers were not contacted and the issue of domestic violence was not addressed;
- outside of family team meetings little contact occurred with parents or providers and ongoing assessment of the parents' progress was not done and evaluations were completed late or not at all when better ongoing assessment would have resulted in faster permanency for the infant;
- face to face visits with children were not completed for several months, the parents' providers were not contacted and no random drug or alcohol screens were completed.

Department's Response: In the last year, the Department has recognized the need for increased support and structure around decision-making in child welfare practice in all phases of a case, including reunification. As a result, the Department has embarked on a number of initiatives to improve the quality and consistency of decision-making with regard to child safety. The new initiatives currently in the process of implementation include:

- Collaboration with the National Council on Crime and Delinquency (NCCD) to implement tools that will guide and ensure consistency in decision making related to case planning, reunification services, and case closure. The use of these Structured Decision Making (SDM) tools will be fully implemented, with all staff trained, by April of 2019.
- The Department strongly supported the passage of LD 1923 in the most recent legislative session. One component of LD 1923 is the expansion of Clinical Consultation Services available to each district office. This clinical consultation is meant to assist district office staff in analyzing complex cases by utilizing experts with a clinical skillset—allowing the Department to better analyze case decisions. The clinical consultation will also include support and debriefings for staff engaged in casework involving child death and serious injury.
- LD 1923 also included funding for a Supervised Visitation pilot program. The goal of this pilot is to provide an evaluation component within parent/child visits to assist the Department in determining when/if a parent is growing in their ability to safely parent the child and whether the parent is able to meet the particular needs of his/her child; and to provide additional evidence and an expert opinion regarding the parent's ability to safely parent his/her child. The provider will be able to share this information with the caseworker and supervisor to help inform case decisions regarding expansion of visits, trial home placements, and termination of parental rights. It is also expected that the provider's staff will testify in court when necessary. The Department has researched promising practices in supervised visitation from across the country and is currently in the process of developing the structure of Maine's pilot so a contracted provider can be secured.
- Team Decision Making (TDM) has long been a component of child welfare practice in Maine. The Department has just completed the rollout of a renewed emphasis on the use of TDM meetings in which Program Administrators and Assistant Program Administrators meet with the caseworker and supervisor to review the case and make pivotal case decisions, including those regarding trial home placement, expansion of visits, and filing for termination of parental rights.
- The Department is currently implementing a statewide Quality Improvement (QI) unit with staff in each district office. The QI staff will provide real-time feedback to caseworkers and supervisors to ensure staff are adhering to policy and statute throughout the life of the case, and that safety and risk are being consistently evaluated to inform case decisions. QI staff will also review case plans to ensure that safety and risk concerns are addressed, appropriate reunification services targeted to the reason for child welfare involvement are identified and included in the plan, and that casework staff facilitate participation in these services.
- The Department is finalizing the implementation of a number of new internal tools to ensure consistent decision-making regarding child safety. These include the automated supervisory checklist, the new streamlined family plan, and the trial home placement checklist. Each of these tools serves to bring the focus back to the best interest of the child, while balancing the Department's obligation to make reasonable efforts to rehabilitate parents in order to reunify them with their children.
- The Department strongly supported LD 1922, which changed the language in Maine law regarding reunification. Current law requires the Department "give family rehabilitation and reunification

priority." When LD 1922 goes into effect in December of 2018, the law will require that the Department make reasonable efforts to rehabilitate and reunify families. The Department anticipates that this change in language, which aligns with the federal reunification requirement, will further prioritize the child's safety interest while respecting the right of parents to parent their child.

- The Department is currently in the early stages of the development of a new Comprehensive Child Welfare Information System (CCWIS). This system will replace the aging Maine Automated Child Welfare Information System, which serves as the electronic repository for all child welfare information. This new system will modernize the electronic system used in child welfare and the Department anticipates that this will allow for improvements in the child welfare system. Some of the anticipated improvements include efficiencies in data entry and management that will allow caseworkers to spend less time on documentation and more time engaging with families; increased capacity for monitoring of case progress, data collection, and other oversight activities; an increase in the amount of guidance provided to staff via the electronic system; and the implementation of policy and procedure guides for staff within the electronic system.
- The Department's child welfare system is currently engaged in a complete system evaluation which is being conducted by a contracted provider with expertise in the field, Public Consulting Group (PCG). The Department has tasked PCG with evaluating Maine law, rule, policy, and practice in all areas of child welfare; researching evidence-based and promising practice in all areas of child welfare from across the country; making recommendations for systemic improvements throughout child welfare to ensure child safety, as well as timely and appropriate reunification; the development of a procedure manual that will guide staff and ensure consistent practice and decision-making in all cases; the implementation of staff training to improve consistency in casework practice; and the evaluation of caseload standards within Maine's child welfare system.

