130th Legislature
Senate of Maine
Senate District 26

Senator Bill Diamond
10 Crown Point Road
Windham, ME 04062
(207) 892-8941
diamondhollyd@aol.com

April 8, 2022

Testimony of Sen. Bill Diamond regarding

The Office of Program Evaluation and Government Accountability's report on Child Protective Services Investigations

submitted to the Government Oversight Committee on March 25, 2022

This report reinforces, once again, the ongoing problems within the Office of Child and Family Services (OCFS). Obviously, many of the deficiencies identified in the report pertaining to the most critical responsibilities of OCFS, deficiencies that continually put children's safety at risk, have not been corrected. Why are these serious problems still persistent? Why haven't they been addressed after all of this time? This report substantiates the same specific problems we've been hearing about for years, especially over the past five years.

In fact, the report shows that critical responsibilities of child safety within OCFS have not only lacked improvement over five years, but sadly have gotten worse. Specifically, I reference the following facts taken from the report.

"Protecting Child Safety."

As explained in OPEGA's report, the Child and Family Services Review (CFSR) "is the mechanism through which the US DHHS exercises its oversight of state child welfare agencies to ensure conformity with federal requirements and to promote continuous improvement in child welfare." The CFSR is also used by Maine DHHS's Quality Assurance (QA) Program to "measure progress in meeting the goals established in the state's Program Improvement Plan (PIP)."

In the 2017 CFSR, Maine received an overall rating of "Area Needing Improvement" for each of the three items OPEGA reviewed (timeliness of initiating investigations of reports of child maltreatment, risk and safety assessment and management, and quality of caseworker visits with a child), as none met the applicable standard for percentage of cases rated as a *Strength*. In each of these three areas, a PIP was set. The PIP goal for timeliness was met in 2020, so OPEGA focused on the remaining two measures:

- **Risk and Safety Assessment** – only 40% of cases were rated as a *Strength* in the 2017 CFSR, and the PIP goal was set at 47%. In the most recent six-month reporting period five years later (period ending December 2021), only 29% of the sampled cases were rated as a *Strength.*

- **Caseworker Visits with A Child** – 63% of cases were rated as a *Strength* in the 2017 CFSR, and the PIP goal was set at 70%. Only 35% of the sampled cases in the most recent six-month reporting period (period ending December 2021) were rated as a *Strength*, a decline of nearly 30 percentage points.

Results of Investigation Cases

OPEGA further examined 109 cases sampled and reviewed by Maine DHHS's QA program between April 2017 and March 2021. All 109 cases included initial investigations.

Risk and Safety Assessment Management – only 13.8% of 109 sampled cases were rated as a *Strength*. The report notes:

- Only 34.9% of the assessment of cases accurately assessed all risk and safety concerns of children.
- Only 14% of reviewed cases where safety concerns were present had an appropriate safety plan developed, continually monitored and updated, and in only 29% of cases were safety concerns were adequately addressed.

The basic responsibility of OCFS is to protect the child's safety first and foremost above all else and yet that responsibility repeatedly is found to be seriously mishandled.

Quality of Caseworker Visits with Child – The report asks the question "Were visits of sufficient quality to address safety, permanency and well-being issues?" *Of 106 cases, only 23.6% scored YES.*

Overall Concerns Raised by the Report

Problems with assessment of children at risk:

- Not assessing all individuals who may serve as caregivers.
- Not assessing all household members – even those residing with relatives.

Concerns with safety risks and plans:

- Not exploring all potential risk or safety concerns.
- Not developing a safety plan or developing a safety plan that does not address all risks.
- Not thoroughly assessing all individuals participating in the safety plan and relying on individuals to carry out and enforce the safety plan who are potentially incapable or unwilling to do so.
- Not monitoring, and potentially not updating, safety plans.

These are not minor flaws in the system, these are fundamental failures that should not be tolerated. The report also reveals several issues of concern relating to caseworkers' lack of proper practices and procedures around child safety.

Other Noted Issues of Concern:

- Employee workloads
- Proper and effective training
- Supervisor/caseworker working relationships
- Mandated reporters' concerns with OCFS or a lack of understanding of their ability to share information
- Employee vacancies/staffing levels
- Lack of thoroughness during investigations
- Access, availability, and engagement in services for families
- Access to medical records and information
- Prevention of abuse and neglect

All of these discouraging facts are on top of the fact that 2021 was a record-breaking year for child deaths. These are all areas that have been brought to the attention of OCFS repeatedly and the responses are always the same: We're doing a good job and looking to improve.

Whether it's another GOC investigation, Casey Family Services Review (selected by OCFS to review themselves), legislator attempts to improve safety practices within OCFS, the Ombudsman (who repeatedly issues annual reports outlining how OCFS continues to struggle with placing children in safe environments), or attempts to implement transparency within OCFS (which their leadership vigorously opposes at every step), **the broken system continues to prevail.**

Proposed Legislation

With only 12 calendar days remaining until the second regular session of the 130th Legislature ends, expecting this committee to submit legislation for this session is probably not realistic. However, that doesn't mean you couldn't prepare something for the 131st Legislature.

Time to Accept Responsibility

After all of these years with the many reviews and investigations of OCFS it should be clear to the public, the media, and the Legislature that we need to stop blaming the caseworkers and those on the frontlines for all of these repeatedly identified problems. These systemic failures within OCFS rest squarely at the feet of OCFS leaders and their associates, and it's time we said enough is enough.

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Commissioner's Office
11 State House Station
109 Capitol Street
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-3005
TTY: Dial 711 (Maine Relay)

Comments from the Department of Health and Human Services
Before the Joint Standing Committee on Government Oversight

Regarding the OPEGA Final Report on Child Protective Services Investigations, March 2022

Hearing Date: April 8, 2022

Good Morning Senator Libby, Representative Stover, and Members of the Joint Standing Committee on Government Oversight:

I am Molly Bogart, Director of Government Relations for the Department of Health and Human Services and I am here today to provide brief comments on behalf of the Department and Office of Child and Family Services (OCFS) on the Office of Program Evaluation and Government Accountability's Final Report on Child Protective Services Investigations.

The Department appreciates the thoughtful work of OPEGA in developing this report. OCFS submitted an agency comment letter which is appended to the report. We appreciate the opportunity to note some of these comments for the Committee.

