SEN. NATHAN LIBBY, SENATE CHAIR
REP. GENEVIEVE MCDONALD, HOUSE CHAIR

MEMBERS:

SEN. LISA KEIM
SEN. DONNA BAILEY
SEN. RICHARD BENNETT
SEN. SUSAN DESCHAMBAULT
SEN. JEFFREY TIMBERLAKE
REP. H. SAWIN MILLETT, JR.
REP. AMY ARATA
REP. MARK BLIER
REP. MARGARET O'NEIL
REP. HOLLY STOVER

MAINE STATE LEGISLATURE
GOVERNMENT OVERSIGHT COMMITTEE

MEETING SUMMARY

July 14, 2021
Accepted August 11, 2021

Call to Order

The Chair, Sen. Libby, called the Government Oversight Committee meeting to order at 10:12 a.m. The meeting was held both in-person in Room 228 State House and electronically. He summarized the meeting process.

Attendance

Senators:	Sen. Libby, Sen. Bailey, Sen. Bennett, Sen. Deschambault, Sen. Keim and Sen. Timberlake
Representatives:	Rep. McDonald, Rep. Blier, Rep. Millett and Rep. Stover Absent: Rep. Arata and Rep. O'Neil
Legislative Officers and Staff:	Lucia Nixon, Director, OPEGA Matthew Kruk, Principal Analyst, OPEGA Etta Connors, Adm. Secretary, OPEGA/Clerk, GOC
Legislators:	Sen. Curry and Sen. Diamond
Executive Branch Officers and Staff Providing Information to the Committee:	Todd Landry, Director, Office of Child and Family Services, Department of Health and Human Services Lisa Marchese, Deputy Attorney General, Chief, Criminal Division, Office of the Attorney General Christine Alberi, Executive Director, Child Welfare Services Ombudsman

Introduction of Committee Members

The members of the Committee introduced themselves.

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New Business

Sen. Libby noted that items on the meeting agenda would be taken out of order. The Committee will begin by hearing from Director Landry, Deputy Attorney Marchese and Christine Alberi. Followed those presentations with question and answer sessions for each. The GOC received correspondence from 2 members of the Legislature asking the Committee to take some action with respect to the issues being discussed at the meeting. The Committee will hear first from Sen. Curry and then Sen. Diamond. Following those presentations, the Committee will have discussion on what steps they would like to take next. He noted, for the Committee, that today's meeting is the beginning of a process. They have gone through a long process of evaluating the Office of Child and Family Services (OCFS) in the last few years and were prepared to engage in some follow-up work, including surveying front-line workers in OCFS. However, the events of May and June have caused the GOC to come together, consider their next steps and perhaps make adjustments on how they would like to proceed in light of the 4 children who have died in Maine, several of which at the hands of their caretakers, or otherwise cases of gross neglect. According to media reports, some of these cases has involved DHHS and OCFS. Sen. Libby said more often than not he looks forward to coming to the Legislature to do their work, but today is not necessarily one of those days because of the tragic circumstances that are before the Committee that caused them to come together to talk with some of the parties involved in child protection services across the State.

Sen. Timberlake noted that at 11:00 he had to leave the meeting for other legislative business. He said it is not because he does not have great interest in the GOC's work today. He said Sen. Libby did a great job describing the dire circumstances and he wanted people to know that when he leaves the meeting it is not because he does not care, he does, the welfare of children is very important to him.

Sen. Libby noted that if Committee members left the meeting, it is not for lack of interest, but because of competing priorities.

- **Pursuant to GOC request, Child Welfare Services briefings:**

  Todd Landry, Director, Office of Child and Family Services, DHHS

  Director Landry presented his testimony to the GOC. (A copy of his testimony and other documents provided by Director Landry are attached to the Meeting Summary.)

  Sen. Bailey wanted to know more about the requested review by Casey Family Programs (Casey) and asked if the Department's request is something they have done before and, if so, where and when.

  Director Landry said he believes Casey works in all 50 States, as well as in the territories. They are one of the largest operating foundations in the Country and are the largest child welfare operating foundation focused on child welfare. This is a service Casey provides and has worked in other states. He will get the GOC a specific list of those states where Casey has done this type of work, or similar, kinds of reviews over the past few years. That work is one of the reasons why DHHS engaged with Casey to do this work in Maine.

  Sen. Bailey asked if Dr. Landry could share with the GOC his request to Casey for this review. She assumed that DHHS put something in writing regarding the requested work to be done and she would like to see that agreement.

  Director Landry said he would be happy to provide that information, noting they did sign their agreement with Casey late last week so that agreement, in the form of a letter of agreement between DHHS and Casey, is something he would be happy to provide to the GOC.

Rep. Stover knows that OCFS provided the Committee with a number of documents for today's meeting with quantitative data, which is great, and some of the areas that OPEGA has looked at in the past has been specific to caseload size, supervision and training and also timeliness of assessments, particularly comprehensive assessments for the family. If reunification takes place she asked what the follow-up assessments for risk are and if Director Landry could speak to some of the concerns that OPEGA has had in the past around caseload size, supervision training, what currently is happening around comprehensive risk assessment and with Casey, what Director Landry envisions happening.

Director Landry said, in accordance with Maine State Statute, since 2020 OCFS has provided a workload analytic tool and report to the Legislature every January. The first report, he believes, was in October of 2019 and then in January of every subsequent year. That report has detailed the analytic tool that was developed in partnership and consultation with PCG (Public Consulting Group). OCFS continues to use that analytic tool to help inform caseload, workload and analytic components. He pointed out in the supplemental information that they shared, the recap of the number of new caseworkers, supervisors and case aide positions that have been added. They also shared in the report, and one of the things they can point to with pride, is the fact that they have been able to significantly reduce caseworker turnover. He believes the high was 23% in 2018 and that had reduced in 2020 to approximately 15%. OCFS has also given the Legislature some comparative data on caseworker turnover numbers based on national data and research from either 2003 or in 2019. That information is there from a caseload and workload perspective and they will have another report on where they stand with workload assessment. From a simple mathematic perspective of caseload, and one of the things that he shares with his staff, is the fact that no 2 cases are identical, no 2 cases are the same, so a caseload size of 10 for 1 caseworker may be very different from a caseload size of a different 10 cases for a different worker. Director Landry said that is one of the reasons why they have focused more on workload because it takes the factors of those different types of cases into account. OCFS can also provide the GOC with the caseload size information if they wish. He believes OCSF's current average caseload size, from a pure mathematics perspective for assessment, is approximately 9.4 on a statewide average basis. For permanency, he believes caseload size is approximately 12. He will get the Committee the exact numbers for the past month. He is pleased with the increase in retention and the reduction in turnover since 2018 and that has been a positive aspect, he believes, with much of the work that has been done, including support from the Legislature and the Administration.

In response to the second part of Rep. Stover's question regarding assessments and the tools used for assessments, Director Landry said one of the pieces worked on with Muskie is revising and updating new caseworker training, which they call the foundations course. That foundations course has been revised with Muskie's assistance and has been implemented. Muskie co-leads and co-teaches all of those foundation trainings for new caseworkers. Muskie also continues to work on the supervisory academy training. The supervisor academy training is provided to all of OCFS's supervisors. Assessment is one of the key pieces and he thinks all agree, one of the other essential key pieces is intake. In OCFS's 2019 report, and shared with the GOC previously, it detailed some of the activities related to assessment. OCFS is currently working with Evident Change as it relates to the implementation of the SDM tools for staff. He wanted to stress that SDM is a tool and is only that. It does not take the place of assessment or evaluation of the assessment and decision-making, but it is a tool that enables and helps staff to make better decisions as it relates to those assessment components. Assessment continues to be a primary focus of OCFS. They have also implemented the SDM tool in other areas including permanency and the Director said there is some significant information in the Committee's packet provided by OCFS about that.

Director Landry said that also included in the information provided to the Committee is the aspect of success in permanency, which is a federally required measure for every state. That success in permanency for Maine is currently at 87%, which is the highest number, he believes, it has been in the past 12 months.

Rep. Stover asked if Director Landry could describe if during a case, OCFS is looking toward permanency, particularly, reunification, and if he could give a sense of what the nexus points are of reassessment of risks from early reunification through a placement returning to the home and what that would look like for a child returning back to their home.

Director Landry said the assessment of risk happens throughout the life of a case and it could be different for each case depending upon the different circumstances that come up with that case. Once a child comes into custody, and even the process of a child coming into custody is not a unilateral decision, nor is reunification a unilateral decision by OCFS, it is part of the court process. The court process includes the guardian ad litem, parents' attorneys and others and are all involved in that ultimate decision. The assessment component goes along with the life of a court case. During that court case assessment for safety can be looked at again at any point. But, in general, the case will always be looked at, or almost always looked at, for example, before decisions are made about a child home placement, before a decision is made about reunification and certainly during the life of the case whenever there are significant issues that arise, as well, in addition to the assessment that is done at the beginning of the case. The safety assessment process is one that does not have only the fixed time points because every case is different.

Sen. Bailey referred to Director Landry's comments about it not being a unilateral decision, that there are many people involved in a case. She said that leads her to ask about the stakeholders he is inviting to participate in the Casey review and report. According to his chart and testimony, the only stakeholders she sees involved are internal people and not included, for example, are parents' attorneys, guardians ad litem, judges or anyone from the court process system. She wondered, first of all, who decides who the stakeholders are that are going to be involved in the review and if it was his department, or someone under his control, who came up with that list.

Director Landry said he certainly did not intend his chart to indicate that those are the only stakeholders that will be involved in the review. In OCFS's discussions with Casey those are the stakeholders identified from the beginning. Based on their document review of each of the cases, as they go through the flowchart of the information he provided, Casey, and their partners, will decide which other stakeholders are important to invite into the facilitated reviews and discussions, as well as, the systemic review that will be done as part of the process. Casey ultimately will decide who else to invite and have already told OCFS that they certainly want staff who were involved to be part of the process. OCFS asked that the Child Welfare Ombudsman be invited and Casey readily agreed to that. Everyone else is at the discretion of Casey so they will make the invitations and OCFS will facilitate those invitations to whomever they choose to invite into the process based on their review of the cases. He thanked Sen. Bailey for clarifying this point as he did not intend for the chart to indicate that it is the final list of those who would be invited.

Sen. Libby said OPEGA staff, over the past 2 ½ years, has developed quite a bit of expertise in this field and have had access to a lot of information that the public may not necessarily have access to, including the GOC. He asked if OPEGA could be involved at certain stages of OCFS's process with Casey and if Director Landry would help facilitate that.

Director Landry said OCFS would be happy to facilitate that and will make sure that Casey knows that OPEGA is interested and willing to participate and may be a valuable resource in some, or all, of the reviews.

Rep. Stover asked if Director Landry could describe who has the final decision of whether to return a child to a family. Is that done by the OCFS worker, supervisor or in a team setting.

Director Landry said the ultimate reunification decision for a child in custody lies with the Court. The DHHS recommendation regarding that reunification is a decision that is made by the caseworker, the caseworker's supervisor and, in many situations, others in OCFS within the district. That is a recommendation for reunification or for any other permanency outcome. Ultimately, for a child in custody, that decision lies with

the Court and involves the input and recommendations of others that are part of that Court process, including the individuals he mentioned earlier.

Rep. Stover asked, when returning a child to the home, how often, anecdotally, does a judge overrule the Department's recommendation to return that child.

Director Landry said he did not have all of that data off-hand. He will see if OCFS can capture that data, but does not think it is data they routinely keep in a metric format and will involve individual case reviews to get that exact number. He said most of the time a permanency decision is agreed to by all of the parties so that decision is agreed to by everyone, including the guardians ad litem, parents' attorneys, etc., but there are times when there are differences. He thinks it is a minority of cases when there is a difference of opinion and there are certainly a number of times, maybe a dozen or more times in the past year, where he is aware of the fact that they made a recommendation and the judge, either in chambers or publicly on record, stated that they disagree or are going to proceed with a different recommendation. He hoped everyone keeps in mind that when he says he may remember 10 or so of those decisions in the past year, that it is out of hundreds of cases. He believes in the vast majority of cases all of the parties agree on the ultimate reunification decision, but there are some when there are differences of opinion.

Rep. Stover asked if the Department has a process, or how would the Department formally appeal a judge's decision in that case.

Director Landry said OCFS does have a process and is where they work closely with the Assistant Attorney General (AAG). The AAG is part of every single case and represents the Department, so OCFS always engages with them. If a decision is made that they think is contrary to the best interest of the child, then they will consult with the AAG in order to decide whether or not to appeal. That is not a decision made solely by OCFS, it is done in conjunction with the AAG.

Sen. Keim commented on the caseworker turnover, noting that the levels now have gone back to what they were in 2016 and that is a great improvement from the turnover rates in 2018. She thinks that is a very important metric because essentially everything rests on having the caseworkers. One of the things she finds concerning about today is the emphasis being placed on Casey and that somehow this is going to be the answer to the problems and to the deaths. There was a pretty substantial overview of our child welfare system after the deaths of Marissa Kennedy and Kendall Chick. She said Maine has a Child Welfare Services Ombudsman and asked if Director Landry has had a change to read what Ms. Alberi provided to the GOC for today's meeting. Director Landry said he was not provided a copy of that information.

Sen. Keim said one of the things she finds concerning is that there already were highlighted issues that, according to the Ombudsman, progress has not been made on, yet Director Landry is saying we are going to have a 90-day turnaround in responding to what Casey comes up with for suggestions and changes, yet some of the underlying issues, that she thinks are very problematic, still have not yet been address according to the Ombudsman. She asked what the Director thinks is going to be unusually different, or helpful, about having yet another review of Maine's system as opposed to just making the changes that have already been recommended.

Director Landry said he has not seen what the Ombudsman has provided to the GOC today so he cannot speak to that so he will speak in general terms. Since he has come into his current role, he has had in most months, a standing meeting, with some exceptions, with the Ombudsman. He reads every single report that Ms. Alberi provides to OCFS, as well as her annual report and interim reports. He believes there are many areas where OCFS agrees with the Ombudsman. Everyone agrees and appreciates the fact that their improvement efforts are a continuous process and that improvement effort means that it continually develops and moves forward. He believes they have made certain improvements and many of those were detailed for the GOC before. He also absolutely agrees that more improvement is still needed and more is still necessary. One of the things he

pointed out and spoke about in his testimony to the GOC, is that it takes, according to OCFS's staff, a year to 2 years for them to feel proficient in their role. The new caseworker positions that have been added to the Department is a very positive thing, but at the same time, that has, by mathematics alone, reduced the average tenure of OCFS's staff. They continue to work to improve, and he believes the proficiency of OCFS staff is improving and that includes in all aspects of the system. Director Landry said there are many cases in the Ombudsman's reports where there is agreement on the case or there is agreement on the review of the cases that she has looked at. There are some cases where it is different. Sometimes the outcome, the ultimate decision is agreed upon, but the process has points that the Ombudsman has pointed out that may need improvement or looking at further. It is a continuous process of improvement. One that they continue to engage with the Ombudsman on and look forward to her role with OCFS and Casey.