The Department strongly believes that all of these new initiatives will function together to support child welfare staff in making timely and consistent decisions regarding child safety, reunification, visitation, etc. The Ombudsman has provided a number of concerning examples, many of which illustrate casework practice gaps that OCFS has also identified and is working to address through these initiatives. The combined impact of the above initiatives is not yet known, but the Department will continue to review individual cases, aggregated data, and other sources of information to analyze the effectiveness of these initiatives in improving child welfare practice in the areas identified by the Department and the Ombudsman. While it is the intention of the Department that these initiatives will address many of the issues identified by the Ombudsman, the Department also remains committed to working with the Ombudsman's office on any issues that may arise involving concerning practice decisions, and the development of solutions for systemic improvement that address any new or ongoing concerns.

2. ASSESSMENTS AND SAFETY PLANNING

Throughout 2018 the Department continued to struggle with assessments and safety planning in multiple instances. There were multiple cases where children were left unsafe with parents and caregivers after DHHS opened and closed an assessment without protecting children or continued involvement without adequate ongoing assessment of the children.

Safety planning continued to be at issue. When parents and the Department agreed to a safety plan because children are at risk in their parents' care, safety plans have often exceeded a planned amount of time and were not properly monitored. Unstructured and poorly monitored safety plans often left children without the benefit of legal protection from their parents and additional resources such as the courts, foster homes and Guardians *ad litem.*

The Department has had difficulty following policy in many areas of assessments, such as having regular face to face contact with children and completing enough assessment activities to ensure that the level of risk to a child is low before an investigation is closed or referred to an alternative response program.

DHHS has recently made many changes to practice in safety planning and has committed to more training in assessment practice due to recent the recent children's deaths. For the most part the above issues occurred before the changes took effect so the overall effect on the system has not yet been observed by reviews done by the Ombudsman's office.

Department's Response: For many years the Department has depended on the practice of "safety planning" to ensure child safety while minimizing the Department's intrusive presence in the lives of children and families. This practice was consistent with the Department's goal of ensuring child safety in a manner that caused minimum disruption to the child's life. In the past, safety planning most often involved a child residing with a family member, family friend, or other loving and supportive adult with whom the child had a preexisting relationship. Safety plans were developed and implemented without the Department taking custody of the child. However, the Department recently began to analyze the use of safety planning and identified several issues. These concerns involved the time children spent in the care of someone other than their parents before a formal reunification process (overseen by the courts) was undertaken; the lack of support for, and emphasis on, parental rehabilitation in situations in which the Department has not taken court action; and the lack of services and supports available to individuals who are providing care for children when the child's parents are unable to do so safely. The Department has since taken steps to improve practice in this area. Primary among these changes was a shift in policy that now requires that safety plans be developed in which the child remains in the home with his/her parents while supports are put in place to mitigate threats to the child's safety identified by the Department. As a result of this change, children, parents, and resource caregivers are no longer left without the legal protections and status afforded to them when the courts become involved in a case. This ensures that the children's needs are met in a timely manner, the resource caregivers can be appropriately compensated and supported, and the progress of parents in reunification can be monitored and evaluated.

In addition, in December of 2018, staff will begin using the SDM Safety and Risk Assessment tools to guide decisions regarding a child's ability to remain safely in their parent's care. As part of this process, the Department's policy regarding assessments has been reviewed, strengthened, and updated. It is now known as the Investigation policy and provides clear guidance to staff on decision making regarding the investigation of allegations of abuse and/or neglect, as well as the decisions that may result from information gained during the investigation.