As referenced in the comment letter, two of OPEGA's three recommendations share significant overlap with improvements identified in 2021 by OCFS through engagement and discussions with staff, feedback from stakeholders, the review of child fatalities in collaboration with Casey Family Programs and Collaborative Safety, and OCFS' own independent, continuous quality improvement efforts. OCFS has already begun work to address these concerns.

To address concerns regarding workload and afterhours expectations for staff, the Governor has proposed additional staff for OCFS in her Supplemental Budget to provide afterhours and Children's Emergency Services (CES) coverage. OCFS believes this will relieve a significant burden from current staff, allowing them to focus on their day-to-day work. OCFS is also collaborating with staff and Casey Family Programs to review the investigation process and minimize duplicative work and study systems in other jurisdictions to determine if the current investigation timeframe is appropriate and helping achieve child safety goals.

OPEGA also identified improved training and supervision of staff as a recommendation. As noted in the report, OCFS previously identified concerns regarding training and, coinciding with the completion of this report, implemented an updated structure for training that OCFS believes addresses the concerns OPEGA and staff surveyed by OPEGA identified regarding the previous structure. This new structure builds upon models previously utilized by OCFS that staff have indicated were more effective in preparing them to work in child welfare. In addition, OCFS has reinstituted the Field Instruction Program (FIP) in collaboration with the Muskie School at the University of Southern Maine, which provides social work students with a comprehensive internship experience. This opportunity allows students to graduate with experience working in

child welfare and minimizes the amount of training required if they choose to become employed with OCFS. The FIP was previously a part of OCFS' training structure and many of the individuals who started with OCFS in the FIP are still with OCFS as employees and now hold leadership positions within child welfare.

Throughout OPEGA's report, OCFS noted significant overlap between issues identified by OPEGA and those identified through the Department's Safety Science review conducted last year in collaboration with Casey Family Programs and Collaborative Safety. OCFS has been working to implement the recommendations of that review since they were issued in October of 2021 and has received positive feedback from staff and stakeholders about the process. This includes a recommendation by the Child Welfare Ombudsman in her annual report, to implement a system for ongoing Safety Science reviews of child fatalities and other critical incidents. As a result, OCFS has continued to collaborate with Casey Family Programs and Collaborative Safety to implement the use of Safety Science in child welfare and OCFS has hired staff to facilitate this important process.

In the comment letter, OCFS also offered additional commentary and information in response to considerations by OPEGA, such as training of new caseworkers, access to medical records and treatment information, services for families involved with the CPS system, and prevention work. We encourage you to review this information and will make ourselves available to answer questions or discuss this work at any time.

We would also like to note and thank the Legislature for their partnership in making important strides and investments toward improving child welfare services during this session. To date, the Legislature has enacted, and the Governor has signed, LD 1960 which bolsters the work of the Child Welfare Ombudsman with additional resources and codification of important practices of collaboration between OCFS and the Ombudsman. The HHS and Appropriations Committees have unanimously supported several child welfare budget initiatives, including the additional staff to provide afterhours and Children's Emergency Services coverage noted above. The Governor has also signed LD 1853, which increases reporting by OCFS and citizen review panels and engagement of the HHS Committee in oversight of this work. Additional investments remain under consideration on the Special Appropriations Table, and improvements not requiring legislative action continue.

Thank you for the opportunity to provide these comments before you today. The Office of Child and Family Services and Department of Health and Human Services continue to be committed to engaging with Government Oversight, OPEGA, the Health and Human Services and Judiciary Committees, and the Legislature as we work toward our shared goal of ensuring every child and family in Maine can be safe, stable, happy, and healthy.

Director Landry, Associate Director Johnson, and I will stay with the Committee for the work session to be available should you request. I am also happy to answer any questions you have now.

My name is Laurie Tomascik and my husband and I have been therapeutic foster parents in Sagadahoc county for ten years. We have fostered nine children. We have one current placement, have adopted a child whose parent rights were terminated, have seen four kiddos reunified with their parents, two placed in residential settings, and one adopted by another foster family. I want to focus my testimony on a child we fostered for thirty eight months. This was a child placed with us as an infant, who never lived with her biological family, had significant developmental disabilities and medical needs, and was considered non-verbal. A child unable to return safely to her biological family because of ongoing domestic violence issues. I am begging you to stop and think about your own life or the life of your own child and how critical those first years are to development and attachment. This child came to live with us as an infant and spent the first three years of her life thinking we were her family. During these three years there were multiple reports of domestic violence committed by more than one family member, open cases regarding siblings, and complaints made by siblings that they were being abused and that their mother was being hurt. There was a case worker assaulted in the biological home while investigating the allegations made by the siblings. And yet visits continued and this child's safety was jeopardized repeatedly. An incident where this child was restrained during an overnight visit in such a way that she had visible fingertip bruise marks on all four extremities, a bruise under her eye, and cuts on her scalp. Again, this is a non-verbal child who has no way to communicate if she is scared or being harmed. The Guardian Ad Litem supported overnight visits the week after this child's siblings made allegations against the parent. The GAL hadn't even read the report taken by local police officers and DHHS hadn't interviewed the siblings yet. It took 25 months for DHHS to file to terminate parental rights. There was not one specialist who felt this child should be reunified because of the ongoing DV issues and her significant medical needs. I can confidently say that this case was solely decided by the unprofessionally biased opinion of a Guardian Ad Litem who fought for the rights of the parents and not the best interests of the child. The Department of Health and Human Services failed to protect this child because a case worker was too overwhelmed with her caseload to file Termination of Parental Rights in a timely manner (her own words). This child did not have visits with her biological family for a period of 3 months when they left the country. Other incidents involved the police being called to a medical appointment so we could safely exit the building with the child after a disturbance with the biological family, verbal threats to our safety, and in-home nursing staff reporting a parent for being physically rough with this child. There was also a nursing agency refusing to provide staff for visits without the presence of a security guard.