To the second part of Sen. Keim's question of what makes this different and what they are looking to achieve is the aspect that Casey has done this work and worked in this field for 60 plus years on a national basis. Director Landry believes what Casey can bring to the table, and one thing OCFS is looking forward to them bringing to the table, is the national perspective of looking at what the national current best practices are, what has been tried in other states that either worked or didn't work and how those pieces can help to inform OCFS's continuous improvement efforts, either to modify them, to change them, to change the order in which they are being done or any of those components. The other piece that Casey will bring to the table is that larger perspective of child well-being and, as he indicated in his testimony, many of their families are struggling with many of the societal challenges that families and fellow-Mainers struggle with, whether that be substance use, domestic violence or other challenges. He anticipates that part of the benefit of having Casey doing the review is for them to look at that larger system-wide work as well. They will do it through the lens of these cases, but he thinks they will also look at other things that they may need to do as a larger system, whether that be within DHHS or outside of DHHS to further help improve child safety. He believes there is some very critical and value-added components that Casey will bring to the process and they look forward to those recommendations and implementing them.

Sen. Keim said in the Ombudsman's letter to the GOC she mentioned that there are fundamental practice issues that occur again and again and one of them she mentions is that the Department continues to fail to complete consistent case work practice during the time in cases where the determination of child safety is most consequential. She wondered what the Director's response to that would be.

Director Landry said case work practice and supervisor practice are essential to any well-functioning system as it would be for any system that you might be talking about. He does believe that over time a caseworker and a supervisor have more tenure experience and training in their roles, you continue to see that practice continue to improve. He believes, generally speaking, that their practices in the total system are improving. Is it improving fast enough that any one would wish it to be? He would say no. You always want that improvement to happen immediately, but that improvement takes some time. It involves consistent caseworker and caseworker supervisor review of cases, learning from those and adapting their practice and improving their practice as they go forward. It is a continuously improving goal that they have for caseworker and supervisor practices. Director Landry understands and respects the opinion of the Ombudsman and that in the selected cases that she is reviewing, she is not seeing enough of that practice of improvement at a total system level. He sees more of that system improvement than Ms. Alberi may be seeing in the individual cases that she is looking at. He said they agreed that further improvement is necessary and part of what he believes Casey is going to assist them with is identifying any specific components of that practice that they need to specifically focus on through the lens of these cases as further improvement efforts.

Sen. Keim said one of the recommendations in the Ombudsman's letter is that frontline staff need to have their voices heard and their opinions considered in all areas. When the Ombudsman mentions the frontline staff is that caseworkers? She asked if the Director could say who that is.

Director Landry said he can't speak for the Ombudsman, but he believes what she is likely referring to are the frontline caseworkers. She may also be referring to caseworker supervisors.

Sen. Keim said one of the concerns she has is that she has had constituents reach out to her, specifically school teachers and school resource officers, who are giving her a very dire picture of their interactions with OCFS and a feeling that the Department is not responsive as much as they should be to complaints. This was happening before the most recent deaths. She thinks some of the most frequent reports are from school teachers and asked if that would be a correct assumption.

Director Landry said that is a correct assumption. In a given year, in 2020 with the pandemic changed the numbers slightly, but said in generally, school personnel, which includes teachers and other staff, account for 1 of the top 3 categories of individuals that make reports to the Department. Generally speaking the top 3 categories in any given typical year would be law enforcement, pediatricians or medical personnel and school personnel.

Sen. Keim gave an example of a teacher sending a text message, which she guessed was an acceptable form of communication, around some concerning circumstances, asking that there to be a home visit. The teacher had to follow-up 3 times in order to find out from a supervisor that in fact, a month later, a home visit was made. With those types of reports coming to her from a teacher, she thinks there is a real problem with communication and can see how these deaths have come about. Also, another thing she heard from the teacher is that when they communicate verbally with the child's caseworker, that may or may not be documented so the information from many instances of reports that may be something a little less concerning, are not being added to the case so there is no information being built up. The teacher was told that the only way to be certain that an incident would be added to a case file is if they fill out an intake report, and heard an intake report apparently takes hours of waiting for someone from the Department to get back to them. It was easier to try to verbally get ahold of someone and tell them what they are seeing so that they do not have to, in the middle of their day, spend hours on hold to try to get a hold of the Department to fill out the intake report. She asked if that is something Director Landry has heard before, is it uncommon, and does it surprise him?

Director Landry said if Sen. Keim wants to share any of the specifics about that with him, he will make sure OCFS follows up on those instances. In general, what he would say, from an intake report perspective, and he can provide the data because they have done it before and have shared it with OPEGA staff, the intake call system has been dramatically improved since 2017 and 2018. The average hold time is in seconds versus minutes. They have implemented a process where if it is going to be a hold time of more than a few minutes, they have the option of OCFS calling them back versus them waiting on hold. He will be happy to provide that data. The perspective of an intake call coming in and being answered, even during the pandemic, has been very positive. He believes what Sen. Keim may have been referring to is the desire by a teacher, or a school personnel, to get a report back from the Department on what happened with that intake report. In some cases, they may be reaching back out to them for additional clarifying information in that intake report. In other cases, they provided OCFS with everything they needed to be able to proceed and decide to go forward. Again, OCFS is limited in what they may be able to share with them based on confidentiality, just as school teachers may be limited with their requirements on confidentiality. Depending on the situation, he can understand the perspective some have shared with Sen. Keim. He can also say that he does not necessarily hear as many of the concerns that she addressed on that topic, but would be happy to look at it in more detail on those individual cases if she wants to share that information.

Sen. Keim said at some point in the near future she will set up a meeting and will go into those instances more specifically, but she did want to bring up the issues in a public forum because she thinks it is important to hear and she considers school personnel to be frontline workers as well. From their perspective, if they are continually reporting that a child that they feel is neglected or abused and they don't see anything change on their end and they are in daily interaction with that child, she thinks that is an important measurement for the

Committee to be hearing on how the Department is doing. She hoped the Department is utilizing school personnel to assess how the Department is doing.

Sen. Keim said a principal was told that they didn't have a place for the children to go and OCFS was not removing the children because they had no place to put them. That was a number of months ago and wanted to know if that was a problem and how much of a problem it is. At previous meetings we talked about hoteling, and was told that was not happening during the pandemic, but she does not know if we are leaving children in unsafe places because we don't have safe alternatives.

Director Landry said DHHS should certainly not be leaving a child in an unsafe situation because of a perception, or reality, of a lack of an alternative placement. What he can share is that OCFS provided OPEGA 12 consecutive months of data as it relates to children, where they are placed, how many children were in a hotel situation and, he believes, all of that data is available from the OPEGA staff, but OCFS would be happy to update that information. He said fortunately they have had a relatively small number of children because of a lack of placement that had to be cared for in a hotel setting. Those are very small numbers and he thinks OPEGA and the staff again will confirm that with the information that they have available.

As Sen. Keim's question relates to general placements, Director Landry said one of the things that he gives a tremendous amount of credit to OCFS staff, with the involvement of also the team at Muskie, is despite the challenges of the pandemic, over the past 2 years they have increased the number of licensed resource homes, sometimes called foster homes, by approximately 30% despite the challenge of the pandemic. That increase occurred in both of those years respectively. With support from Muskie during that time period OCFS also changed, modified and improved their resource parent training and quickly pivoted that training during the pandemic to virtual versus in-person so that there was no delay, or a minimal amount of delay, in continuing to license those resource families. That does not mean that they have appropriate amounts of placements spread throughout the entire State for the needs of the children. He would be the first to say, that large sibling groups, which OCFS tries to keep together, can be sometimes a challenge to find a resource home where all of the children can be placed together, particularly if there are 4 or 5 children in the group. It can also be a challenge sometimes finding placements for older youth, teens and adolescents, particularly if they have very significant behavioral health challenges. There are times, even though OCFS may have on paper a number of available resource families, because of the type of child they are willing to foster, or care for at the time, can be a challenge and that may result in a short-term hotel stay where the child or youth is being cared for. Director Landry said, but in general, and again he thinks OPEGA staff can share with the Committee all of that data, those numbers are quite small and that is something he gives a lot of credit to OCFS staff. One of the things that they continue to focus on is when a child has to come into care and a judge, the courts decide that they are going to sign the PPO in order for the child to come into the care and custody of the State, OCFS hopes to find a placement with the children's own relatives or a family member who can safely care for them. OCFS currently has approximately 43% of the children who are in OCFS's care and custody placed with relatives and that he thinks is very positive, especially when you consider the national average, which he believes is in the mid-30s as a percentage. Again, that is something OCFS is pleased about and proud of. The other piece is that they are one of the lowest in the country in placing youths in residential settings, non-family settings, such as a residential treatment center or something along those lines. Approximately 2½% of their children in their care are placed in those non-family settings and that he believes is one of the 2 or 3 lowest percentages in the country. That is a positive thing because they always want children to be cared for in a family setting versus in a residential or group setting wherever possible.

Sen. Keim said the increase in foster homes is good to hear and thinks it was mentioned before and it is good to be reminded of because that is important. She thinks it is important that they listen to the community stakeholders and get their feedback on how the Department is doing, not just from the caseworkers, but from the people who are on the other side of the caseworkers.

Director Landry reminded people that when they are talking about the larger group of stakeholders, that in the fall of last year, OCFS agreed with the Judiciary Committee and the Health and Human Services Committee to conduct a series of public forums. They had hundreds of people participate in those virtual forums and the report of those findings were compiled for them by a professor at UM Farmington and is available on OCFS's website. It included the voices of teachers and school personnel as well.

Rep. McDonald said she had a number of questions about the risk assessment and intake process, particularly as it applies to young children. In the February 2019 OPEGA Information Brief one particular paragraph stood out to her in the Policy and Practice Change section – "OPEGA heard from many interviewees that the SDM tool impacts decisions on types of abuse in ways that differ from previous practice. Those situations involve drug affected infants, domestic violence and physical abuse with younger children present, and drug abuse with younger children present. Prior to SDM, we heard that reports of abuse in these situations generally would result in appropriate reports (triggering OCFS assessment). Currently, the SDM tool classifies reports in these areas as inappropriate for further action. We heard from workers that case-by-case adjustments were made because of concerns that SDM was causing the Department to overlook cases where child safety may be at risk. This happened by way of the Central Office asking intake to use caution and to override SDM decisions in these types of cases. We also heard that this led to workers being less clear on the decisions that they should make." She asked if Director Landry could explain if this has been addressed and how it was addressed.

Director Landry said the SDM process, or tool, is exactly that. It is a tool and just like any tool that they have at their disposal, it is important to make sure you use the tool with discretion and with oversight. There is nothing automatic that should be associated with that tool and that is why there is always the opportunity for that tool to be reviewed and overseen and perhaps changed. Just like any tool that any of us may have in a tool box, it provides information and data, but it does not necessarily always have the exact answer. That is why it is important to make sure that OCFS staff know that SDM is exactly that, a tool, and he thinks since 2019 they have been working with staff to do that, including incremental training from the SDM developers in order to ensure that they have that feedback and further training on the appropriate use of that tool. The one way that he tries to explain it to staff is SDM, like anything, is one of many tools that hopefully they have in their toolbox and what they need to do is to make sure they are using the appropriate tools at the right time and recognizing that even in the cases of SDM, that just because it may provide a certain assessment rating, or may provide a certain piece of information, it still has to be done with judgment and oversight on the part of the caseworker or caseworker supervisor and potentially others that are in involved.

Rep. McDonald asked if in the event the SDM tool does not find a need for assessment, is that reviewed by a caseworker and perhaps their supervisor?

Director Landry said it can be. It goes in either situation. It may recommend that the next step perhaps not be taken and that can be adjusted or overruled using your language or the opposite can be true. Again, it is a tool that OCFS wants their staff to use because they think that tool provides a good structured way of looking at a case in an assessment, but it is not the only thing that should be considered when making a decision.

Rep. McDonald asked is it not automatic or is it not policy that the Department review it? For example, OCFS has a new caseworker using the SDM and it is found there is no reason for further assessment, that would not automatically be reviewed, it is optional? Director Landry said it will be reviewed. It is optional whether or not it is changed.

Rep. McDonald clarified that it is not common practice, particularly for a supervisor, to review it?

Director Landry said it is a very common practice for the supervisors to review. Rep. McDonald asked if it had to be requested by the caseworker or will it automatically be reviewed by someone else. Director Landry said

he believes it depends upon the situation with the caseworker. He believes in most situations where it is a newer caseworker then that process is automatic. If you have a more tenured caseworker, it may not be.

Rep. McDonald asked if a criterion was specific to very young children in the risk assessment process? Director Landry said he believes the risk assessment process does certainly consider the added vulnerabilities of young children versus perhaps older children, so said yes.

Sen. Libby said after 2 plus years of engagement with OPEGA and the GOC, Director Landry reported to them in April 2021 and gave a thorough presentation and it gave the Committee the sense that things were really on the up-and-up and that the condition on the ground was improving significantly. Perhaps it is a coincidence, but not long after that, they were made aware of 4, potentially 5, cases of children who have died at the hands of their caretakers. He asked for Director Landry's opinion of what happened, what went wrong, how did these cases slip through the cracks?

Director Landry said he believes that is part of what DHHS will continue to look at to see what went wrong with their internal review, as well as with Casey's assistance. To look at these cases specifically and answer that question. To Sen. Libby's larger question, he thinks one of the challenges for anyone in this system and anyone in this kind of role is the fact that you are looking at a multitude of different types of inputs from a question of improvements in the system. He takes that responsibility very seriously. It is why he reads every one of the Ombudsman's reports that come back in because that gives a lens into certain specific selected cases. He also looks at a variety of other reports, some at the system level and some at the case level. One of the challenges that they have is, and is endemic in all of these situations, is you look at data and information, some of which he has provided to the GOC at a system level that looks at, for example, federally required measures that may show directional improvement that looks very positive. At the same time, you may also hear of individual cases, or other data points that show that improvement is not necessarily being made, or not being made as fast as you would like. You have to take into account and balance all of those factors, including these individual cases to help inform larger system-wide practice and that is exactly what they attempt to do and what they will continue to try to do with the assistance of Casey on the individual cases.