3. LACK OF MENTAL AND BEHAVIORAL HEALTH RESOURCES FOR CHILDREN IN NEED OF SERVICES

Maine has not allocated sufficient resources to effectively treat and keep safe older youth with serious mental health and behavioral issues. For example, after being discharged from a mental health hospital, a

fifteen year old child was placed in a temporary step down placement with no treatment available, and later at a homeless shelter. Another child, also fifteen, was harmed by a wait for crisis beds, a delay in placement in appropriate residential facility, and placements at the Preble Street Teen Center and New Beginnings Homeless Shelter. Both of these children were in state custody at the time.

Additionally, children continue to be harmed by waitlists for in home counseling services. Maine would also benefit from children's therapists trained in evidence based practices. Children's therapists in some cases made recommendations that were not based on clinical findings or evidence based practice that resulted in delayed trial placement or to kept children from visiting with parents, when it was safe and appropriate.

Department's Response: DHHS recognizes the challenges related to serving children with significant mental and behavioral health needs. To improve services available to youth in Maine, the Department has developed a Psychiatric Residential Treatment Facility (PRTF) to increase the number of youth that can be served in Maine, instead of being placed out-of-state to receive this level of service. The Department is also engaged in ongoing efforts to develop treatment foster care resources, including the implementation of recent legislation that increased the rates of reimbursement to foster parents. Furthermore, the Department is currently engaged in a full evaluation of Maine's children's behavioral health system of care. The Department has contracted with PCG, an independent provider with expertise in this field. Through this evaluation, the Department is seeking to improve the array of behavioral health services available for children and families in the State of Maine. The evaluation will utilize stakeholder input, systems analysis, and research on successful children's behavioral health systems across the country, to develop recommendations for systemic improvement. This study will serve as the basis for the development of a statewide strategic vision that ties together all the future initiatives and projects undertaken by the Department to ensure these initiatives are improving the programs and services available to clients, while eliminating inefficiencies in the system, and improving the outcomes for children and families.

CONCLUSION

The Governor, Legislature, and the Department have recently taken important steps towards adding crucial resources to child welfare services and the Department is making practice changes that will help protect children who are at risk of child abuse and neglect. While these steps are important, more work and resources are needed, as well as ongoing evaluation of the effectiveness of changes and flexibility in identifying additional needs.

ACKNOWLEDGMENTS

As the sixteenth 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 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 Acting Director Kirsten Capeless 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, Ally Keppel, Allie McCormack, Maureen Boston, Virginia Marriner, and Katherine Knox for their support and dedication to our agency.

Child welfare caseworkers perform difficult, sometimes dangerous, stressful, and heartbreaking work every day with the objective of keeping children safe. These professionals care deeply about the children and families that they work with and deserve our support and thanks now more than ever. However, child welfare caseworkers cannot do this alone. Schools, clinicians, case managers, attorneys, police, housing, doctors, nurses, Guardians *ad litem,* behavioral health providers, transportation providers, hospitals, drug treatment programs, mental health facilities, and any number of other professional and community organizations are essential parts of the system. Support for key organizations and individuals outside of the Office of Child and Family Services means support for child welfare social workers, which in turn means support for children. These stakeholders are crucial and also deserve our thanks.

CHILD WELFARE OMBUDSMAN

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Maine Children's Alliance

Testimony of Shawn Yardley, representing the Maine Children's Alliance
before the Government Oversight Committee
Public Comments - OPEGA Information Brief on Frontline Workers in the State Child Protective System
March 8, 2019

Senator Chennette, Representative Mastraccio, and members of the joint standing committee on Government Oversight. My name is Shawn Yardley, and I am here as a board member representing the Maine Children's Alliance, whose mission is to advocate for sound public policies and promote best practices that improve the lives of children, youth, and families in Maine.

Through the results presented in the OPEGA Frontline Workers report, it is clear child protective caseworkers have been carrying too great a burden. The stress and emotional exhaustion they often encounter in their work can lead to burnout, job dissatisfaction, and ultimately high turnover rates. To retain these critical front-line workers, leadership at the Department should take steps to create and maintain a positive working environment that will support the emotional well-being of their employees, which in turn will enable them to be more effective in their work supporting vulnerable children and families.