Fostering is about keeping a child safe while their future is decided. We knew going into it that it was our job to support reunification and follow all the rules and regulations set by the department. But I want to ask all of you whose responsibility is it to make sure that the Diamond Law (http://www.mainesenate.org/diamond-bill-to-prioritize-child-homicide-trials-enacted-by-legislature) is being upheld by all parties involved in the Child Welfare System? Is this law just a suggestion? Are there not guidelines that stipulate that reunification has a timeframe? No child's life should be in limbo for months and years on end. This child's voice was not heard. Her emotional and psychological well-being were sacrificed in the name of reunification. The voices of her medical team were dismissed. And I have to say even the voices of some at the department were silenced by one single human being, the Guardian Ad Litem. Foster parents deserve to be heard, we are not just a babysitting service. We did everything in our limited power to advocate for this child. We used our own funds to hire an attorney so we could file for status in her case, filed a complaint against the Guardian Ad Litem with the Maine Bar Association, and filed with the Ombudsman's Office which resulted in that office opening a case. The Maine Bar Association will not investigate a GAL until the case is closed which makes little sense to me. And it was a year after we filed with the Ombudsman's Office before we received a letter stating that her findings were basically "none of our business". I cannot tell you how disheartening this is and how absolutely devastating this case was for our family and this child. Our system failed this child and left her future undecided for 38 months. Her disability was trampled on and knowing that she can't speak her trauma eats at my soul. What I have shared in this

written testimony is only a fraction of what transpired during this case. I am asking that you hear my voice today and that we all find a way to communicate with each other to ensure the safety of children in foster care. If I could suggest any one thing it would be that each and every child that comes into care is appointed a psychologist whose opinion about their best interests carries as much weight before the court as that of the GAL and the department. No one person should decide the future of a child. There must be accountability and laws that protect these children and these laws cannot be "flexible". We have worked with amazing case workers who pour their heart and soul into protecting the child and guardian ad litems who fight for the best interest of the child. What happened in this case though was, in my mind, heinous and inexcusable. I humbly ask all of you hearing testimony today to fight for the best interests of these children and to please hear our voices.

Respectfully Submitted,
Laurie Tomascik
Resource Parent
Richmond, Maine

CPS safety investigations analysis

Public Comment Testimony in regards to the OPEGA report given to GOC on March 25, 2022.

Thank you for the opportunity to testify before you all today. My name is Melanie Blair, and I live in Lisbon. I testify in front of you with twenty-five years as a mother, fifteen+ years as an educator in special education, ten+ years working in behavior programs, and 7+ years as a foster parent.

According to the OPEGA Report given to the GOC on March 25th, The scope of OCFS goes beyond child protection as reflected in the mission of the Office which is: "***joining with families and the community to promote long-term safety, wellbeing, and permanent families for children."*** As is evidenced by this report, as well as my personal experience as a foster parent, this is just not happening consistently, and the children continue to pay the price. When will we stop accepting minimal progress, a lack of communication and transparency, the same excuses year after year, focusing solely on the lower-level workers as the problem, and address the upper-level management structural and procedural problems that are failing these children? When will we REALLY put the safety and well-being of the children as top priority?

Cases briefly in point:

Case 1-

This child we had twice. The first time was when the child was 8 years old and removed from an unsafe primary caretaker. The child was very hyper, had challenges in school, and was in a special behavior program. However, was happy, healthy, and making progress during the approximately two months at our home. This child was then sent to live with the other biological parent that had D.V. history. Approximately two years later, this child came back into care at 10 years old. The child that returned to my home, was sadly not the same child that left. This child was sickly thin, beaten and bruised in the face to the effect that the mouth on one side drooped and speech was significantly affected.

Case 2-

This next family of four children was a local family that I made two reports on. The second report was the most disturbing and concerning. The parent involved, who has had open and closed cases previously, was involved in a D.V. incident in front of the children in which an ax was used as a threat. I was told by the investigator that my report was screened out.

Just a few months later, another baby was born to this parent testing positive for substances, and all children were taken. Three of them went to their other biological parent who also has history of DV and abuse of a minor. Also at this time, the oldest child was not able to be located, so the department reached out to me since we knew this child personally and I was able to locate the child, who had resourcefully found their own safe place to be.

Case 3-

This next case is my own personal experience. I share this in extreme brevity, as this is very difficult to share. At the end of 2021 all 7 of my fosters were traumatically removed from my home as we were sitting down to eat dinner. All stemming from a dissociative report by a young child that was subsequently and intentionally aggravated by a false report made by a disgruntled community member. Rather than sticking to the original plan as discussed on the phone with the investigating caseworker, the department disregarded all other caseworker feedback and investigative work that had been already done, ignoring the fact that we were a vested foster family with many department worker relationships, even though on a monthly basis I had between 5 and 10 workers visiting my home with these children. The event that took place at my home that night by the department traumatized every child and adult in my house. The amount of resource, time, and money that were used on this is astonishing.

But perhaps even worse, was 'the process' that occurred over the next two months. The lack of communication, misinformation, or no information, and the covering up and passing the buck that occurred was unbelievable. The people that we have spent so much time working directly with over the past few years, including attorneys, had little to no input in my case. As a matter of fact, they were actually excluded from the meetings that were occurring because my case was being handled by central office. Despite my regular email requests for a meeting with said workers from central office (who remained anonymous), I was not once answered. During this process, I also realized how little information the investigators have access to that they should have. Our investigator did not have critical information about my family that would have changed the direction of this case prior to the trauma that our household of 13 suffered at the time of the removal. All of this information the department actually had in their computer system, but the investigative worker claimed she did not have access to it. During this process two of our five caseworkers left the department, I had attorneys in disbelief questioning the department regularly as to why they would not resolve this issue and return the children to my family, I had workers, and community members reaching out in support, including a daycare I had been using for six years, and worst of all, I had kids placed all over, some in homes that were previously not approved by the department. The amount of fight we had to put into resolving this was unbelievable. All the while, cases of real concern were being mishandled and shuffled around.

I share this story in fear. Fear of not only retaliation, but in serious concern that the department's ability to assess reports of suspected abuse or neglect safely and appropriately is compromised at a much higher and greater level than any of us are really seeing. These kinds of issues do not change with more money and more case worker positions, as FY 2018/2019 should evidence, as approximately 30 positions were added to alleviate workloads and training concerns. We are no better now with child deaths than we were then. During all of this, I have done my own research, read several of your reports and legislative proposals, have spoken to many foster parents, kinship relatives, and other frontline caretakers, and can assure you, that these concerns and experiences are not just mine. I have heard horror story after horror story, and most of them will not come forward in fear of department retaliation and the desire to continue fostering.

I strongly believe that if the committee would provide some kind of whistle blower assurance for other families to come forward without retaliation, you would see a clear pattern of not only poor choices and decision making, but deceptive practices that can only change at higher levels. My experience showed me firsthand that the lower-level workers are primarily doing what they are told to do, even if they disagree. Consequently, no matter how many positions you add, how much more training you provide, if the culture of the department and the communication and procedural practices do not change, you will not see the changes needed to keep children safe, and you will continue to see caseworker and foster parent burnout as you have for years because nobody is really listening to those of us that are in

the field every day. For significant change to occur, legislative changes need to happen from the top down.