Sen. Libby said, understanding the law of confidentiality that Director Landry has to operate under, asked what is the response, what does the process look like when OCFS, starting with Director Landry, are notified of a child death where the child had engagement with OCFS. He asked, in a general matter, if the Director could walk them through the steps, beginning with himself, down to intake and community partners of the Department's process for responding to that information.

Director Landry said whenever there is a serious injury or fatality he is notified, as well as others within the Department. That initial report usually contains specific information about the circumstances with which that serious injury or fatality may have occurred and the knowledge that they have at that point. That information may initially come from medical personnel, it may initially come from a law enforcement individual, or it may initially come from a different referent. As soon as that information comes in, that information is shared, including with him and others within the Department. Generally speaking, the next step in the process is more information then needs to be found. There is generally a number of next steps as far as what happens at that point. Some of that information may be related to garnering additional information from law enforcement, getting additional information from medical personnel or gathering additional information into OCFS's own files, data and information. At some point, for some of these cases, there is a further analysis done regarding that case and that situation from the perspective of not only garnering more information, but also beginning the learning process of what can be learned of what may have occurred in that case, as well as, how it informs potential changes that they need to make to future practice or policies and things of that nature. Eventually in the case of certain serious injuries and deaths, if there is a prosecution, or a case is complete, then it can at that point reviewed by the Child Death and Serious Injury Review Panel, which is one of the required panels under

the federal CAPTA law and they in turn will do a larger system review. That usually occurs some months after the serious injury or the fatality so all of the information can be collected.

Sen. Libby asked if the practice the Director just laid out is captured in a policy document. Director Landry said certain components are captured in a policy document. He is not aware that there is one document that has that entire process documented. OCFS can certainly do that, but they do have certain policies, practices and procedures that lay out that exact process.

Sen. Bailey, following up on Sen. Libby's questions, said she did not hear anywhere in the Director's response about some provision for accountability. She saw where there is an analysis and there might be some recommendations for changing and learning, which is all done internally, but where is the accountability.

Director Landry said certainly accountability is part of that process as well. If there is a piece of the process where something did not go according to policy or procedure, then that is certainly addressed on an individualized basis for those individuals, wherever those individuals are within the organization. Accountability is part of that and he believes there is also the aspect that they all collectively share accountability and responsibility whenever a situation like this may occur, whether it be a serious injury or a fatality and they take that seriously as well.

The members of the GOC thanked Director Landry for his testimony and for answering their questions.

- Lisa Marchese, Deputy Attorney General, Chief, Criminal Division, Office of the Attorney General (AG)

Deputy Marchese said she, along with being Chief of the AG's Criminal Division, is Chair of the Domestic Violence Homicide Review Panel which is a statutorily mandated panel that reviews all domestic violence homicides which includes intimate partner homicides and intrafamilial homicide. She said the Committee just heard reference made to the Child Death and Serious Injury Review Panel, noting the one she is Chair of focuses on domestic violence. She noted that Rep. Stover was on the Panel for many years.

She hopes she can be helpful to the GOC and said the Criminal Division of the Maine Attorney General's Office prosecutes all non-motor vehicle homicide cases. Homicides in Maine are investigated by the Maine State Police, except in the cities of Bangor and Portland. In those cities their own police department conduct the homicide investigations. The District Attorney's offices prosecute those child abuse cases which do not result in death. The AG's Office has charged 3 people in 3 different child death cases that occurred in late May and June. In each of the cases, the police are conducting thorough investigations of the facts leading up to the death. If the AG's Office charges a person with murder or manslaughter, it is their responsibility at trial to prove beyond a reasonable doubt that the person charged is the person responsible for the death. A homicide investigation contains the investigative reports, the policy reports and those records are confidential by statute pursuant to the Intelligence and Investigative Records Act which can be found in Title 16 MRS, §§801 – 808. Deputy Marchese thinks it is important to understand why these records are confidential. Simply because charges are brought does not mean the investigation ends. Public dissemination of facts in any case can affect the recollection of witnesses so that witness' memories are impacted by what they saw or they heard in the press or on tv as opposed to what they actually saw and heard.

As a prosecutor, she has to be mindful of defendants' rights and their ability to impanel an impartial jury and extensive publicity can adversely impact that. Any records request also requires the AG's Office to ensure that there is not unwarranted invasion of a person's privacy.

Deputy Marchese said there are generally affidavits filed with the court that lay out at least some of the facts in the case. Affidavits in homicide cases are generally impounded for a period of time and then released to the public. She said she can assist the GOC with 2 affidavits in currently pending cases. One of the affidavits has

not yet been released. She said it is likely the AG's criminal investigative file will not become fully available for several months. She thought it was also important to note that the AG's criminal investigative file does not contain a copy of the DHHS file. The AG's Office has to get DHHS's file pursuant to court order. Additionally, she said, simply because a person is charged with a crime involving a child does not necessarily mean that DHHS was involved with that family prior to the death.

Deputy Marchese wanted to assure the GOC that the AG's Office has no desire to interfere with the work of the Committee. It is her duty to balance the needs of the criminal investigation with the needs of the GOC and others to do their work. Obviously, the easiest way to do that work is at the conclusion of the criminal matter, but she recognizes that is at odds with the GOC's timeframe and certainly, Dr. Landry's timeframe. She said unfortunately there is a back log of homicide cases and any of the pending cases will not be adjudicated for at least 18 to 24 months. In the meantime, she will provide information that she is permitted to under the law. In 2013 the Legislature did create an exception to some of the prohibitions that she previously mentioned. It says that a government agency responsible for investigating child or adult abuse, neglect or exploitation or regulating facilities and programs providing care to adults or children can be subject to the reasonable limitations, or exempted from the reasonable limitations. Deputy Marchese said the problem there becomes secondary dissemination, but she is happy to work with DHHS and OPEGA, but the further dissemination of information may be problematic.

Deputy Marchese wanted to assure the GOC that the Homicide Review Panel and the Child Death and Serious Injury Review Panel will look at these cases at their conclusion.

Sen. Bailey said it sounds like the AG's files will not be available to Casey in doing their review and asked if that was accurate. Deputy Marchese was not sure it was 100% accurate because she can put what is called reasonable limitations upon their review of a file. The GOC may recall that a few years back when OPEGA did their investigation into the deaths of Marissa Kennedy and Kendall Chick cases, the AG's Office shared their files to the extent that they could. The problem then becomes a secondary sharing. In other words, making certain information public. She said she can make files available confidentially to Casey, but she could not allow them to share the investigative files beyond their own review until the criminal case is over.

Sen. Deschambault referred to the Deputy's last sentence in her testimony and asked if she could restate it. It was about a review of the cases is almost independent of the legal review. She was questioning for what purpose would she have from going from the legal and criminal case to then looking at it in what way and what would she look for.

Deputy Marchese said as Chair of the Homicide Review Panel, they look at systems. So, part of looking at all of the systems, is looking at the case file, looking at DHHS's files, and occasionally there is confidential information from the State Forensic Unit. What they look at is all of the intersections of the systems to see what could have happened or what they could have done to prevent the death. She noted that in late April the AG's Office sent by email to legislators the 13th Biennial Homicide Review Panel Report which is a 20 year retrospective of all of the cases they had looked at. She said she will deliver hard copies of the Report to the members of the Committee.

Sen. Bailey asked Deputy Marchese if, to her knowledge, has the Department of Health and Human Services or its predecessor, or any State agency ever been charged with negligent manslaughter. Deputy Marchese said not that she is aware of.

The Committee thanked Deputy Marchese for providing information to the Committee and answering their questions.

Christine Alberi, Executive Director, Child Welfare Services Ombudsman

Ms. Alberi presented her testimony to the GOC. (A copy is attached to the Meeting Summary.)

Ms. Alberi said to Sen. Keim's question regarding stakeholders, she said she was referring to caseworkers and supervisors in this particularly instance, although agreed that all stakeholders have a lot of value to contribute. Everybody who is working with children, are involved with child welfare, has a lot of value to contribute. She thinks it is important that caseworkers' voices are heard when some of these improvements, initiatives and policy changes are being made. She said that does not always happen and that, for example, in the current policy initiatives and rewriting the policies with the Muskie School, she does not know that the caseworkers were involved. She said at least at the outset they had chance to speak to the policies after they have been drafted.

Ms. Alberi said she disagreed, to some extent, that the Ombudsman's and OCFS's communication has been regular over the past year. Her meetings with Director Landry, and others, have not been as regular as she would have liked, although that has been addressed recently and she thinks they are on to a better path now. In general, she thinks the communication and collaboration has been less than she would like, not with just Director Landry, but with others in the Department. She is always happy to offer anything she can do to lend her expertise and assistance to any of the reforms they are making, to any plans or thoughts in the future.

Ms. Alberi said it might be of interest to the GOC that she has worked with Casey a little bit recently. The New Hampshire Ombudsman's Office has been working with Casey for several years doing case specific reviews, and they have a great process. She had not been involved in the agreement with Casey to figure out exactly what they will be doing in Maine, but they did a review in the NH Ombudsman's Office in 2019. Casey has a lot of expertise and put on a great presentation about what to do and what not to do in the wake of highly publicized child deaths. She remembered thinking that Maine could have learned a lot from Casey in the wake of the Marissa Kennedy and Kendall Chick deaths and she is glad Casey is going to be involved because they have a lot expertise to contribute.

Ms. Alberi said she thinks it is really easy when things like this happen to blame the caseworkers and frontline staff who are involved. In general, the things she sees in cases where things go wrong, the deaths that the Committee is talking about today, it is not because someone is acting in bad faith or does not care about the children. Caseworkers worry about the children on their caseloads all the time. Generally speaking, when something like this happens it makes their jobs even harder because they get a lot of pushback from people who are angry, understandably so, about what they are seeing in the news. She wanted to take a moment to say that supporting the caseworkers is one of the most important things we can all do, going forward. A lot of them are doing good work.

Sen. Bailey referred to one of Ms. Alberi's recommendations about increasing transparency and said that is something she struggles with in this area because it seems to her that the child welfare system is a very closed system. She understands the need for confidentiality, for protecting children, but what that leads to is a very closed system and the only people who know everything are the very people who are also looking at what needs to be done. It is a circular system. She asked if Ms. Alberi has any specific recommendations on how we can increase transparency because, again in this area, the courtroom is closed, the case files are closed, everything is closed. There is no one from the public or the outside looking in on this system at any time and that is a problem that they need to find a solution for.

Ms. Alberi said she thinks the easier answer to Sen. Bailey's question is to increase transparency, not in terms of the actual facts of the cases that are involved, but to increase transparency at all levels of decision-making within the Department. Transparency on how the decisions are made, who is making the decisions, which stakeholders – we talk about stakeholders, but it is extremely important to have people with a variety of

different types of expertise involved in making decision. Someone who is an expert in domestic violence, for example, to make sure that all of the new policies have domestic violence included. If there is some kind of new initiative that is happening that involves hospital nurses, make sure that the hospital nurses are involved. Basically, making sure that the lines of communication are open because there is so much that we can communicate about that does not have to do with confidential details of child welfare cases.

Ms. Alberi said there are a number of reasons, and good ones, why the laws surrounding confidentiality of child welfare cases exist and why they are probably not going to be changed soon, but there are statutory bodies in Maine, herself, and the Serious Injury and Death Review Panel and OPEGA, who all can get access to that information and she thinks all of them can share that information as much as possible without revealing confidential details. That way the Legislature and the public knows that with the Department, Ombudsman, Serious Injury and Death Review Panel and OPEGA, are looking at a situation. If we say "X" "Y" and "Z" needs to happen because we looked at this confidential information then she thinks it will make some people feel better.

Sen. Keim asked if there was any type of feedback loop or assessment on caseworkers that Ms. Alberi was aware of where they are connecting with families they work with or other stakeholders within the community to assess the thoroughness of their job.

Ms. Alberi said if a teacher, anyone who, calls and makes a report to Child Protective Intake and it results in an assessment, the caseworker is suppose to contact the person who actually made the report and follow-up with them to make sure there isn't any additional information. That does not happen if it is a report that is not marked as appropriate for an assessment. It is very difficult for caseworkers sometimes to get in touch with people who call to give them information because they can't always say what they are doing or what is happening. That is different from what Sen. Keim was asking about where the teachers were concerned and wanted somebody to check on the child. Ms. Alberi said, aside from that formalized part of the policy where the person who contacts Intake has to be contacted at the beginning of an assessment, she is not aware of any formalized policy where that happens, but it does happen. If a service case, or a court case, is open and there is a family team meeting, sometimes some of those providers are invited to the family team meeting to help plan. She finds that, in general, cases go a lot better when there is open communication, particularly with the schools. The schools are sometimes the last to know about safety plans, or changes in custody, and schools have a lot of valuable information about kids.

Sen. Keim said one particularly school she was talking with said that now they have a school resource officer who works in their local police department and working together and coordinate efforts has changed outcomes for kids. She said possibly those 2 stakeholder groups are siloed from DHHS. Obviously, caseworkers are doing the job because they want to protect children, but she wondered if there was any assessment that Ms. Alberi knows of where DHHS will look at how a caseworker is doing by following up on that caseworker and their thoroughness with the people that are in the community.

Ms. Alberi said she did not know the answers to how specifically supervisors are supervising the caseworkers or if supervision includes whether caseworkers are following up with witnesses.

Sen. Keim thinks it is an important point to consider because if people making reports to OCFS of their concerns about children and are not hearing back, which is what she has heard, it is easy to see how children could drop through the cracks. When they don't hear back they do not know if they should annoy someone and keep reaching out or do they assume OCFS has taken action. Some of the information Sen. Keim heard is of concern to her.

Sen. Keim said another thing in Ms. Alberi's testimony that she appreciated was the idea of qualitative measures because today when she asked about if there was a safe place for the children to go it was mentioned

that the number of children that are being housed in a hotel has dropped significantly, but that is not a good measurement on its own if those children being put some place safe. It is good that they are not in a hotel, but not good if they are not in a hotel because they were left in an unsafe location. She asked Ms. Alberi the same question she asked Director Landry, is she aware of there not being enough placements, or safe locations, for DHHS to move children and whether or not that is affecting the timeliness of children being removed from the home when they should be?