Surveys like the one conducted by OPEGA are a good example of something the Department can do to seek and respond to feedback from their caseworkers. Asking them directly what they think about their workload and work environment on a regular basis will enable supervisors and leadership to more regularly assess how they are supporting front-line workers. In addition to surveys, conducting regular, in-person conversations between supervisors and caseworkers will give employees another opportunity to express concerns and feel heard by leadership.

Caseworkers work in stressful and emotionally difficult complex family situations. They often bear witness to troubling scenes and can experience their own trauma from that. The Department should ensure that child protective caseworkers are given adequate, regular opportunities to receive counseling or training to process and manage that secondary trauma.

While we cannot entirely alleviate the stressors that come by nature of the work of child protection, the Department can implement a standard for caseload limits of those front-line workers, support them with the appropriate ratios of supervisors and administrative staff, and bring on any necessary additional caseworker positions to maintain that caseload standard.

We want to recognize the work the Department has already done, and continues to do, to address the current concerns of caseworkers. We are hopeful this will result, over time, in improvements to a system that clearly needs our attention and resources to strengthen it.

Child protective caseworkers are on the front lines every day, responding to, assessing, and working with families and children in tremendously difficult situations. They are professionals with experience and expertise we must show respect for. We can do that by giving them adequate workloads, emotional

and administrative supports, and a responsiveness to any issues they might have. We have a responsibility and necessity right now to ensure caseworkers are supported so they can do the important work of protecting children and supporting vulnerable families in Maine.

Our vision for Child and Family Services

All children deserve safe childhoods. We do this work because we care deeply about Maine children. We are determined to protect them, support them and build families that also can protect and support them. We believe that to do this effectively, serious changes need to be made to Maine DHHS policies, practices and programs. We must recruit and retain staff to stabilize quality public services for Maine children and families. The people who do the front-line work must be empowered to shape the policies and program they implement each day.

How do we get there:

- **Reduce the caseload to a manageable caseload that matches the national standard of no more than 12 cases per caseworker**. This will provide the necessary time with every child and capacity for family plans.
- **Hire more administrative support staff**, allowing caseworkers to have the time they need to focus on casework.
- **End forced overtime**, taking work home, and missing work breaks and lunch breaks, all of which are leading to burnout and stress.
- **Ensure the safety of staff** as they work in the field.
- **Provide the technology that truly functions to meet the needs of the Maine Office of Child and Family Services workers and efficiently integrates into their work**. This means investing in the right tech and the right training, not just the cheapest.
- **Reduce unneeded or duplicative paperwork**, including making case plans more accessible and usable for families.
- **Give front-line workers a voice in policies, practices and programs** so they can meaningfully participate in developing and implementing them.
- **Establish a night shift for coverage across Maine DHHS districts**.
- **Provide the necessary resources for support programming**, including public health nurses and housing, mental health and addiction resources. Caseworkers need these types of services fully resourced and staffed so Maine families can get the support they need.
- **Reassess the foster parent certification process, training and support** to better build and support Maine's network of foster parents.

FOR IMMEDIATE RELEASE
Contact: Tom Farkas, 624-0609
Detailed survey results online here

Over 1,000 state workers identify barriers to delivering quality services

Heavy workloads, staff turnover, understaffing, inadequate equipment and training, job stress and overall lack of resources are among the problems, survey shows

In a comprehensive survey, over 1,000 State of Maine workers identified understaffing, staff turnover, inadequate equipment and training, stress, lack of resources and concerns about their ability to support themselves and their families as barriers to the quality public services they provide to Maine people.

The Maine State Employees Association, Local 1989 of the Service Employees International Union, conducted the survey of both union members and nonunion members employed in all State of Maine Executive Branch departments.

Eighty-three percent of respondents identified problems in recruiting and retaining staff due to pay or other departmental problems. Sixty-three percent said their worksites or offices are insufficiently staffed.

"Due to the dramatic increase in reports of abuse and neglect of elderly Mainers and Mainers with disabilities, my coworkers and I are overwhelmed," said MSEA-SEIU Member J.B. Whipple, a human services caseworker for the Maine Department of Health and Human Services in Portland. "It's important for us to protect these vulnerable populations. However, we feel like we're running in circles chasing our tails due to understaffing, budget cuts and steadily increasing volume. It would break our hearts to see a fellow citizen go unprotected simply because we are understaffed. I'm hoping the State of Maine can address this issue so we can see to it that our vulnerable fellow citizens are safe."