The OPEGA report that was presented to the GOC in essence reaffirmed what we have all known for at least five years, so I ask those of you charged with ensuring the children are ' first and foremost safe from abuse and neglect', pass meaningful legislation to make changes from the top down-rather than solely focusing on this as merely a caseworker caseload and training issue. I ask you instead to scaffold the issues of WHY safety assessments and investigations are still not being properly completed. The problem ultimately falls on leadership and the department culture. Questions do not get answered, the buck gets passed, the fault lies on the frontline workers and the children pay the ultimate price. Legislation needs to delegate and hold accountable central office to make major policy changes otherwise we will continue to get the same results we have been. As my personal experience has shown me, central office is far too removed from the real, day to day ongoing and interpersonal relationships that these children are involved in and are far too often making bad decisions.

In my plea to you, I will highlight the following from the report: "the tool", staffing and training issues, the pendulum swing and department culture. During the OPEGA report to GOC, Senator Bailey asked a critical question that honestly was answered with a non- answer, as I have grown accustomed to hearing. She asked, 'how can we fix the investigation process if we do not have access to the tool in which you are using to make your assessments?' Mathematically speaking, this would be like being asked to solve an advanced mathematics problem without knowing the formula. This question, as well as many others, was referred to Dr. Landry to answer. Which in answering, I'm not sure I could tell you what he said the answer was. How can anyone, or any agency solve a problem without having all relevant information available to them? After all, this is what the department claims hinders CPS investigations, correct? Not having access to the critical information such as mental health records, medical information, etc.. Is it fair to expect this committee to complete such an important task such as monitoring OCFS' ability to adequately assess childrens' safety without access to such critical information from OCFS?

To answer Senator Bailey's question regarding the tool from my personal experience, the answer is that the answers to the questions the tool asks can be changed until a certain point. In essence, it is much like online tax software. You input the data you have and can go back to say, 'adjust' some information to perhaps get more of the result you were hoping for. But once you've gone so far as to "submit to the IRS", for example, you cannot change the results. You, committee members, need to have this information in order to see where the problems are occurring. In other words, transparency from the department.

Secondly, the frontline workers- foster parents, caseworkers, kinship providers, child care workers etc., are given the least amount of incomplete information, yet are held more visibly responsible and accountable but are not included or listened to regarding safety issues. For example, the OPEGA report claims to have surveyed 109 stakeholders, none of which were categorized to be foster, kinship parents or daycare providers who spend the majority of their day with these children. We are with them all day, have built important relationships, yet we are not considered to be part of this survey, or the solution? Because I was curious, and wanted these frontline workers to be included, over the last approximately 10 days I completed my own survey which was very similar to the surveys used in the OPEGA report. The results are included in this report at the end, and not only show that most foster parents do not feel the department is safely and adequately assessing the safety of children, but in doing so, I discovered that most people do not reach out, question, or complain due to fear of department retaliation. There has become, in the foster parent world, a culture of silent intimidation

well known amongst seasoned foster parents. We have no rights and they know it. If we question too much or advocate too hard there is a price to be paid. If there wasn't, I can assure you, you would have people lined up to tell you their stories. But they are fearful of department blacklisting and retaliation and speak quietly amongst themselves instead for support. All frontline workers should have a voice and be valued, not just be a rest stop for children and a scapegoat for mistakes made.

Next, I will take a trip down the staffing and training issue, as well as the pendulum swing. In the two decades of educational experience and behavior program training I have completed in crisis management and response programs, I have completed TCI, MANDT, and SAFETY CARE more times than I can remember. One thing that has always stuck out to me as crucial in keeping the children safe was to appropriately manage the environment and evaluate and adapt to the ABC's of the childrens' behavior. In theory, if the childs' environment is managed appropriately, negative behavior is minimized and the childs' safety and well-being is intact. When something happens to trigger an event, the ABC model is used as a group to discover the antecedent to the behavior, the behavior, and the consequence of the behavior. If, in the case of safety assessments the department cannot determine- due to a lack of transparency, information, and collaboration, the cause or antecedent of the behavior, then the behavior and the consequences of the behavior will not change. In other words, if they can't determine why the safety assessments are not made correctly then they will continue to be made incorrectly and the children will continue to pay the price.

We cannot continue to be reactive, firefighting a problem, and expect meaningful and significant change. We cannot, again say as was done in 2018/ 2019 that the solution to the problem is just better training and adding another 30 plus positions. This was done in 2018/ 2019, and the results did not change. The turnover has been and continues to be an issue for case workers as well as foster care providers. Yes, the job is stressful and needs some improvements. But it is so much more than that. It is a culture of fight or flight, reactive responses, where lower level people who are doing the day to day field work are not listened to, valued, and are often excluded. They are not given the information that they need to be successful. Therefore, it is no wonder that retention continues to be a serious problem. Many people are just giving up, foster parents especially. They have no voice, no advocate, or consistent equitable training themselves. They are left on their own to find supports and do the best they can while hopefully not saying too much as to upset the applecart and get blacklisted. Much like my local McDonald's, the department expects to solve their staffing problems with a sign on bonus and more positions. Unfortunately, money does not change the work environment and culture. It is a vicious cycle of hiring, training, and quitting that never seems to end. Vested workers have invaluable experience, and should be valued in the decision making process. Another personal example I can share is that of a short season I spent working at a particular behavior program in an elementary school that was seriously struggling with out of control student behaviors. After about a month, it was blatantly apparent to me that it was not a staffing issue at all. Rather, a scheduling and mismanagement issue. The program needed to be changed and restructured in how it was run in order to best utilize the resources they had, and be run in a more efficient way which in turn was safer and more pleasant for everyone. More money and more positions did not solve the problem in 2018-2019, and it won't completely solve them now either.