Ms. Alberi said she has not seen that particular issue in a case, that it was that clear or that obvious. She thinks it has been difficult for a long time because the State does not have as many foster homes as they would like. It is one thing for children to be able to go to a safe foster home, but ideally the State should have an array of foster homes to choose from so that child can be placed in a home that is best suited to their needs. She thinks the State struggles to place older youths and does see that a lot. They struggle to place older youths in foster homes, and particularly youths of all ages that have behavioral difficulties. The State could use a lot more therapeutic foster homes and there certainly are cases where children get placed out of their district. Ms. Alberi thinks it is a difficult problem to solve because the amazing foster parents that do take the therapeutic cases are hard to find. It is not something that everybody can do and she knows there have been recruitment efforts by DHHS. She would say the hoteling issue has gotten less, but not having enough foster homes, is an issue.

Rep. McDonald was hoping that Ms. Alberi could shed some light on the Serious Injury and Death Review Panel's process. She assumed they make recommendation and issue reports and asked where those reports and recommendations go and does the public have access to them?

Ms. Alberi said she did not know a lot about the Panel, but that in the past they have issued public reports. For example, in about 2016 they issued a report that detailed that SIDS or death of infants for no apparently reason was a serious issue in Maine and, in fact, more babies were dying of that than anything else. That is the kind of information the Panel can collect, put in their public report and that actually resulted in some changes in the Department to make sure that babies were going to sleep safely. That has been her experience with them. She didn't know what happened, but there was a long time that the Panel didn't issue a report. It would be something that would be valuable to look into because they may have a lot to add, because they have doctors and experts of all kinds on the Panel.

Rep. McDonald had to leave the meeting, but said she strongly supports moving forward with further action by the GOC.

Rep. Stover said she appreciated the information Ms. Alberi provided because she honed in on some specific things. One of those is the theme within about accurate risk assessment at different periods of time and wondered, not necessarily to this specific tool, but in general, if Ms. Alberi can speak to any specific ways or any specific area of improvement she would recommend about risk assessment at any period during a case that would speak to some of the concerns she outlined.

Ms. Alberi said as you heard Director Landry mention, there are SDM tools, which are the Structured Decision Making tools and are one way of measuring risk assessment. SDM tools are great tools. The issue can be is if there is a vacuum of other information, sometimes the information that is put into the SDM tool is not sufficient for the SDM tool to spit out an accurate number. She knows Rep. Stover asked about reunification cases and said the things that a caseworker or supervisor needs to look at during a case to decide whether or not a child should go home any time soon, is that the questions are much less about the child, although that is part of it, especially if the child has significant needs of some kind, but the question is really about the parent. How is the parent doing? What was going on in this parent's life when the child entered custody? What types of services does this parent need in order to address the issues they have? A common case is you have a parent who is a victim or perpetrator of domestic violence who has substance use issues, underlying mental health issues and then often times criminal histories and many times has their own history as a child in child welfare. You have

to address all of those things. You have to address their trauma, impulse control issues, and if they do have an official mental health diagnosis, that needs to be treated. Their parenting skills may need to be addressed. It is important from the very first day that child enters custody, or the very first contact the caseworker makes with that parent, that as fast as possible, there is an investigation into what is gong on with that parent. Will that parent be able to participate in treatment? Is the Department sending the parent for random drug screens? Is the Department talking to the parents' therapists regularly about issues that came up in the last family team meeting where the parent lost their temper and stormed out? Is the parent getting the correct level of substance use treatment? It is a difficult task because no matter how much information you have, you never quite know what is going on with a parent. Some of the work is face-to-face visits with parents, getting to know them, seeing how they are doing. It is a combination of social work, trying to help the parent be able to make changes in their life, while also investigating them, sending them for random drug screens and doing unannounced visits to homes if they are not doing well. Ms. Alberi said that is an odd combination of work for a social worker to do and many do it very well. She said they have to consistently gather all that information because none of the changes happen overnight and sometimes it ends up being an evidentiary issue in court. For example, if you don't have those random drug screens, if you don't have contact with the parents' therapist, if you never followed-up on that psychological evaluation that said they needed this other kind of trauma therapy, then there is nothing to give to the judge even though you know that parent is not safe. You have known them and know they are not doing well, but how do you prove to the court that child should not in fact go home. It is a complicated process, but those are the types of things that a caseworker uses to access the risks in a family as time goes on in the case.

Sen. Keim said as she listened to Ms. Alberi realized how much the Ombudsman's position is needed in Maine. She asked if there was anything that hindered Ms. Alberi's ability to do her job or to be more effective.

Ms. Alberi said there a couple of things that could make the Ombudsman's Office more effective. Back in 2019 they submitted proposed legislation that would strengthen the Ombudsman's Office and thinks a lot of those things still hold true. There are 2 things that she thinks would be of most help. One is to increase the Office's staff. She was fortunate to be able to hire their new Associate Ombudsman, Ashley McAllister, about 3 months before the pandemic hit. She was an OCFS caseworker with a Master's in Social Work (MSW) and has added enormous value to the Ombudsman's process and organization, but they could still use more staff. She wishes they could do more, could talk to more people and provide more information. The other thing is that currently their program only has a normal contract with the Department of Administrative and Financial Services. She thinks it would increase the Office's independence from the government if the Ombudsman was appointed for a term just as the Director of OPEGA is appointed, or a number of other types of organizations. The other New England Ombudsman, aside from New Hampshire, are actually called Child Advocates and are all appointed for terms. Ms. Alberi said she has the 2019 legislation and can share it with anyone who would like to receive it.

Sen. Bailey said in reviewing the Ombudsman's report noted one of the categories is "Action Cannot Be Undone" and asked if Ms. Alberi could give an example of what is being talked about there.

Ms. Alberi said say in April there was a child who was left unsafe in the home after an OCFS investigation. Three months later a new assessment came in or something else happened and the child was removed and put in State custody. The issue in that report would be the fact that that child should have actually been removed 4 months ago and was in the home for that period of time and unsafe, but we can't undo that now. The child is safe now, but we can't go back in time. If that is within her reporting period then she is going to note it as a practice issue of the Department.

Sen. Libby said in the beginning of Ms. Alberi's testimony she noted that she is independently reviewing 3 of the deaths out of the 4 that is being talked about at this meeting. He understands there are disclosure issues, but should he interpret that to mean that 3 of the 4 cases being discussed had OCFS involvement.

Ms. Alberi said at this time she did not know that yet because she has not received any of the information at this point. Sen. Libby asked if that was typical in this process. Ms. Alberi said she did her normal process and it is just coming up on the deadline when DHHS would have to respond to her.

Sen. Libby said his next comment will be more for OPEGA staff. He said Ms. Alberi noted in her testimony that they completed a "review of 43 child welfare cases. Out of the 43 cases, 17 had substantial issues, equating to 40% of cases." He said on the Committee's follow-up work on this subject he hoped they could zero in on some of the details, understanding there is case details they may not have access to, but if there are themes or patterns that come about, he thinks the Committee would be interested in digging into that more.

The Committee thanked Ms. Alberi for her testimony and answering their questions.

- **Request for review of the policies and practices of the Office of Child and Family Services (OCFS) within DHHS to ensure child safety in the home**

Sen. Libby noted that the GOC has received requests to conduct a review of policies and practices at OCFS from Sen. Curry and Sen. Diamond.

Sen. Curry presented his testimony to the GOC. (A copy of his testimony is attached to the Meeting Summary.)

Sen. Libby said he hoped that some of what Sen. Curry suggested can be incorporated in the GOC's next step as they investigate these issues.

The Committee thanked Sen. Curry for his letter and testimony.

Sen. Diamond presented his testimony to the GOC. (A copy of his testimony is attached to the Meeting Summary.)

Rep. Millett said Sen. Diamond has been involved with child abuse in the State for many years and as noted in his testimony, the problem has not been fixed. It calls for action to be followed through with specific outcomes to address the issues that Sen. Diamond has been speaking out on for many years. At today's meeting we heard about the commitment to involve a reputable group, Casey, to look at the system in a 90 day time frame and for the Ombudsman and OPEGA's involvement of gathering input from stakeholders, looking at training, policies, procedures and resources, all of which fall in the input equation. If they don't come out with hard recommendations that are measurable and that will fix the problem, do we have the right game plan because he knows Sen. Diamond spoke about the importance of rectifying previously identified short-comings. Sen. Curry talked about barriers to organizational change. All of that reminds him that we know we have a problem, evidence proves it and times have verified it over and over. Are we on the right track or do we need more of an action plan rather then a gathering of feedback and input? Are we fulfilling our role as a legislative oversight entity if we don't toughen up the plan that is emerging before them today? He was interested in the Senator's thoughts on if we are heading down the right path or is it a rabbit hole that is not going to fix the problem?

Sen. Diamond said he does not think it will fix the problem if the State continues on the way it is and if we simply say here is another well respected agency that is going to come in to take a look, do some analyzing and come up with answers. He thinks the information Casey comes up with will be helpful, but for him, the GOC, above all other committees, needs to make sure that we just don't do a frontline worker survey, as was done in 2018. That was helpful, but he said he talked with some people who participated in that survey who were still afraid to give honest answers because they did not trust the fact that the information would not get back to their superiors. He thinks the only way to address this is for the GOC to find a way with OPEGA to take OCFS's system apart, look at it piece by piece, which would include surveying, but also to dismantle and take a hard look and maybe Casey could do a good part of that work. He thinks they are wasting Casey's potential if the

State simply has them come in, the Department directs them on what they would like them do and they do it. He thinks the State should take advantage of Casey by taking the system apart. He didn't know why Casey's review is for 90 days because everyone knows solving a problem that he has been aware of for 20 years, is not going to be solved in 90 days. Sen. Diamond said the State should take advantage of Casey and their expertise and take OCFS apart piece by piece and then rebuild it. We have to analyze the policies and procedures. Why are they putting kids back in the homes that are unsafe? Why did Maddox Williams go back into that home? Knowing the facts now, no one would ever do that. He said the State has a tremendous opportunity here, which is why at the start of his testimony he thanked the GOC for doing this. We have a tremendous opportunity and can make a difference and define OCFS. Sen. Diamond wanted OCFS to know that this is not pointed at any individual, any commissioner, any governor. He is saying let's work together and we can't work together unless we are willing to say this is more than a flat tire, we have blown an engine and we need to really take a look at this. He thinks Casey coming is good, but we cannot just sit back and only rely on that report and we end up with a not transparent operation.

Rep. Millett said he feels the need for a stronger legislative imprint on the plan that is approved at today's meeting, or subsequent meeting, than simply accepting what is actually ongoing at the moment. It feels to him that the GOC needs to be accountable, not only to their own constituents, but to the people in the Executive Branch that they are in an oversight relationship to. Until they get an answer to the question that Sen. Diamond posed – what went wrong – then we are only enabling a process without accepting personal and committee accountability. He is hoping, as the GOC finishes their work at this meeting, that they actually give it more of a push than simply saying go to it. He wants to be more active.

Sen. Bailey said what she is taking away is 3 broad themes and she wanted Sen. Diamond to let her know if there are others. The 3 she has picked up on are transparency, accountability and oversight.

Sen. Diamond thinks the functionality within OCFS is several layers deep and there are some culture issues, not just with the current Administration, but it has been that way for other Administrations as well. He thinks there can be a detailed analysis and it might fall in the 3 themes Sen. Bailey mentioned, but also to focus on making sure there is a clear understanding of how OCFS actually operates. Sen. Diamond said that does not require confidentiality. It does when talking about individual cases, but there is no reason why we can't find out exactly what they do and how they do it and double check and get some accountability on those answers.

Sen. Keim said part of the frustration she feels listening to the testimony at today's meeting is that there are a lot of walls up because of protection and privacy issues around the children and the situations. It seems like the questions we would want to ask that would help them to dig down, they can't get answers to because of confidentiality issues. She asked if Sen. Diamond could talk about that and what he sees as the GOC's role being and how do they dig in with those things hampering their abilities.

Sen. Diamond said one of the things he learned sitting through the trials of Julio and Sharon Carillo and Shawna Gatto, was all the things that actually happened within OCFS, and said it is not like television where you watch it for an hour and there is a Perry Mason ending. That doesn't happen. He thinks that all of the information that can come out at that point, albeit late, can and should be utilized in restructuring. He said you can go as far back as Logan Marr's death in 2001, to see what happened there and compare it what happened in 2017. Although that had been done, we can do a different approach to the Kendall Chick and Marissa Kennedy cases. There is a lot of information when you get into the Kendall Chick death where a caseworker testified that she visited once in 6 months. He thinks you can look at that and say was she doing what was expected? Was she unable to get back for visits because of other reasons? There are a lot of assumptions, but there are ways of getting to that information and he is confident in the process of assessing and really dismantling a system that he does not think can be patched up. Sen. Diamond thinks the information is there, especially the policies and practices and we need to see how they have been applied, or would apply, to some of the tragedies.

Sen. Deschambault said she was a caseworker and had worked with the people who have ended up in prison committing these crimes. First, she said she is a caseworker and brings this to light because someone said frontline staff need to have their voices heard. She said that will never happen. Maybe because of what Sen. Curry said about it being a toxic environment and we are not just talking about DHHS. Caseworkers in the State of Maine, or any state, either work for a state department, it could be Riverview, Dorothea Dix, in any behavioral health umbrella institution or in prisons. When they said to have their voices heard, she was thinking in what – development of policies? Again, that will not happen, but they need to be heard in an environment where leaders, commissioners, etc. Maybe even anonymously, but they need to be able to share what the barriers are for them to do their job well. Sen. Deschambault thinks the Ombudsman touched upon it in that the powers that be, who run big institutions, not only the State or the government, outside private hospitals, recovery areas and nursing homes have caseworkers, really protect their environment and they do not want to let out a lot of information. What you do is you measure it quantitatively and numerically. There is nothing worse for a caseworker to be told to put the numbers in and not be able to do case management one-on-one because the only thing that matters is the sheet that says quantitively and numerically what it is you are doing. She was truly appreciative of what Rep. Millett said and agreed with him that it is time to have something a little more solid. She has heard good things about Casey. She said how many times have we been on these committees and we say that is not Maine, you are bringing us something from New Mexico and this is not what we are doing. We need something more than that and agreed that for the people who are in charge, that is a much easier action to take. The Department of Corrections just went through this and said, well we had these national experts tell us this and it collects dust. We don't want it to collect dust anymore. Sen. Deschambault said she is in full support of Rep. Millett's recommendations.

Sen. Diamond agreed with Sen. Deschambault about frontline workers' voices not being heard, but said the GOC's voices will be heard, and that is the big difference.

The Committee thanked Sen. Diamond for his presentation and for assisting the GOC. Sen. Libby noted that Sen. Diamond had some materials, that may be able to be shared with OPEGA staff. The GOC would welcome that. Sen. Diamond said he had already cleared it with some individuals and is able to share the information and he thinks the information will be helpful.