"Nothing is more urgent than the moment you dial 911. Yet the state dispatch centers handling 911 calls have been woefully understaffed for years," said MSEA-SEIU Member Lora Tourtelotte, an emergency communications dispatcher at the Maine Department of Public Safety's Regional Communications Center in Augusta. "Stress in the workplace needs to be addressed better."

The state's recruitment and retention problem is likely to worsen unless the underlying problems are addressed, according to the survey results, as 59 percent of respondents reported they have considered leaving state service. They reported an overall lack of resources in doing in their jobs. In addition to understaffing, they mentioned heavy workloads with 58 percent unable to complete assigned tasks in the time they have. Forty-one percent reported inadequate training, while 40 percent reported using programs that don't work properly. Nineteen percent reported mold in their worksites.

The workers who completed the survey cited concerns about their ability to retire (82 percent concerned), healthcare costs (70 percent), their ability to pay monthly bills (41 percent) and student debt (39 percent). Eighteen percent work a second job. Ten percent struggle to afford childcare or eldercare.

"Our state agencies need highly qualified technical staff, including professional engineers, to provide essential services such as keeping pollutants away from our soil, air, water and protecting our natural

resources," said Kerem Güngör, an environmental engineer with the Maine Department of Environmental Protection in Augusta. "It is becoming increasingly more difficult to recruit and retain these professionals."

Understaffing problems also are impacting the Maine Department of Transportation at the height of plowing season.

"When everyone else is told to stay off the roads due to a storm, I'm out plowing day and night," said MSEA-SEIU Member Brian Markey, a transportation worker for the Maine Department of Transportation in Bangor. "Yet here we are again in the middle of a Maine winter and we're still short DOT plow drivers statewide. That's not right. We're putting our lives on the line every time we plow."

In the survey, the state workers committed to taking action to address their concerns through contract bargaining with management, other labor-management processes, and through legislation pending in the Maine Legislature. See detailed survey results here.

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The Maine State Employees Association, Local 1989 of the Service Employees International Union, represents over 13,000 Maine workers and retired workers, including workers in the Executive Branch of Maine State Government. The workers quoted in this news release are speaking as MSEA-SEIU members.