In conclusion, if child safety is really first and foremost the number one priority of OCFS, then all of the goals from the OCFS website concerning child safety should come before anything else. Therefore, from the goals chart on the website, children deserve a safe and nurturing environment and children deserve permanency should be second and third on the list and parents rights and responsibility to raise their own children should be subsequent, if not last. If these children were for

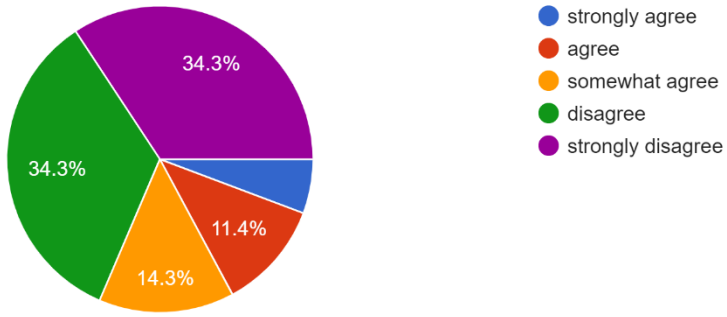
good reason removed from their parents' care due to safety issues, then why would the parents' rights supersede the childrens' rights to a safe and nurturing environment and for permanency?

In their report, OPEGA recommends designing and implementing policy and program changes. In order to do so, you need to change the structure and culture of the department from the top down, not the bottom up. You need to improve transparency, communication and collaboration across different levels. Then you will not only be able to maintain current staff, but fill additional needs, and ultimately keep kids safer, which is the goal after all. I also believe that the information that goes into the tool needs GOC oversight. Without accountability and transparency, we will never know where the problem lies in safety assessments. Oversight should also be done on a minimum number of cases regularly and by district utilizing all frontline workers with the opportunity at some level to share ideas for means of improvement. I believe you will find, in time, that public misconceptions and negative perspective of the department can be countered by not only educating, but including the public in your surveys and feedback, by taking accountability and giving all frontline workers a voice free from fear and retaliation, as well as consistent and equitable training and opportunities for all.

Thank you for your time and consideration in reading this report. Please see the following two stakeholder survey results create on google forms:

Do you feel your concerns regarding children adequately addressed?

35 responses



If you did not "strongly agree" or "agree" to the above question, what topics are a primary concern for you?27 responses

-Child safety

-Issues concerning reunification, concerns about visits and issues that occur at visits, medical care etc

-Lack of followup! accountability..and the push for reunification

-placement, honesty, timely communication

-Children need more say in their lives. FP need to be able to speak up without retaliation.

-Caseworkers close assessments without truly understanding that children are at risk

-Timelines, excuses, best interest of the child

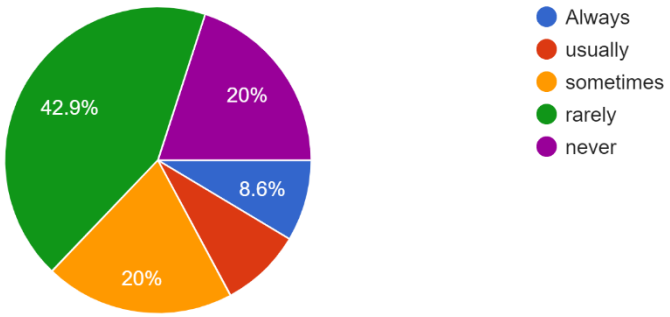
-Communication, ability to speak with anyone at all, how investigations are completed

-Communication

-I feel like the workers hands were tied many times in our case. Where she didn't really want to move the child back but didn't have any choice.
-I believe I have the dream team when it comes to case worker/GAL combos.
-As a foster parent I spend 24/7 with our placements. There needs to be more value in what I see and the concerns I voice.
-I don't want to be told what I want to hear or what the department thinks I want to hear. I want facts.
-Team cmunication
-I've been made to do things that I know are questionably unsafe with my fosters. I've questioned and pushed back and never received an answer.
-This list is very very long. They system is critically broken.
-Safety, putting the child first, considering the foster families needs and boundaries.
-Lack of communication is the biggest problem with DHHS.
-Our gal was completely absent and no way to request a new one. She started telling lies and never met fs in almost 22 months. As well as bioparents missing/late for a lot of visits and lying and getting rewarded for it.
-Missed visits. Return to bios when they are clearly not cooperating and misinformation provided by caseworkers to make parents look like they are.
-Child safety w/regard to bio parents
-Lack of resources and follow through. I've had CW tell me they can't possibly review full files, it would be a disservice to other kids on their roster, we've had GALS who never once set foot in our home to check on kids, the list goes on
-They generally tell us what we have to say is not important no matter how the kids are doing
-Our words are considered bias and we are not taken seriously. Even when we have personal support saying the same as us.
-Child safety, manipulative communication, incestuous nature of the players
-Neglect, child abuse, domestic violence, and substance abuse.
-The dept doesn't consider the child's well being at all. Things move way too fast for a child that has never had any contact with bio parent at all

Do you feel that your feedback and input is BOTH valued AND used in decisions regarding the safety and well-being of children?

35 responses



What are your primary areas of concerns in regard to the safety and well-being of children that you would like to have more voice in decision-making?28 responses

-Mental health screening of the parent
-The state rushing reunification when families are not ready. Putting more emphasis on the parental desires rather than the well being of the children.
-Total overhaul
-placement
-What is in the child's best interest.
-Resource parents should be treated like our voice matters and not as a glorified babysitter.
-timelines
-The efficacy of investigations. Each worker seems to go by their own guidelines so there is no uniformity among the department. Lack of actually protecting children even with overwhelming evidence of abuse or neglect.
-Parents needs and interests being out before the childrens
-In our case mom had extensive history spanning 15+ years with the department and they were still moving forward with trial home placement. They didn't listen to me when I told them I knew mom was using again.
-I felt like our first caseworker did not take our concerns seriously.
-The length of time that kids are in care. There has to be an across the board time frame, not just a suggested amount if time. --We need to stop playing with their lives.
-Permanency
-Placement back to bios
-It's not that I don't have a voice- I do. But case workers either don't have time to help you or don't have resources and Families don't have access to get them for the kids. If we did, and dcfs would pay for it, we could take a lot off dcfss plate. Instead, kids don't get resources and homes disrupt because the kids go into crisis. It's not the kid's fault.
-I just want to be heard and validated. I know I don't know what all is going on with cases but I'm living the day to day with the children.
-If I had to pick one place to start make case loads much smaller. Much. Then maybe the currently broken system can limp along.
-Shortening the time children are in the system, giving parents a set amount of time to reunify so kids can get to permanmcy quicker with less transitions, forcing children to visit with their abusers.
-Reunification
-We were told to right down everything the child was going through behaviors health issues and never once were asked to hear how is day to day was, especially at the beginning when he was withdrawing from drugs
-Return to bios, drug screens, follow up by dept for med appts and evals set up while in care. If missed it should be grounds for immediate removal.
-I don't feel the foster parents are taken into consideration at all. We're there to serve a purpose, yes. But we also observe a lot more interactions with bios, behaviors following visits, real-time conversations with bios as they become more comfortable with us. I don't feel any of that is truly taken into consideration when it comes time for the big decisions.
-I think foster parents should be included in all parts of team meetings, not just to report, so they can help support parents in their journey to reunification (if that's an option). I believe every child that enters care should be assigned a therapist and visits should be mandatory. I believe there should be accountability when GALS, case workers or supervisors don't respond or fail to --follow up on issues
-Where they go for medical and emotional help, whether their parents are safe
-The lack of guidelines or rules around what "in the children's best interest" looks like in practice. The continued "repeat offenders ", and how this seems to be the only "system" in America where you can commit the same wrong doing and your consequences never worsen with each time your children are returned to care. How all of this happens on the back of our most