Sen. Libby said the GOC had received a lot of information at the meeting. The Committee has 2 requests from legislators for the GOC to do an investigation of OCFS. He was hoping to come out with a motion at today's meeting to direct OPEGA to begin work immediately on flushing out a scope of work for this project and that they give OPEGA staff time to develop that scope based on the Committee members' input and bring it back for the GOC to consider and finalize at their August 11th meeting.

Director Nixon said in addition to the testimony the Committee heard at the meeting, they have the letters that were submitted by Sen. Curry and Sen. Diamond making the request for an OPEGA review. She would note that the possible topics, or scope areas that were highlighted in Sen. Diamond's request was evaluating agency policies and practices around assessing and ensuring the child's safety in the home and evaluating the agency's actions to address system shortcomings and protecting children identified by the Ombudsman. Sen. Curry's request was to understand barriers and successful implementation of the recommendations from the Ombudsman to address shortcomings, to ask questions about what are the barriers to implementation and how the Legislature can provide more effective oversight and ensure the implementation of reforms. To put this in the context, as mentioned several times at the meeting, OPEGA and the GOC have been working on these issues for a number of years. Obviously, as Sen. Diamond suggested they go back much further than that, but said as the GOC thinks about its next steps, it may help to quickly review what OPEGA and the GOC has done in the last 2 to 3 years. Director Nixon summarized the GOC and OPEGA activities regarding child welfare and the child protective services system summary. (A copy is attached to the Meeting Summary.)

Director Nixon noted that the follow-up survey of frontline workers is on the OPEGA Work Plan and is to be started soon. The GOC has in the wings, further work on out-of-home placement, should that continue to be an important topic. Before the Committee today is 2 new requests that have come about in light of the recent deaths of young children and an interest in taking some swift action and looking into what are the pressing issues. As the GOC heard in various parts of today's testimony, there has been again the mention of frontline workers and can consider if the Committee would like OPEGA to proceed with that work to shed some light and draft new questions that emerged from the current concerns. Also, there has been significant attention to the issue of child safety, both at the point of the initial assessment and whether the child should stay in a home and at the point of determining reunification. A third theme you heard is about strategies to improve legislative oversight, as well as how the different entities and oversight bodies, including the Ombudsman, the Serious Injury and Death Review Panel and the Domestic Violence and the Homicide Panel work, including what are the roles of these separate entities and what are the potential opportunities to strengthen their work in protecting children. She said it is important, as the GOC thinks about what they want to direct OPEGA to do, that they think carefully about what gap can OPEGA fill that is not being done. DHHS has Casey coming in, the Ombudsman is doing her own review, plus participating in the Casey work. What is the specific added value that OPEGA could bring to that. What are the tools that they have, what is their expertise? OPEGA is most adept at doing performance evaluations or review of how agencies are operating, where there are systemic problems. They can do surveys, case reviews, review agency data and case records, and do interviews. The GOC should think about where OPEGA can add value or do things that other people are not doing, to avoid duplicating their work.

Sen. Libby said in terms of the Committee's next step, what they were hoping to accomplish at the meeting is to have a motion made to initiate an immediate review of OCFS with the contingency that they will have OPEGA staff come back on August 11th with a proposed scope that addresses the members' requests and those of the 2 Senators to define the project.

Sen. Libby suggested that the GOC ask OPEGA to initiate an immediate review and that this matter be placed on the Work Plan with final consideration of the scope of work at the Committee's August 11th meeting. Within the scope of work, he suggested including the specific requests made by both legislative sponsors, and if members are open to this process, they would now add their additional request for information to be drafted by OPEGA and ready for the Committee's final review on the 11th.

Motion: That the GOC ask OPEGA to initiate an immediate review and that this matter be placed on the Work Plan with final consideration of the scope of work at the Committee's August 11th meeting. The scope of work, will include the specific requests made by both legislative sponsors, and if members are open to this process, they would now add their additional request for information. Get that information together in a list and will have a draft scope for final review on the 11th. (Motion by Sen. Bailey, second by Rep. Stover)

Discussion: Rep. Millett agreed with the motion.

Sen. Bailey wanted to make sure the motion encompassed the GOC's direction for OPEGA to go forward with the survey of the frontline workers.

Sen. Libby thinks the Committee wants to have that included in the scope. They may want to have discussion about how they would like to shape that survey given what was heard at this meeting and in the last month. The survey will be an important tool in this work. He noted the Ombudsman had shared some information about 43 cases and he thinks some analysis of that could be helpful in this work and added that Sen. Diamond has brought to the Committee a file of correspondence from folks he had heard from and the GOC needs to think through how they might gather data in a safe and confidential way to respect those folks, but figure out a way to incorporate that feedback into their project.

Sen. Deschambault asked what is the intent of the survey? How would that survey be conducted? Would it come from OPEGA? Director Nixon said the last survey OPEGA did was a survey of the full population of frontline workers and done by OPEGA. OPEGA got a list from DHHS of all the workers and the survey was issued by OPEGA and reported back to OPEGA. That same process would be followed. Sen. Deschambault said from what was said at today's meeting, she thinks the GOC needs more information.

Sen. Keim said the GOC should do some sort of review of the Department. Sen. Curry mentioned cultural issues and just a survey of the frontline workers is not enough. They need to figure out where is there a disconnect between what the Committee is hearing in Department report backs, which is we are doing all of this and changes are in place so we are on our way to making sure everything is running well, but as Sen. Diamond said, that type of reporting has been done for years and yet things are not going well. What she heard from folks in her district points to a disconnect between what is being experienced and then what is making it up the chain in the Department. OPEGA is good at doing Department reviews and we need to figure out how is there a disconnect between what legislators are being told is happening, that good changes are happening, but that is not playing out.

Sen. Libby thinks he understands what Sen. Keim is trying to accomplish and asked Director Nixon if she had information from OPEGA's 2018 and 2019 reports where they did do some interview work with community service providers, schools, law enforcement, etc. Director Nixon said she would need to double check on the details of who was interviewed, but thinks the type of work that Sen. Keim is talking about is definitely in OPEGA's wheelhouse to interview, not only staff within the agency at different levels, but also community partners and other parts of the system and that could be part of the process to see where the disconnect is. Sen. Keim agreed that is something she would like to have added to the scope.

Rep. Stover referred to the Ombudsman's report where she outlines the 3 panels that analyze, particularly whether it is sentinel events or death and also serious injury. The 3 panels include the Child Welfare Ombudsman, the Serious Injury and Death Review Panel and the Maine Child Welfare Advisory Panel. Those 3 panels should be considered as stakeholders and the Domestic Abuse Homicide Review Panel should not be left out of the equation because there are crossover issues. She thinks when considering stakeholders, the work of these panels should be included because every time they issue a report, they point to specific recommendations and they are often systemic recommendations. She would find a way to pull the best from those 4 existing bodies who have all looked, with different lenses, at child welfare. Sen. Libby agreed that should be included in the scope.

Director Nixon said what the GOC wanted OPEGA to look at or frame how they would look at would be understanding or gleaning from the work of those 4 independent or quasi-independent panels, what their role is, how they could work better together, what can be learned from them, etc. Rep. Stover said that was correct, and also to follow the recommendation of the Ombudsman because it is a good one.

Sen. Libby noted that Rep. Millett had mentioned earlier about trying to figure out a way for the Legislature to have some oversight over the Casey project. He asked if the motion before the Committee accomplished that or is Rep. Millett seeking something in addition. Rep. Millett thought it was on track. He assumed that the Committee is the legislative oversight agency over the Executive Branch and this is an area of major concern and they need to not walk away without having a plan that fulfills their duty and responsibility.

Sen. Bailey noted Rep. Millett's comments and said that is why she requested to see the actual request because she thinks that would give the GOC members an opportunity to comment if, for example, they thought the request was lacking in some way. But, without actually seeing the request, she can't comment on it. She is hoping that information will come to them soon and certainly they would have an opportunity to address any concerns it raises, or not.

Sen. Libby understood from Director Landry at today's meeting, that OPEGA staff would be welcomed at the work sessions for the Casey project and that is another avenue to understand how that process unfolds. Following the Committee's discussion on Sen. Bailey's motion it was noted that the motion includes OPEGA consideration of the following in developing the scope of work:

(1) Requests of Sen. Curry and Sen. Diamond;
(2) Analysis of 43 cases referenced in Child Welfare Ombudsman's testimony;
(3) Survey of frontline workers;
(4) Disconnect between DHHS reports and what legislators are hearing from constituents/schools; and
(5) Roles and recommendations of oversight entities:
   – Serious Injury and Death Review Panel
   - Child Welfare Advisory Panel
   - Domestic Violence Homicide Panel
   - Child Welfare Ombudsman.

Vote: The above motion passed by unanimous vote 10-0, 2 members absent. (Sen. Bennett, Sen. Timberlake and Rep. McDonald voted on the motion in accordance with the GOC Rules.)

Unfinished Business

None

Report from Director

None

Planning for upcoming meetings

In addition to considering and voting on the Scope of work for review of the Office of Child and Family Services at the August 11th meeting, the agenda will also include the public comment period for the OPEGA Citizen Initiative and People's Veto Process Report that was presented at the June 25th meeting and OPEGA will also be doing a presentation on the Evaluation of the Seed Capital Tax Credit Report.

Next GOC meeting date

The next GOC meeting is scheduled for Wednesday, August 11, 2021 at 10:00 a.m.

Adjourn

Sen. Libby adjourned the Government Oversight Committee meeting at 1:24 p.m. on the motion of Sen. Deschambault, second by Sen. Bailey, unanimous.

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

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Commissioner's Office
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Testimony of Todd A. Landry, Ed.D., Director
Office of Child and Family Services
Maine Department of Health and Human Services

Before the Joint Standing Committee on Government Oversight

Hearing Date: July 14, 2021

Good morning Senator Libby, Representative McDonald, and honorable members of the Government Oversight Committee. I am Todd Landry, Director of the Office of Child and Family Services within the Department of Health and Human Services.

The death of a child is a tragic loss – for that child's future, their family, their community, and our state. It is our responsibility as a state and as a society to do all we can to help children grow up safe and ensure they have the love and attention they need.

As Commissioner Lambrew stated, this is a call to action. And action is being taken without delay. I'll be sharing information in today's presentation about the work we have and will be doing to improve our practices.

Due to confidentiality laws and to avoid compromising ongoing law enforcement investigations, I cannot speak to specific cases. That said, the Department, including the Commissioner, myself, and all those who work within and with OCFS, are committed to in-depth reviews of these fatalities and the use of that work to inform continued improvements to protect Maine children. As we have announced, OCFS is partnering with Casey Family Programs to gain the outside perspective of national experts in the field. We have also been begun conducting our own in-depth review of any information we have related to these children and their families.

This work is also being conducted in the context of the unprecedented COVID-19 pandemic, a factor that has challenged everyone and all systems in our state and country.

As an organization and as individuals, we care deeply about child safety and wellbeing and are working to do all we can to learn from and improve our approach to child welfare based on the circumstances that resulted in these child fatalities and our longer-term improvements. I also want to mention our staff, including frontline caseworkers and supervisors, who have been directly impacted. We recognize the unique challenges presented by the work they do and the grief and concern we share with families and their communities. We have worked to offer support to the frontline staff impacted by these tragedies, including meeting with staff in impacted offices and ensuring that supports are available to our frontline staff at all times while they do this difficult work.

As Director Nixon requested, I'll keep my presentation to 15 minutes or less. Additional background information has been provided to you separately which I am happy to discuss with you in this meeting or in the future.

As you know, the Department has asked Casey Family Programs – a national leader in improving child safety and the wellbeing of children – to assist the Department in its investigation of these deaths, to evaluate existing child safety policies in the context of the deaths, and to offer interim policy recommendations that could be implemented by the State of Maine immediately to support child and family safety. We have given Casey no limitations in what recommendations they can make or what aspects of the system to review.

We want to know what policy and practice recommendations Casey will make as swiftly as possible so we can begin to act on them. Many months or a year is too long. We share Casey's value on supporting child safety within their families whenever possible as we recognize the trauma that can result from a child's removal from their family. While there are cases where removal is necessary and in the best interest of the child, we want to avoid as many unnecessary removals as possible. We have targeted approximately 90 days for this work to be completed. And while this timeframe is an ambitious one, we believe it is both attainable and necessary. Additional details of the 90-day timeline is shown on chart in your packet. The project timeline includes specific action steps as part of the process with Casey and their partners. It begins with document review, includes specific facilitated debriefings as well as a systemic review of conditions. The end result of the process is a final report or reports which will include recommendations from the lens of the cases reviewed. DHHS has committed that these recommendations will be shared publicly while also protecting the confidentiality of the individual cases. Recommendations could include policy, practice, training, and other areas that impact child protection and the larger child well-being systems.

Stakeholder and staff engagement is part of the process with Casey Family Programs. As we announced publicly, DHHS invited the Child Welfare Ombudsman to participate in this process with Casey Family Programs and we appreciate that she has accepted that invitation. Staff involvement with the process is also key and we have already informed staff that some of them will be invited to participate in the process.

At the same time, we are leveraging our relationship with other components of the larger child well-being systems to support children and families in the state. This includes recent guidance from the OCFS medical director to pediatricians and other medical professionals.

The training of staff and the policies and procedures that support the decisions they make are fundamental to ensuring child safety. OCFS benefits from a child welfare workforce that cares deeply about children and families. They have devoted their careers to ensuring child safety and work diligently to provide the best services possible. Our staff have told us that it takes 1-2 years for a new caseworker to feel proficient at their job. Similarly, it takes time for supervisors to learn their new role after being hired or promoted.

One of the recommendations of the 2019 system-wide assessment that was conducted with staff, stakeholders, families, and youth, was to review and update policies, procedures and training to

aid staff. Through a cooperative agreement with the USM Muskie School, new and revised trainings for staff and resource parents have been implemented. Several policies and procedures have also been updated with more in process. Additional details of the specific policies are included in the supplemental memo shared with you. The work with Casey gives us an opportunity to benefit from their national perspective and expertise to inform and further improve on the ongoing work with Muskie.

As some of you have noted in prior discussions, the public child welfare agency is a large piece of the social safety net for children and families and we recognize that our work is not done in a vacuum. Other factors, such as domestic violence, substance use, poverty, mental health, and more, all impact child safety. And despite the progress made in turning the tide on the pandemic, evidence from Maine and across the country continues to suggest that people are experiencing heightened mental health and substance use issues, including parents and children.