State Employees Identify Barriers to Providing Quality Public Services

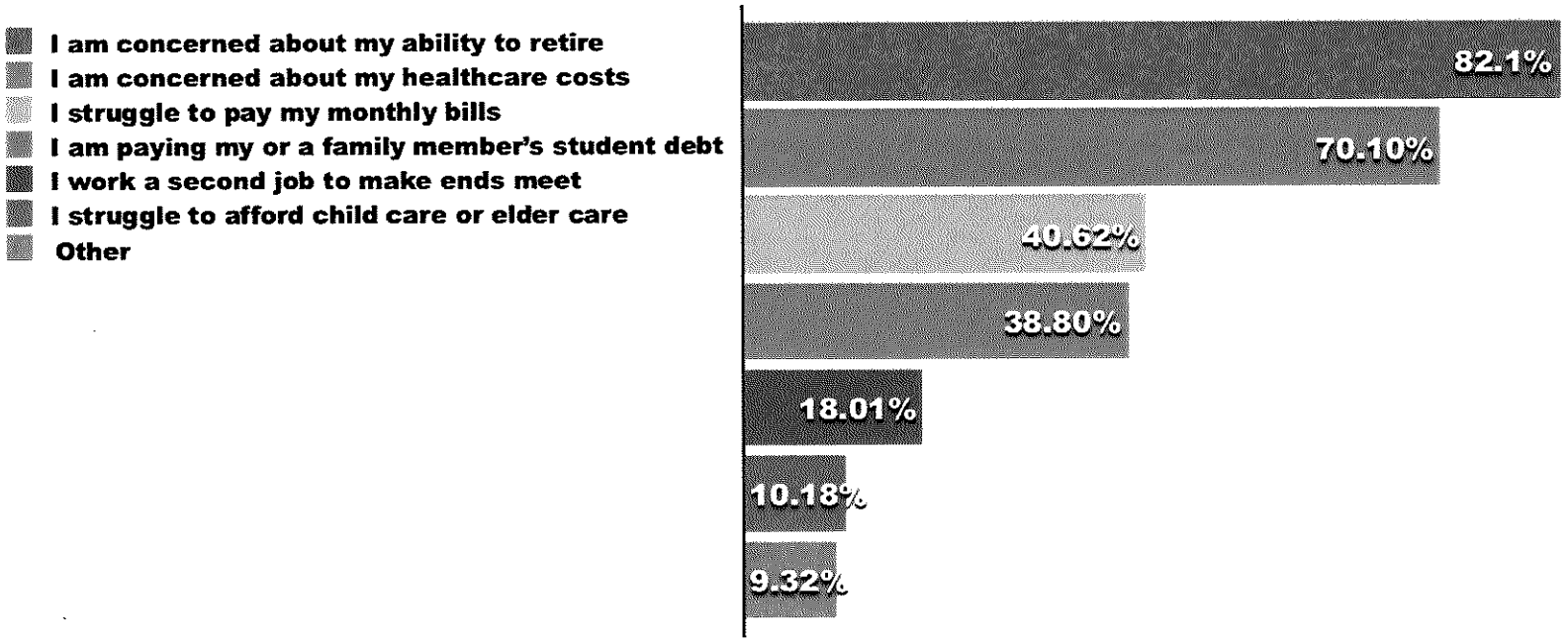
maine state employees association
MSEA

FIGHT FORWARD

MSEA
LOCAL 1989
SEIU

From October to December 2018, over 1,000 employees of the State of Maine's Executive Branch agencies responded to a survey about their experiences as State employees. Their responses identified a number of concerning trends about recruitment and retention, effectiveness, staffing and workload, technology and safety.

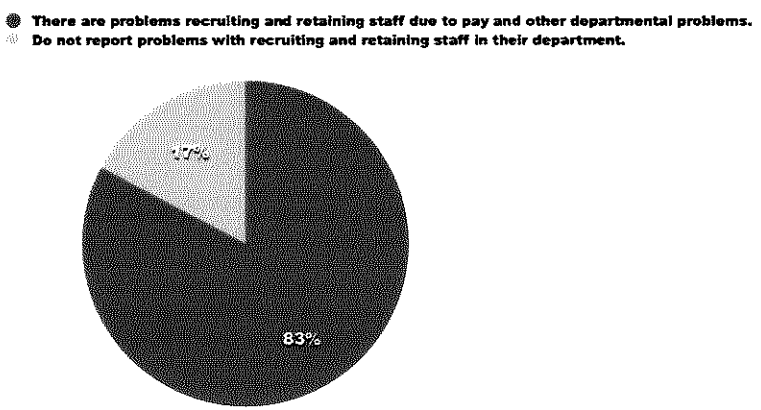
Economic Concerns

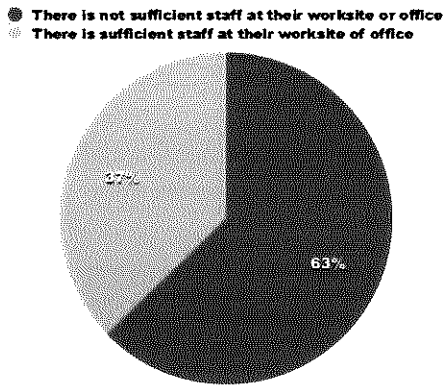


Economic Concerns

- "I do not believe I will ever be able to actually retire."
- "I have declined testing for possible cancer due to the cost."
- "I have worked multiple jobs for over 5 years so I don't have to move my family out of the state."
- "I am a single mother who has almost $100k in student loan debt. I struggle to pay my bills and make ends meet. I now make too much to qualify for help with child care. Making an extra $1000 a year doesn't help when I have to come up with $5000 a year extra for child care."
- "We need to apply for the sliding scale or charity care [for medical costs] due to our struggle with other bills."
- "My pay is not enough to cover my household's needs and it probably never will be if I remain employed with the state. Since 2011, our benefits have decreased and more of the cost sharing has been placed on us. For a healthier work/life balance, I need more support."
- "Options to afford housing and having a family are limited if I stay with my current position."