vulnerable citizens and they are the ones “punished” for the wrong doings of their parents. Also there are no consequences for the department if they do not meet deadlines or timelines placed before them, but we as recourse parents have consequences for every move we make. Their is no body that governs the department and checks their regulations, that doesn’t have their paychecks signed by the state.
-"best interest of the child"

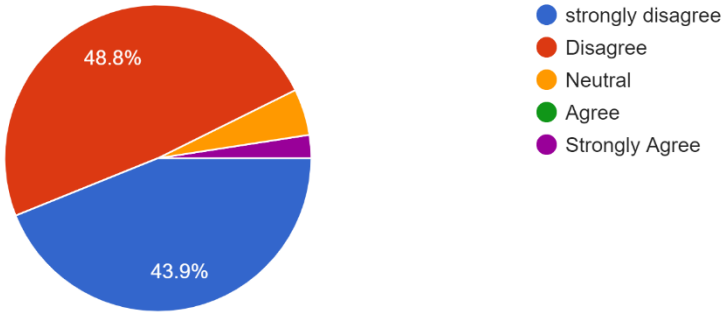
-Reunification, following through on things dhhs outlines for parents to complete before reunification, other forms of drug testing.

Do you wish to remain anonymous? If so, why?27 responses

No
Yes. Fear of being “black listed”.
yes-retaliation
Yes, I do still have guardianship kiddos
No
Yes, I have active foster kiddos that we are waiting for the adoption process on
Yes. I currently utilize DHHS low income help and that has been an impossible task enough.
Yes
Yes. So I don’t have retaliation from dhhs
I don’t care either way.
Yes,I don’t want any retaliation.
Yes. Very worried about department reprisal and being blacklisted. I speak out to my CWs all the time, but even THEY acknowledge there is vindictive decision making happening that impacts foster families and our kids
I am in the process of adopting one and have a foster. I don’t want to jeopardize their place with me. I’ve had both since birth. I have no trust that they wouldn’t be taken from me in retaliation. When I am done fostering I’m planning on speaking out but keeping them as safe as possible is worth holding my tongue for now.
Yes - I don’t trust the system :(
Yes.
no
Yes. Fs is in trail placement and would not like to ruin anything
No, I closed my license for a reason. The red tape and lack of communication was just too much to keep going with foster care. If my honest feedback can help fix things for resource families in the future, I’ll happily provide it.
I’d prefer to remain anonymous because there always seems to be backlash if not
Because what you say can and will be used against you
Yes because we are in the process of adopting and The department can make your life hell if they do choose.
Yes, retaliation
Yes, because things are used against you

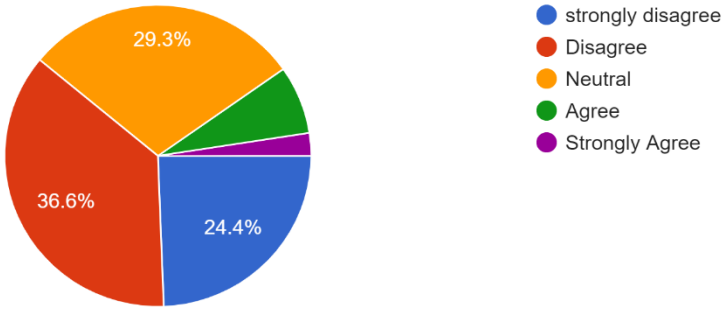
I am confident in the decisions the department makes.

41 responses



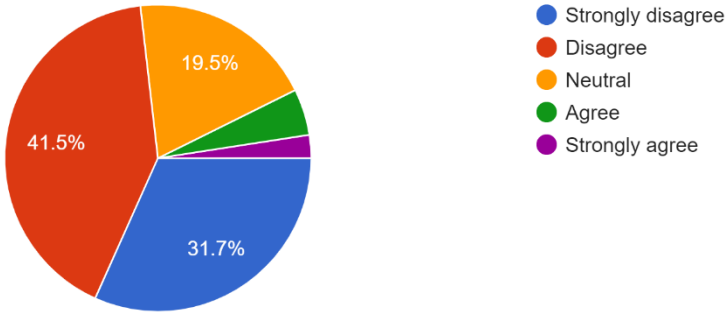
Department child safety investigations are thorough.

41 responses



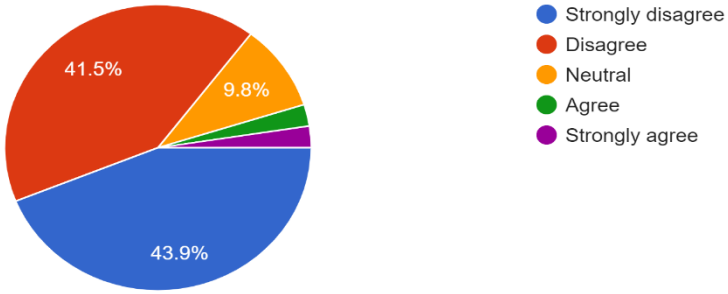
Department workers are able to accurately access risk.

41 responses



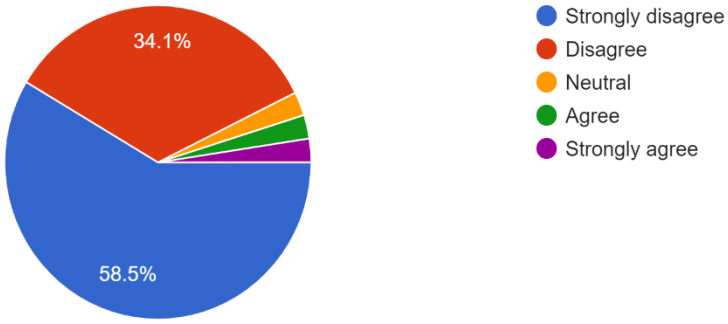
I believe DHHS appropriately balances child safety and and family preservation.