Among the actions taken, the Department has extended and broadened its StrengthenME campaign, which offers free stress management and resiliency resources to anyone in Maine experiencing stress reactions to the pandemic. The Department is also continuing and expanding the Overdose Prevention Through Intensive Outreach, Naloxone, and Safety, or OPTIONS, initiative with a particular focus on the opioid crisis.

The pandemic has challenged but not slowed our progress to implement the Family First Prevention Services Act in Maine, which will allow DHHS to draw federal funding to support evidence-based prevention services intended to keep children safe while preventing the need for them to enter state custody. Maine was the first state in New England to submit its state plan to the federal government and we are on track to implement in October. As I have noted to this committee before, this work will add valuable tools to our toolbox for protecting children in Maine and supporting families to facilitate safe homes, including an infusion of $2.4 million annually for prevention services.

As Commissioner Lambrew has stated, “Every child in Maine deserves to have the opportunity to grow up healthy, to get a good education, and to live a productive, happy, and meaningful life.” With the expert assistance of Casey Family Programs, we will learn all we can from these recent deaths and continue our work so that we can reach our North Star where all Maine children and families are safe, stable, happy and healthy.

For additional information, I refer the Committee to the materials we have shared including important information on data related to the child welfare system as well as updates to major initiatives, and more details on the implementation of the Family First Prevention Services Act.

Thank you for your attention and I’m happy to take questions that you may have.

Office of Child and Family Services

Briefing to the Government Oversight Committee

Dr. Todd A. Landry

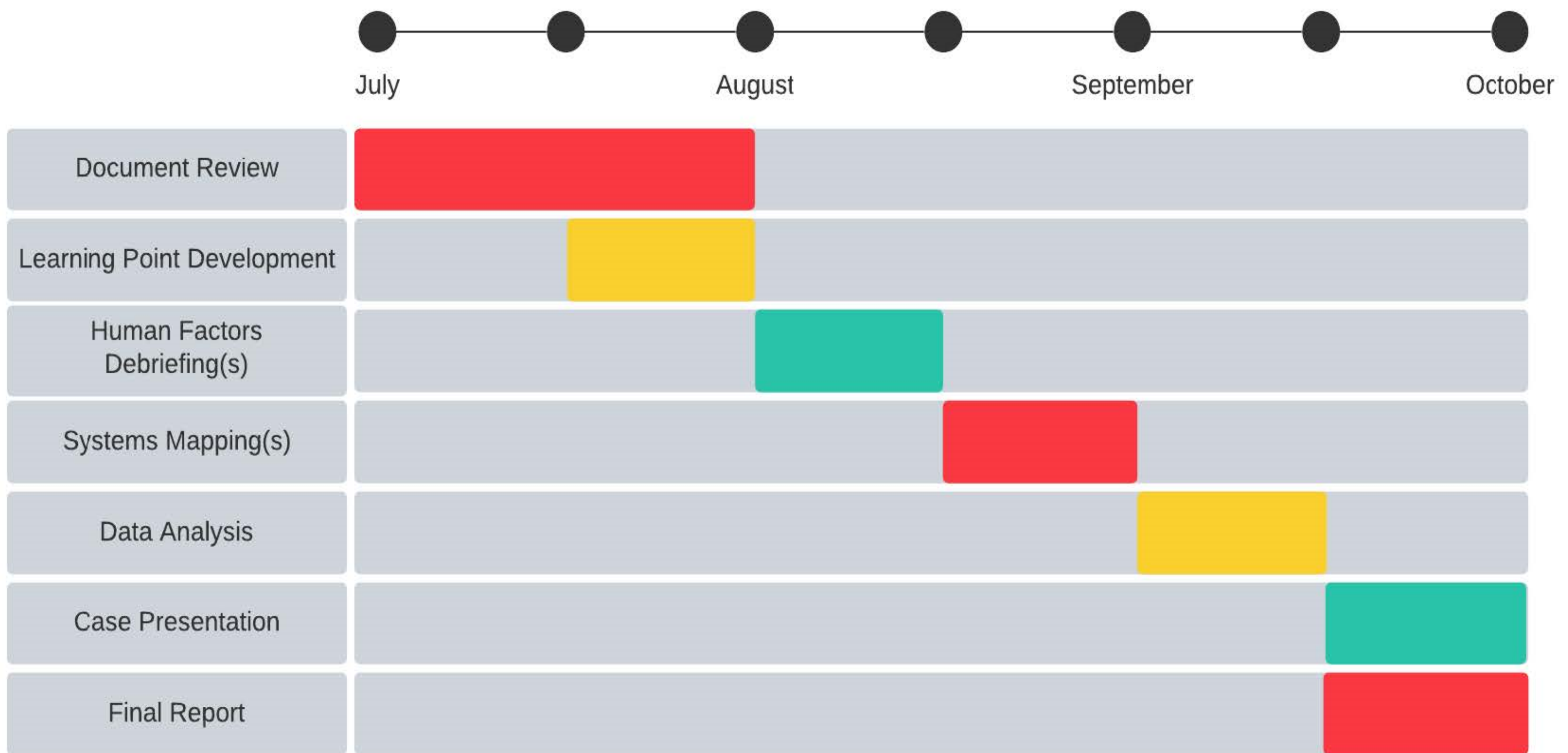
July 2021

Casey Family Programs

- Casey Family Programs is the nation's largest operating foundation focused on safely reducing the need for foster care in the United States.
- Focus on:
  - Supporting more effective public investments in strengthening families to keep children safe
  - Promoting a shared sense of responsibility for ensuring the wellbeing of every child and family
  - Safely reducing the need for foster care
- Provide:
  - Consulting services to child welfare systems
  - Direct services to children and families
  - Public policy resources
  - Research and analysis

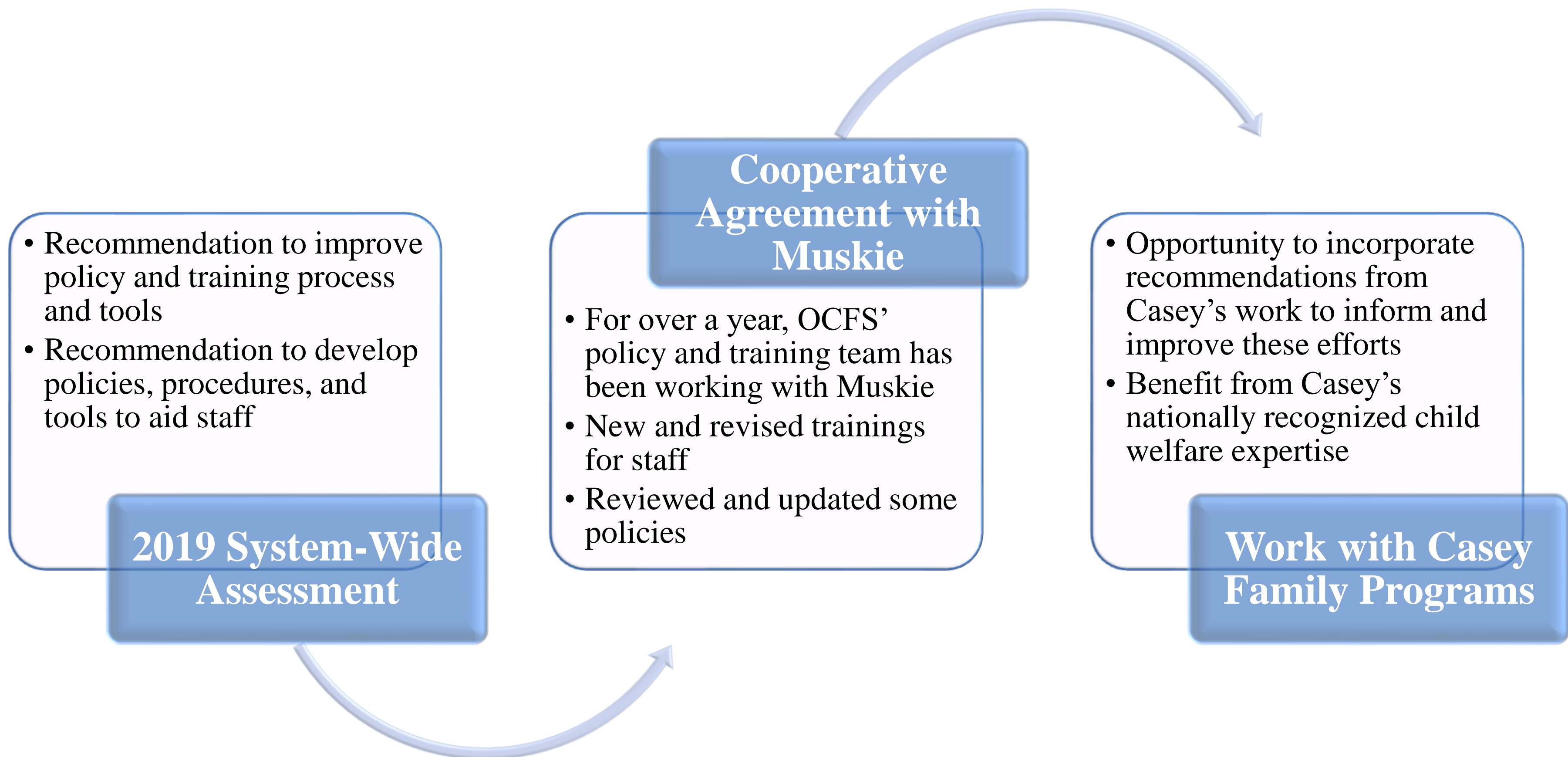
The Department recently finalized its agreement with Casey Family Programs and anticipates that the process will take approximately 90 days to complete. Work will incorporate staff and stakeholders, including the Ombudsman.

Preliminary Project Timeline



Stakeholder Engagement

Policy and Training Efforts

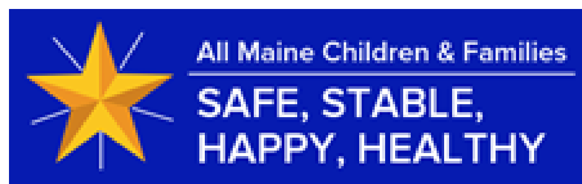


System-Wide Efforts

- OCFS is a large piece of the social safety net for children and families and we also recognize that our work is not done in a vacuum
- Other factors, such as domestic violence, substance use, poverty, mental health, and more, all impact child safety
- The Department is continuing to work to make improvements in systems of care, including behavioral health, that can positively impact child safety
- Examples include:
    - Expanding accessibility and affordability of childcare
    - Increasing rates for MaineCare services to expand accessibility to mental and behavioral health services
    - Responding to the unique challenges of the global health pandemic and its impacts on children and families
    - Planning and preparing for the implementation of Family First – Maine was the first state in New England to submit its plan to the federal government
    - Extending and expanding the scope of Strengthen ME
    - Continuing to tackle the opioid crisis (including the continuation and expansion of the OPTIONS initiative) as well as focusing on addressing substance use disorder in youth
    - Partnering with domestic and sexual abuse and violence advocates to conduct a system-wide needs assessment to inform future funding and policy decisions

Thank You

Todd A. Landry, Ed.D.
Director
Office of Child and Family Services



Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

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MEMORANDUM

To: Government Oversight Committee
From: Office of Child and Family Services
Date: July 14, 2021
Subject: Additional Background Information re: Child Welfare

Given the limited time scheduled for OCFS' testimony, we are providing this additional background information for the Government Oversight Committee meeting on July 14, 2021, related to child welfare.

Number of Children in Care

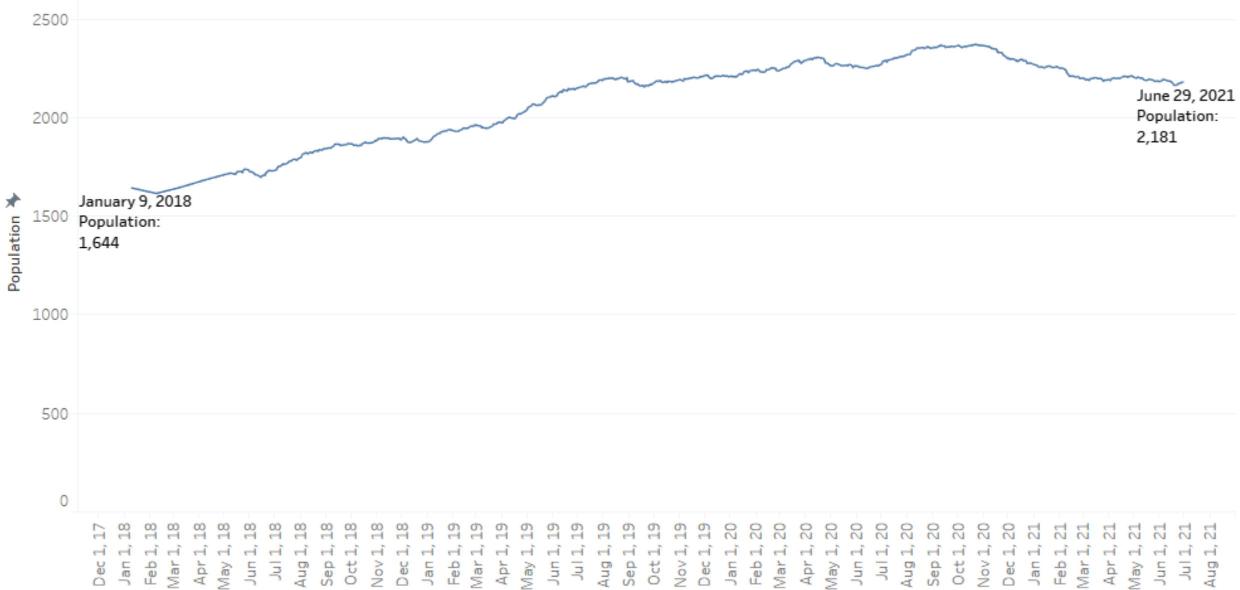
The number of children in the care and custody of DHHS is reported publicly on the OCFS website.

The total number of children in care is affected both by children coming into care and children exiting care. For example, in a given week 20 children may enter the Department's care, while another 20 may exit to be reunified with their parents or adopted, which would result in no change in the total number of children in care. As court hearings and other child welfare practices have generally resumed or increased, OCFS has continued its focus on timely and safe exits for children in care to long-term permanency. The data indicates that this has resulted in an

overall decline in the number of children in care as children exit to reunification, adoption, and permanency guardianship.