Staffing Shortages

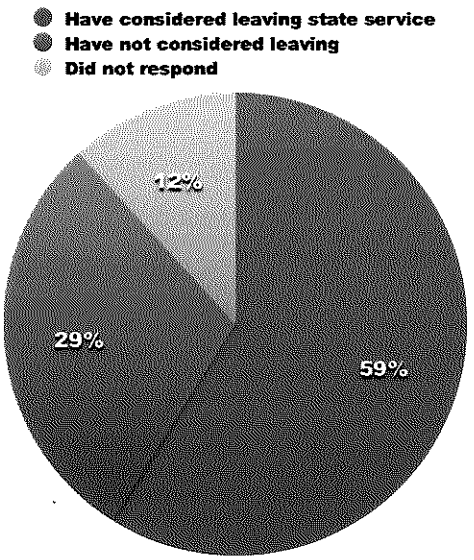




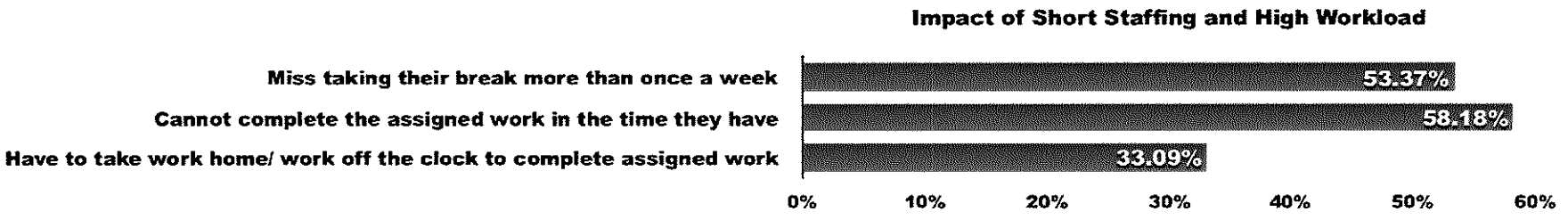
- "Two equal positions in my Department have become vacant and the positions are not being replaced. My team of 7 has now become 5 and we are forced to absorb the additional work."
- "We have lost so many employees – I believe 15 in 2018 alone. It's negatively impacting our work and our clients."
- "If I could, I would leave due to working conditions. We are down seven people and just don't have enough people left to do the job to our standards."
- "Crews are getting smaller despite increasing workloads."
- "The mission of the Department was impaired [over the last 8 years] and many good, experienced staff were lost."

Employee Retention

- "We are expected to perform our work tasks without proper training, equipment and respect. We are overworked, underpaid and not appreciated."
- "Yes, due to management causing stress and low morale."
- "Yes – lack of IT and other resources to adequately complete tasks."
- "Yes – too much of a workload and management doesn't listen."
- "Yes – struggling to keep up with the workload and most weeks I work over 40 hours without compensation."
- "Yes - in pursuit of better training and advancement opportunities."