41 responses



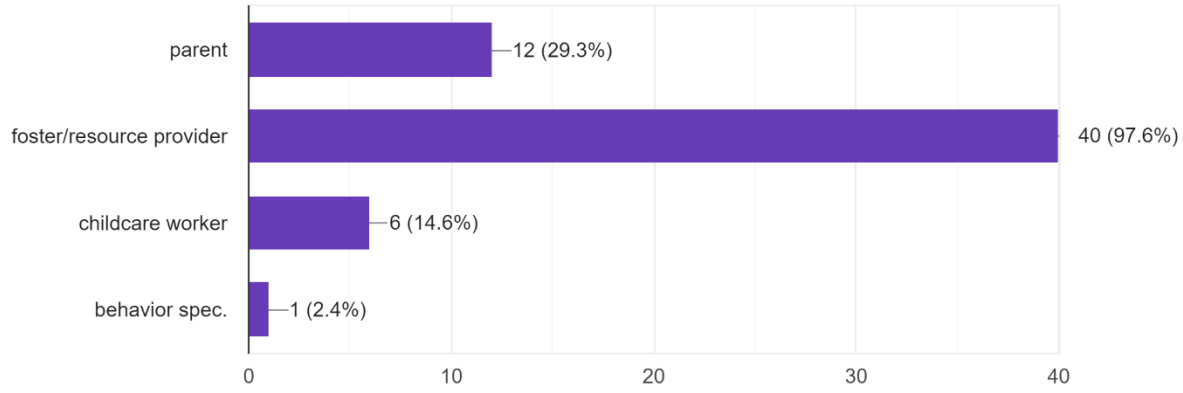
Department decisions appear to be in the best interest of the child.

41 responses



I am a :

41 responses



Testimony of Melissa Hackett
Maine Children's Alliance and Maine Child Welfare Action Network
Before the Government Oversight Committee
Public Comment on OPEGA report, Child Protective Services Investigations
April 8, 2022

Senator Libby, Representative McDonald, and esteemed members of the Government Oversight Committee. My name is Melissa Hackett. I am a policy associate with the Maine Children's Alliance. I am also the coordinator for the Maine Child Welfare Action Network, a group of organizations and individuals in Maine working together to align, strengthen, and sustain efforts to ensure the safety and well-being of all Maine children, youth, and families. I am submitting this testimony in support of recommendations in the OPEGA report*, Child Protective Services Investigations*.

We would like to first commend the work of OPEGA staff in producing this report and key findings. Considerable time, effort, and careful work clearly went into conducting this thorough evaluation. We would like to reinforce the key issues and recommendations of the report, many of which echo similar issues cited in recent child welfare reports, including the Maine Child Welfare Services Ombudsman[1] and Casey Family Programs/Collaborative Safety.[2] We encourage members of the committee to take action where possible and appropriate now, and in the next session, following the anticipated September report regarding reunification and permanency.

The issue of high workloads and the impact of that on thoroughness of investigations has been identified as a key concern in recent years, by multiple entities, including OPEGA.[3] OCFS already provides a workload analysis to the legislature annually, as part of legislation that passed in 2019 (LD 821). We encourage committee members to consider that despite recent reports indicating deficits of 42 (2021) and 33 (2022) caseworkers, no specific legislative action was taken to provide funding for additional caseworkers, or to otherwise address workload. The legislature should explore funding mechanisms to hire additional caseworkers as indicated by the annual workload report. As emphasized in this report, it is essential to child safety that caseworkers have adequate time to conduct thorough assessments of *all* risk and safety factors during the investigation phase. Given the survey results of caseworkers and supervisors strongly indicating a lack of confidence in their ability to conduct thorough assessments within current time constraints, action must be taken within OCFS to extend the 35-day timeframe based on their study findings and report implementation to GOC by June 30th, 2022.

We recognize and appreciate the work OCFS and the administration have done to prioritize funding for Child Emergency Services staffing in the current supplemental budget proposal. If finalized in the budget, this represents a tangible response to concerns raised in this report, and elsewhere, regarding caseworker after-hours coverage. That said, we encourage the committee to establish a process by which OCFS will communicate progress in staffing this unit. Given turnover and vacancy of caseworkers to varying degrees in district offices across the state, it is important that challenges are acknowledged and addressed in building up the specific after-hours coverage staffing.

To address specific caseworker practice concerns, OCFS should expand existing quality assurance (QA) to incorporate additional continuous quality improvement (CQI) processes that involve workers at all levels in ongoing practice improvement efforts. This will ensure caseworkers and supervisors communicate feedback, learning, and improvement regarding concerns that arise in practice in a timely manner.

Regarding additional considerations offered by OPEGA, we encourage OCFS to survey caseworkers following participation in and completion of the new Foundations training, that began in January 2022 and was not captured in this report. We also urge OCFS leadership to consider workload/caseload specifically for new caseworkers. The feedback from caseworkers in this report indicates a need to consider establishing lower workloads/caseloads for new workers, to reflect the need for on-the-job training, and to incorporate additional partnering in the field and greater supervision, until casework has been established as proficient. This is an important investment in a solid foundation of good casework practice and will ensure caseworkers feel supported as they learn in the field, which are both important to effective casework practice and worker retention.

Given the findings in the report that caseworkers experience challenges in accessing critical case information, we urge OCFS leadership to continue the work of establishing information sharing protocols with medical providers, law enforcement, school personnel, and service providers. We note that the report did not include surveys of mental health and substance use treatment providers. Given that these providers offer critical insight into family risk factors, we urge the committee to request a survey of those providers, from an oversight body, to gain a better understanding of the challenges in collaboration and information sharing. As has been noted in recent reports, ongoing and meaningful communication between the department and community providers working with families is essential to an effective child welfare system.

Turning to GOC, we recommend the committee further investigate services for families. While survey responses strongly indicated a lack of available services for families as a concern, we do not have an established understanding of where and what the specific service gaps are. Yet we know issues with availability of family supportive services are not new.[4] The committee should consider assessment of service availability, mapping, and barriers to access across the state. We also urge the committee to support pending legislation, namely LD 1850 and behavioral health investments in the Governor's proposed change package, that provide an important opportunity to bolster the availability of family supportive services.