OCFS would also note that in December of 2020, the Federal government enacted the Supporting Foster Youth and Families through the Pandemic Act, which suspended youth from aging out of foster care and permitted re-entry of youth who had left foster care from January 2020 to April 2021. Youth that otherwise would have aged out will be eligible to remain in state custody through September 30, 2021. The number of children in custody in these charts includes youth who are over the age of 18 but have remained connected to the Department through a Voluntary Extended Support (V9) Agreement. In March of 2020, OCFS received guidance from the Federal Children's Bureau on the implementation of the Supporting Foster Youth and Families through the Pandemic Act and began implementing the legislation, allowing youth who otherwise would have aged out of the V9 program to remain connected to the Department and those who previously aged out to reconnect through a V9.

The chart below shows the number of children in care over a longer period of time.



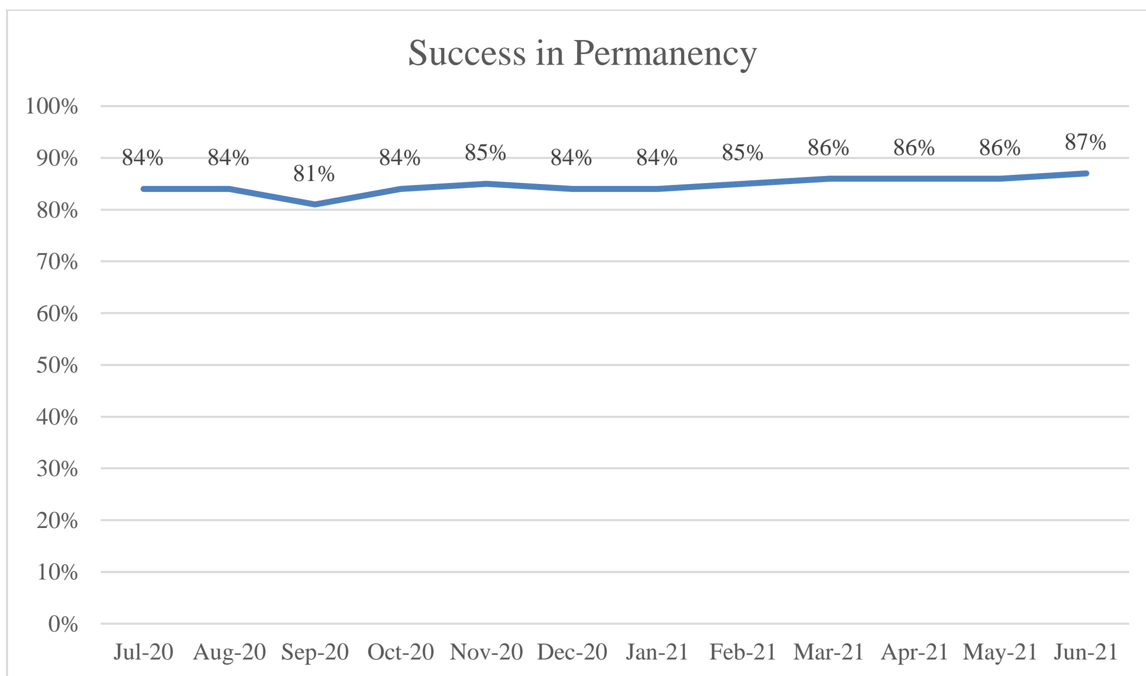
<u>Child Welfare Measures of Performance</u>

The federal government, through the Administration of Children and Families (ACF), requires states and territories to report on a number of performance measures. Three of these measures are reported publicly on the OCFS website and are shown below with discussion.

One key federal performance measure is **timeliness of permanency**, measured by the percentage of children who have achieved permanency within 12 months of entering care. The following chart shows the current performance is the highest level of achievement in the last four years.

Federal Measure	FFY 17	FFY 18	FFY 19	FFY 20	FFY 21 (YTD through June)
Permanency in 12 Months of Removal	26.5%	29.0%	30.9%	26.7%	**33.3%**

The federal government also recognizes that while timeliness to permanency is important, success in permanency is equally so. As a result, an additional federal performance measure is **success in permanency**. Maine is currently at 87%. Note that the performance over the past year has slightly increased, indicating that success in permanency has not diminished while timeliness of permanency has increased.

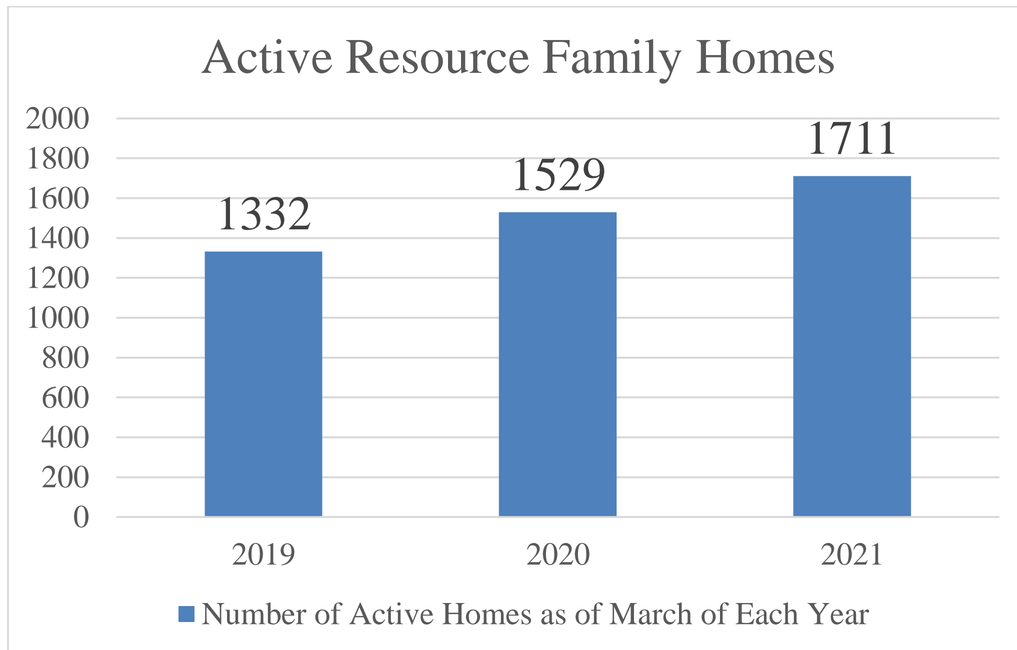


The third federal performance measure that OCFS reports publicly on its website is **Safety While in State Custody**. This measure is a rather complicated rate calculation specified by the federal government. It is not a percentage, and in this federal measure a lower result is indicative of better performance. The national benchmark is a rate of 8.5 or less. Maine is surpassing the federal benchmark with a rate of 6.52. Maine has posted results better than the federal benchmark in 11 of the last 12 months.

Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
8.79	8.23	7.78	7.48	7.21	7.06	6.92	7.44	6.97	7.74	6.13	6.52

Recruitment and Retention of Resource Parents

OCFS' effort to recruit and retain resource parents continue. From 2019 to 2021 there was an increase in the number of licensed resource homes by 379 (a 28.5% increase), this increase included the time period from 2020 to 2021, as we started to see a decline in the number of children in care, the number rose by 182 homes. OCFS continues its work with A Family for ME to recruit individuals interested in providing care to children in state custody, including targeted recruitment based on the needs of specific Districts or children in care.



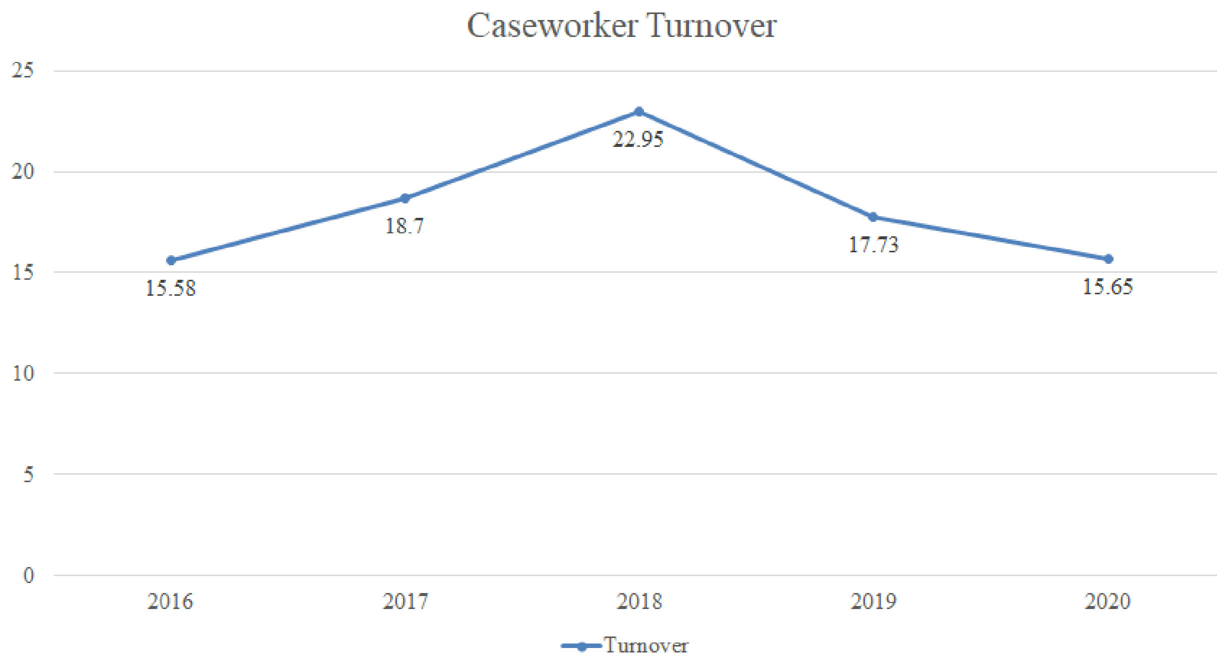
Recruitment and Retention of Child Welfare Staff

Since September of 2018, OCFS has benefitted from several initiatives which have increased staffing within child welfare, including new caseworker, supervisor, and support staff positions. These new staff have made a significant difference in OCFS' ability to provide quality child welfare services throughout the state.

CY	Caseworker	Supervisor	Support Staff	Authorized Child Welfare Positions
2018	16 (10 case carrying; 5 Intake; 1 Background Check)	16	8 (all lines effective 10/1/18)	578 (as of October 1, 2018)
2019	41 (33 case carrying; 8 Intake)	8	5 (all lines effective 9/1/19)	632 (as of September 1, 2019)
2020	16 (all case carrying)	2	2 (all lines effective 7/1/20)	654 (as of July 1, 2020)

Caseworker turnover (annual basis) has decreased from 22.95% in 2018 to 17.73% in 2019 to 15.65% in 2020. A 2003 study by the GAO found turnover of 30-40% on average nationally. A more recent study in 2019 by the Quality Improvement Center for Workforce Development found the average state has an annual turnover of 14%-22% for caseworkers, with 17 states having caseworker turnover greater than 25%.

Caseworker turnover data reflects OCFS' progress in retaining staff when compared to the turnover experienced in 2018. This reflects efforts to recruit new qualified staff, but also OCFS's work to improve training and support for both new and existing caseworkers.



<u>Policy and Training Work with Muskie School of Public Service</u>

The work begun with the Muskie School in late 2019 continues. Much of the work with Muskie is related to training and policy review and updating. Progress has been significant as shown in the information below.

- Training
    - Foundations (new worker) Training – Muskie took over the delivery of this training in the Fall of 2020 and continues to work to revise and improve the training for new caseworkers
    - Supervisory Academy
    - Use of a new Learning Management System (LMS), known as Brightspace
        - Reliable learning platform with 24/7 access via all types of devices
        - Better ability to engage staff through modern, accessible, and user-friendly interfaces

        - Engaging and interactive course content, including the ability to utilize various types of media and presentation techniques
        - Ability to track and assess trainings completed for each worker (supervisors and managers will be able to track progress of staff through trainings and their successful attainment of knowledge through quizzes)
    - Revised substance use training
    - Currently in the process of developing trainings for the new LMS focused on
        - Human trafficking and commercial sexual exploitation of children
        - Methamphetamine exposure
- Policies
    - Completed updates:
        - Interstate Compact on the Placement of Children
        - Safe Haven
        - Staff Safety and High-Risk Situations
        - Immunization of Children in the Custody of DHHS
    - Policies in final stages of approval:
        - Intake Screening and Assignment
        - Human Trafficking
        - Youth Transition
    - Policies in the staff and/or stakeholder comment stage:
        - CPS Investigations
        - Family Team Meeting
        - Substance Exposed Infants
    - Policies with management for review:
        - Permanency Policy
        - Adoption Policy
        - Placement with DHHS Employees/AAGs
        - LGBTQ+
    - Policies at the workgroup stage:
        - Authorization of the Use of Psychotropic Medications for Children in Foster Care
        - Resource Home Licensing
        - Entry into Care
    - Policies in the pipeline:
        - Background Check
        - Domestic Violence
        - Decision Making and Service Authorization
        - Collaboration in Child Welfare

Testimony of Christine Alberi, Child Welfare Ombudsman
Government Oversight Committee
Child Welfare Services Briefing
July 14, 2021

Good morning Senator Libby, Representative McDonald, and members of the Government Oversight Committee. Thank you for having me here today. We are here today because recently reported child deaths have resulted in a renewed focus on child welfare improvements and reforms. The Department plans to work with Casey Family Services to review four of the deaths, and the Ombudsman's office has been invited to be part of that process. The Ombudsman's office will also independently review three of the deaths in the same manner as our case-specific reviews allowed by statute.

Maine's Child Welfare Ombudsman program is an independent non-profit authorized by 22 M.R.S.A. § 4087-A to provide information and referrals to individuals requesting assistance with child welfare and to perform case-specific reviews of child welfare involvement. Under the statute the Ombudsman also has a duty to analyze and provide opinions and recommendations to agencies, the Governor, and the Legislature on state programs, rules, policies, and laws.

The Ombudsman's opinions and recommendations are based on our case-specific reports. We receive a complaint from an individual who calls the Ombudsman and then the complaint is referred to the Department. Then we review all of the information relevant to the determination of the complaint, including a response from the Department. A report is drafted, we receive feedback on the report, come to an agreement about the contents of the report, and then finalize the report.

For many years, including prior to the deaths of Marissa Kennedy and Kendall Chick, the Ombudsman has been flagging serious practice issues within child welfare that cause children who are unsafe to be missed, or returned to their parents before it is safe.

In the most recent Annual Report of the Child Welfare Ombudsman for fiscal year 2020, we found that the Department has continued to struggle with practice issues and decision-making around two crucial points of child welfare involvement: 1) when making the decision whether the child will be safe in the home during the initial investigation and 2) when making the decision whether the child will be safe in the home once reunified with the parents.