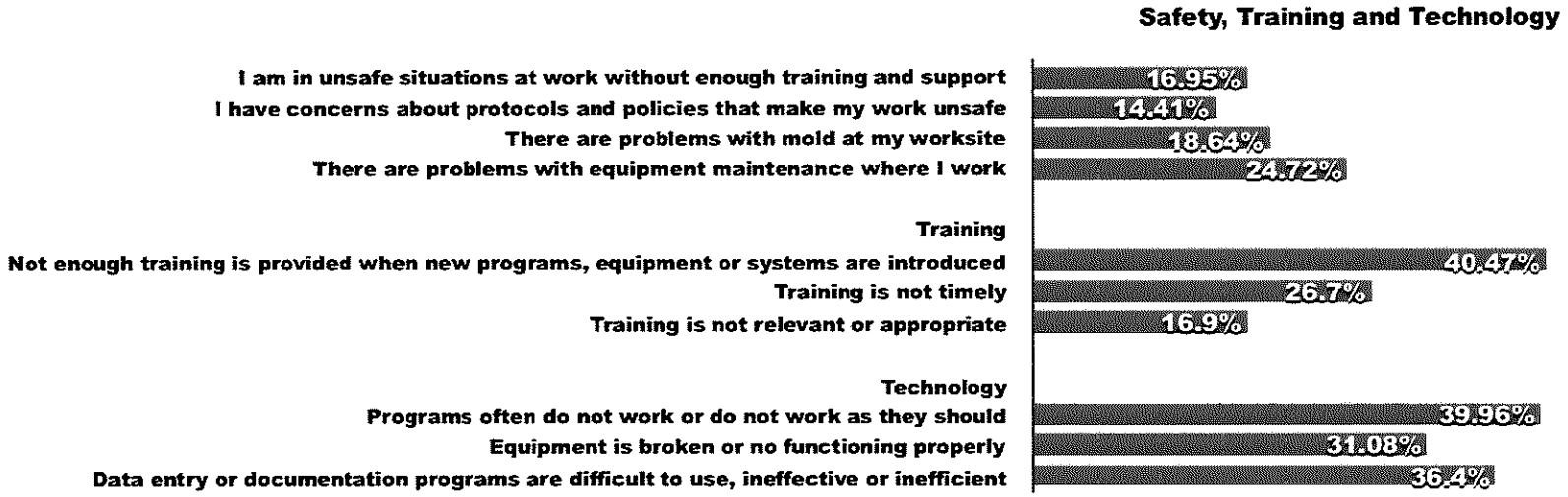


Workload



- "Overtime is not allowed so work goes undone or I work without pay."
- "I feel stressed by not being able to provide the best customer service."
- "I don't remember the last time I took a 15 minute break."
- "Unable to work overtime, so work never gets caught up. With constant vacancies, we fall further behind."
- "It's very depressing to never be caught up with work."

Lack of Resources



- "I have been told there is no time for trainings."
- "Outdated and painfully slow computer systems don't talk to each other."
- "Computers are out of date and take up to 30 minutes to boot up in morning."
- "Proper and complete trainings on technology programs are ineffective, inefficient, and incomplete."
- "My supervisor doesn't have time to train me."
- "Safety of the public and employees is compromised due to lack of appropriate training."
- "I usually have to use YouTube to get training in how to use latest programs."
- "[I am] required to travel during unsafe road conditions."
- "As an essential 24/7 staffed unit, we do not have simple door security to keep the overnight person safe from someone breaking into the building."

In addition to sharing their experiences, nearly 70% of respondents indicated that they are willing to stand together with their coworkers, speak about their concerns, and fight to address these issues so that they can provide high quality, effective public services to the people of Maine.

March 8, 2019

Good morning. My name is Jan Strout and reside in West Gardiner. I am a volunteer advocate for Kinship Families and am volunteer co-facilitator for the Central Maine Kinship which has support groups for kinship families at the Augusta Elk's Lodge and in Waterville at the Alfond Youth Center. The Augusta Group has been in existence for nearly 20 years and we have some members who have been attending nearly that many years. Raising children doesn't happen over night. Our group members have tried to be proactive to raise the awareness of kinship family needs and to support legislative change to safe guard children.

Rep. John Picchiotti submitted several bills for us that we had carefully considered. We strongly felt that children many children were not being well served by the current system and that children's safety was not priority.

We asked that :
1. the de Facto Parentage Act be reviewed as it impacts relatives who have had children placed with them through the department,
2. A kinship administrator be established to review kinship issues,
3. Complete GAL be done which must include relative caregivers and that the GAL Review Board accept complaints from relative caregivers,
4. The Best Interest of the Child wording be adjusted to include "family"
5. Standing in the court be allowed for kinship caregivers and

6. The word Abandonment of a child be redefined.

We did accomplish getting the law adjusted to allow caregivers to seek medical care for a child in their care without parental consent, if the parent is unavailable.

In closing, I would like to say that it is my strong belief that if our pleas for the safety of Kinship children had been acknowledged with laws and procedure changes, both at DHHS and in the legislature, one and both of these dear children would be with us today. We told many people of authority that it would take a dead child for any changes to be made. Much more needs to happen to change a system stuck in "parental rights" over child safety.

Rep. Warren has submitted LD 633, a bill for this session to establish a Kinship Administrator at DHHS. Had this already been passed, as we requested in the past, this person would probably have realized that a problem existed for these girls. Let's not wait for more dead child to be propel to action.