Unfortunately, the practice issues detailed in the 2020 report have not improved. From October 1, 2020 through April 30, 2021 the ombudsman finalized review of 43 child welfare cases. Out of the 43 cases, 17 had substantial issues, equating to 40% of cases. These numbers are virtually identical to the first six months of last year (though cover the first seven months of 2021).

The Department continues to fail to complete consistent casework practice during the moments in cases where the determination of child safety is the most consequential:

- During initial safety investigations of cases when the safety of children is not accurately determined. This includes safety plans, both in and out of home that are not appropriate or adequately monitored.
- Once children are in state custody, during ongoing assessment of parents' progress in reunification. If the assessment is not thorough the Department reaches the end of a case without enough information to accurately decide whether or not a child will be safe if returned to a parent. This includes issues with assessment of the safety of children in trial placement.

Child welfare cases are complex and progress is not easily measured by numbers and percentages. The measurement of progress of child welfare improvements is at the heart of the Ombudsman's disagreements with the Department. It is a mistake to overly rely on quantitative assessments of child welfare data, in place of qualitative assessments.

For example, the initial child protective investigation has a number of quantitative measures that are done for every assessment. The caseworker must make initial contact with the child within 24 or 72 hours, depending on the nature of the report; the SDM tool must be filled out in order to determine a numbered risk level that is used in decision-making; the investigation must be completed within 35 days. These numerical measures are important, and provide data that is easy to collect, but do not provide any information about the quality of the investigation. The quality of the investigation determines whether decisions about child safety are accurate.

Here are some examples of qualitative measures of the initial investigation: was the interview with the out of home parent thorough? Were all of the police reports obtained after the Department learned that the mother's boyfriend had a history of domestic violence? Did anyone knock on the neighbor's door to see if they knew anything? Did the Department follow the evidence to where it led? Was enough information collected to enter into the SDM tool to have it accurately determine the level of risk?

These qualitative measures are the focus of case-specific reviews of the Ombudsman. The Department's own Quality Assurance department completes these types of reviews as well, consistently done in accordance with federal guidelines and should also be given weight. The OPEGA report on the deaths of Marissa Kennedy and Kendall Chick similarly focused on the quality of the child welfare system.

These differences in measurement come up during the reunification portion of a child welfare case as well. The most important example of is the quantitative measure of how long a child is in state custody. One of the Department's main focuses is the measure of timeliness to permanency. This is the basic questions of how long a child has to stay in state custody until they can be reunified with their parent or adopted. The amount of time until they have a permanent home. If there is pressure to provide timely permanency without making certain that casework practices within these high-risk cases collect enough information, children will be reunified before it is safe.

The qualitative measures in the reunification portion of the case might include whether or not there were meaningful face to face contacts with parents throughout the case, meaningful

contacts with service providers, making sure that the parents have the correct services for their needs, and following information and evidence where it leads.

In other words, we know that we want children to exit state custody as fast as possible, but do we have enough information to say whether the child will be safe if they go home? We have found that the answer to this question is, not always.

The Ombudsman's office has consistently recommended increased training for staff, both caseworkers and supervisors, that targets these areas of basic assessment and investigation practices, both initial and ongoing. The Department has currently partnered with the Muskie School to provide new caseworker training and to issue updated policies, but these tasks, while important, do not effectively address the fundamental practice issues that occur again and again.

Recommendations

- Frontline staff need to have their voices heard and their opinions taken into account in all areas.
- Improvements in child welfare need to be laser focused on training for staff at crucial decision-making points. Staff must also have enough time to perform their work.
- The Department should increase their inclusion of stakeholders in their planning and decision-making. Transparency should be increased and trust built.
- The role of the Child Welfare Ombudsman, the Serious Injury and Death Review Panel, and the Maine Child Welfare Advisory Panel should be strengthened and the relationship between the three organizations should be fully collaborative both with the Department and with each other.

Maine's at-risk children deserve the very best we have to offer. And I want to take a moment to highlight the fact that although we are here today discussing concerns about the Department's performance in child welfare, there are many, many dedicated caseworkers and supervisors who do their job as best they can under almost always very difficult circumstances.

130th Legislature
Senate of Maine
Senate District 11

Senator Glenn "Chip" Curry
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Testimony by State Senator Chip Curry
Requesting an Investigation of the Office of Child and Family Services and Child Protective Services
Presented to the Government Oversight Committee
Wednesday, July 14, 2021

Senator Libby, Representative MacDonald, and distinguished colleagues of the Government Oversight Committee:

My name is Chip Curry. I am honored to serve as the State Senator for Senate District #11, which comprises the 26 rural, coastal, and island communities of Waldo County.

I present today to you on the behalf of Maddox Williams, Kendall Chick, Marissa Kennedy, and unfortunately, too many other children who have lost their lives here in Maine. The death of a child is always tragic, especially when it could have been prevented.

The Department of Health and Human Services' Office of Child and Family Services and Child Protective Services has failed these children. We all have failed these children. We said this after the death of Marissa Kennedy when support staff, caseworkers, and other adults in her life failed to intervene before she was killed from years of physical abuse. We said this after the death of Kendall Chick when a thorough assessment and monitoring of her placement could have changed the course of her life. Now, we say this again after the tragic and preventable death of Maddox Williams. There is no excuse for our failure to act on child welfare reform. The deaths of Maddox Williams along with three other children in the last month prove that our actions have not been sufficient.

Please do not misinterpret my statements as seeking an easy scapegoat or a simple answer to these tragedies. I know many dedicated public servants who work for OCFS at many levels and they have my great respect. I also know there are youth alive and healthy today because of the care, commitment, and professionalism of OCFS staff. But we have problem.

The Maine Child Welfare Services Ombudsman did substantial work to point out the flaws and holes in our system, and yet, few of these recommendations have been implemented. Despite changes in policies and the implementation of new tools, the Ombudsman reports many of the same basic investigatory and monitoring issues remain. Poor support practices, especially in the first month of an investigation can leave children defenseless for months or years.

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I am deeply concerned as to why and what barriers exist that prevent achieving the systemic goals outlined by the Ombudsman. If the knowledge and information on how to reform our department and our systems exists, what is keeping us from succeeding and where do we need make further changes? Since making my request to this committee I have heard from anonymous current and former staff who report a toxic work culture, where child safety is in direct competition to meeting deadlines. I have heard stories where overloaded staff feel pressured to rush investigations for fear of poor performance evaluations. I don't know if these experiences are rare or pervasive throughout the agency. But if these dynamics are preventing us from effectively protecting children, we need to find out.

I ask the Government Oversight Committee to work with the Ombudsman to investigate and identify the barriers to organizational change and possible strategies for overcoming them so as to build up a more effective child welfare system.

Our Legislature has a responsibility to all of the residents of Maine. We need to be more effective in providing oversight and ensuring the implementation of reforms. Therefore, I also ask the Government Oversight Committee to investigate more effective ways our Legislature can provide ongoing oversight and monitoring. I understand that the Department of Health and Human Services has brought in an independent investigator who will provide recommendations as well, and I request that the independent investigator work along with the Legislature so that work can be transparent and lead to real solutions.

Inaction will continue to cost Maine children their futures.

Thank you for your time and consideration on this critical matter.

Bill Diamond
Senator, District 26

THE MAINE SENATE
130th Legislature

Transportation Committee
Chair

July 14, 2021

Good morning Senator Libby, Representative McDonald and members of the Government Oversight Committee. I'm Senator Bill Diamond, I live in Windham representing District 26.

Thank You!

I want to extend my sincerest thanks to you for holding today's hearing and hopefully extending your investigation of the current procedures and policies of the Office of Child and Family Services (OCFS). The prestige you bring to this critical issue is exactly what is needed. The uniqueness of your committee, including the strict bipartisan make up along with the legislative experience and seniority of you, the members, are the key ingredients for success.

One of the problems with previous legislative reviews regarding child protection issues has been a lack of legislative endurance. As a Legislature we go home, either in June or April depending on the year, therefore not being able to do proper follow through and monitoring of legislative expectations. But… you don't go home.

Our Goal Should Be…

I'm not an expert in child protection services, but I am a persistent learner about child protection, especially those children in state care. For what seems like a lifetime, I've watched OCFS move too slowly and then stall and even regress over the past 20 years. My frustrations center on knowing full well that under their current practices there will be more child deaths that could have been prevented.

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Because of the four June deaths, the Department is now contracting with Casey Family Programs from Seattle to help analyze their problems. Why have they waited? Why haven't they taken the advice of Maine's own very competent Ombudsman Program, who has repeatedly pointed out the serious deficiencies concerning child safety?

My goal: OCFS admitting that their **SYSTEM IS BROKEN** and then we all focus on the appropriate changes instead of the constant resistance to change.

(Questions?)

Child Deaths 20 YEAR Timeline

2001 – 5-year-old Logan Marr dies in her foster mother's basement. Sally Schofield convicted of manslaughter. DHS said then, "We'll fix the problem."

2004 – The fix! Combining DHS and the Department of Behavioral and Developmental Services, thus doubling the size of the bureaucracy and further losing sight of the Child Protective Services, dropping even further into the bowels of the state's largest bureaucracy.

Children in state care keep dying – a report in 2017 indicated that at least 22 children died while in state care. The inconsistency of changing policies based on whatever the details were of the most recent death is a consistent problem. Example: reunification vs not.

2017 – Kendall Chick, 4 years old. Grandfather's girlfriend, Shawna Gatto, convicted of depraved indifference murder, sentenced to 50 years in prison. OCFS failed to follow the most basic protocols, the trial revealed.

2018 – Marissa Kennedy, 10 years old. Stepfather Julio Carillo and mother, Sharon, beat her to death over three months. Both convicted of depraved indifference murder. Julio sentenced to 55 years and Sharon to 48 years. Total OCFS system breakdown – poor assessments, lack of coordination.

Both cases DHHS said, "We'll fix the problem."

Gov. LePage came to this committee and stated that he was going to hire 70 additional caseworkers. Simply adding more bodies is not a solution – it's more complex than that.

June 1, 2021 – 6-week-old boy dies of shaken baby syndrome. Father Ronald Harding charged with manslaughter.

June 6, 2021 – 3-year-old Hailey Anne Goding dies. Mother Hillary Goding charged with manslaughter.

June 20, 2021 – 3-year-old Maddox Williams dies. Mother Jessica Williams charged with murder.

From initial reports, OCFS did have involvement with Maddox in terms of placement. We must wait to see if OCFS was involved with the children in the other two cases. One of the glaring problems OCFS continues to have is the inability to assess when a child is in danger both in the home and if/when to reunite a child with a parent (source: Ombudsman Report, 2020).

(Questions?)

Maine Child Welfare Services Ombudsman

Maine's Child Welfare Services Ombudsman was created by statute as an independent and neutral overseer of child welfare polices at OCFS. Their annual reports have highlighted repeated problems with OCFS assessing child safety. Specifically, in the most recent 2020 Annual Report, it was stressed that OCFS has difficulty assessing if a child could be safely reunited with a parent and whether a child is safe in their current placement.

This is exactly what happened with both the Kendall Chick and Marissa Kennedy cases. Also, the Maddox Williams case could be another prime example of when a child should not have been reunited and put in a known unsafe situation. We'll see when the evidence is made public.

It's very frustrating when the Ombudsman clearly tells OCFS where the problems exist and nothing changes and kids are still being placed in those dangerous situations… and dying.

NOTE: *The Child Welfare Services Ombudsman Program operates on an annual contract that must be approved by DHHS. This contractual arrangement puts the Ombudsman in a precarious position when analyzing and reporting on the effectiveness and practices of OCFS. The Ombudsman should be truly independent from the department being analyzed.*

(Questions?)

OCFS Continual Resistance to Meaningful Change and Transparency

OCFS continually opposes attempts of transparency and change. In 2019, I submitted a bill, LD 1554, to establish a commission to reform Child Protective Services. The Department and OCFS vigorously opposed the bill and, of course, it failed. They did agree to allow public input when they visited their designated regions around the state.

This session they also opposed my bill LD 1263, which would have created a separate agency at the cabinet level including OCFS and other child-centered groups. The Ombudsman testified in favor of the bill, as did the Maine Association for the Education of Young Children. OCFS and DHHS opposed the bill, resulting in a committee vote of 12-1 ONTP. Yet the Senate, surprising everyone – especially DHHS – passed the bill 22-12. DHHS lobbied the House, where it was killed. Their opposition focused on the costs involved and funding issues instead of how best to serve the children under state care. This bill could have initiated meaningful discussions.

When the June child deaths became public, I asked the Ombudsman to look into those cases and see if OCFS was involved with the children prior to their deaths. The law specifically allows the Ombudsman to see such information and keep it confidential. Upon the initial request the OCFS refused to give the information to the Ombudsman. She reminded the Director that the law was clear and he must share the information. He finally conceded.

One more case of questionable obstruction – why? OCFS should see the Ombudsman as a partner, not someone to fear, but that seems to be the consistent modus operandi for OCFS.

More facts will be forthcoming on the tragic June deaths. Other than the Williams case, the question remains: did OCFS have any involvement with those children prior to their deaths? OCFS knows that answer – the rest of us will know soon.

NOTE: *After these most recent deaths, for the first time, we didn't hear the infamous proclamation from DHHS, "we'll fix the problem." Instead, we heard a new pledge saying that these deaths demand "a call to action!"*

(Questions?)

Citizen Outcry

As a result of my bill, LD 1263, and the accompanying publicity, people from around the state started contacting me wanting to share their experiences with OCFS. I heard from former and current OCFS caseworkers, former supervisors, foster care parents, Maine's Child Death and Serious Injury Review Panel, a former Assistant Attorney General who worked at DHHS, victims of domestic abuse who had children and many more. Some of their stories are chilling, to say the least.

These are the folders containing those emails, texts, and calls from these people – many of whom do not want their identities known out of fear of retaliation from the Department and possible loss of their jobs. Others have offered to share their experiences with you if you make the request.

For as long as I've been working on child protection issues, I've never experienced this kind of outpouring from the public, the media and those associated with DHHS and OCFS. This bodes well for the potential for significant changes, and perhaps for the first time, the redefining of OCFS.

We could actually guarantee success **IF** the Department, and specifically OCFS, would simply admit that their system is broken instead of making excuses and listing all of the changes they've made and are making. Then and only then can we all work together with a common purpose of building a system that will protect the children in state care.

In closing, I don't think anyone here would disagree with the fact that as we sit here right now there are children in state care who are being abused in horrific ways. Sadly, we won't know their names until they die and then… it's too late for "a call to action."

Thank you for listening.

(Questions?)