The scope and effectiveness of current prevention of child abuse and neglect efforts is an important consideration for committee follow-up action. As our Network has noted previously,[5] there is currently no statewide plan for prevention, and a lack of clarity regarding coordination and effectiveness of efforts within state government and outside entities. The importance of prevention was also recently emphasized by the Ombudsman. Legislation currently being considered, LD 393, proposes a new position reporting directly to the DHHS Commissioner to oversee child welfare reform and prevention efforts across state agencies and in coordination with community partners. A focus on prevention is needed within leadership in state government, and investment in prevention should reduce the current strain on child protective services. We urge committee members to support this legislation, and to take additional steps to assess primary and secondary prevention efforts both in and outside of state government, including investment and effectiveness.

It is worth noting that in Maine, statutory language regarding prevention and family supportive services is subject to limits, "consistent with available funding."[6] We urge legislators to consider what it means to restrict our commitment to preventing child maltreatment, trauma, and family separation in this way. A collective, sustained commitment to ensuring child safety and family stability is necessary. Federal resources are largely directed downstream, in the child protective end of the child welfare system.

These are Maine children and families. Adequate and ongoing state investments in prevention and services for families are critical to protect children and support families to stay safely together.

We urge the committee to continue to explore and support ways to improve the way our child welfare system supports the Maine children, youth, and families it is meant to serve. Thank you.

REFERENCES

1. Maine Child Welfare Services Ombudsman, 2021 Annual Report
https://secureservercdn.net/50.62.194.59/233.32d.myftpupload.com/wp-content/uploads/2022/01/2021-Annual-Report-Maine-Child-Welfare-Ombudsman.pdf

2. Casey Family Programs and Collaborative Safety,
https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Maine%20Review%20Summary%20Report%20and%20Recommendations.pdf

3. *In the four years since 2018 that OPEGA has been engaged in reviews of child protective services, there have been ongoing concerns related to the workload of caseworkers, the timeframes in which their work must be completed, the completion of all tasks required in an investigation, and the impacts of these issues on assessments of risk and child safety.*

4. *In the 2017 CFSR, the State's array of services available to children and families in the CPS system was rated as an area that needs improvement. Stakeholders interviewed at the time of the CFSR statewide assessment reported waiting lists for core services and major gaps in services available, particularly in rural areas.*

5. Maine Child Welfare Action Network, A Framework for Child Welfare Reform,
https://mainechildrensalliance.org/site/assets/files/1901/framework_for_maine_child_welfare_reform_1_13_22.pdf

6. *The department may take appropriate action, consistent with available funding, that will help prevent child abuse and neglect and achieve the goals of section 4003 and subchapter XI-A*,
https://legislature.maine.gov/statutes/22/title22sec4004.html

NATIONAL COALITION FOR
CHILD PROTECTION REFORM

53 Skyhill Road (Suite 202) / Alexandria, Virginia, 22314
(703) 212-2006 / (703) 380-4252 / info@nccpr.info / www.nccpr.org / @NCCPR

Written Testimony of Richard Wexler, executive director, National Coalition for Child Protection Reform, to the Maine Legislature Government Oversight Committee Concerning the OPEGA Report on Child Protective Services Investigations, March 30, 2022

My name is Richard Wexler. I am executive director of the National Coalition for Child Protection Reform. At the end of this written testimony, you will find details about this non-profit child advocacy organization including our stellar Board of Directors and what others in child welfare have said about us.

But right at the start, I want to focus on NCCPR's role in Maine.

It dates back more than two decades, to even before the death of Logan Marr. We issued two comprehensive reports on Maine child welfare and testified before committees of this Legislature. We worked closely with Maine foster parent Mary Callahan and the group she founded, the Maine Alliance for DHS Accountability and Reform. It was NCCPR that suggested to producers for the PBS series *Frontline* that they examine the case of Logan Marr, resulting in their landmark documentary about the case.

Those efforts contributed to real reform that, briefly, made Maine a national leader in child welfare. Maine's child welfare transformation even was a finalist for Harvard's John F. Kennedy School of Government's Innovations in American Government award.

Maine was so successful because, at that time, it understood that child safety and family preservation are not opposites that need to be "balanced." Rather, during the administration of

former Gov. Baldacci and under the leadership of the late Jim Beougher at OCFS, there was a recognition that family preservation is the *safer* option for the overwhelming majority of children the overwhelming majority of the time. Their approach made all of Maine's vulnerable children safer.

But Maine has forgotten its own legacy. It was undermined first by former Gov. LePage. And, sadly, it is still being undermined by a variety of individuals and organizations today.

Unfortunately, that includes OPEGA.

That is not their intent. I do not for a moment question the dedication and integrity of the OPEGA staff who prepared this report.

But they fell for two myths. One is the myth I mentioned above, that child safety and family preservation are opposites. The other is the myth that how a system operates on paper is an accurate representation of what happens in real life.

To understand the error we must return to a tragedy too many in Maine seem determined to forget: the death of Logan Marr.

There are many reasons five-year-old Logan Marr died in 2001. The most important is that she was placed with a foster mother – and former caseworker for OCFS – who tied her to a highchair in the basement with 42 feet of duct tape. Logan died from asphyxiation.

Another reason is that Maine, like every other state, routinely confuses poverty with neglect. I suggest that anyone who wants to see how that played out for Logan Marr watch that PBS *Frontline* documentary, *The Taking of Logan Marr.*

But there was another reason: Maine's embrace of the Big Lie of American child welfare – the one I mentioned earlier: Sure a child might be emotionally harmed if we tear her from everyone we know and love, it is said, but at least she'll be safe. It's the lie that says family

preservation and child safety are opposites that need to be "balanced." It's the lie that says if you do less to keep families together children are safer and vice versa.

It is the lie that contributed to the death of Logan Marr.

The Logan Marr tragedy is a horror story, and I've written over and over that one should not draw sweeping conclusions based on horror stories. But I've also written that when anecdotes collide, it's time to look at the data. And, precisely because most cases we think of when we hear the words "child abuse" are nothing like the horror stories and far more like the case of Logan Marr, the data show that, almost always, family preservation is *safer* than foster care. You can read about those data here and here. So the issue isn't family preservation vs. child safety – it's family preservation vs child *removal.*

Given how this myth contributed to Logan's death, one would hope Maine would be the last state where a body charged with doing independent research for the Legislature would be suckered by it. Unfortunately, OPEGA did indeed fall for it in its report.

An entire section of the report called "Child Welfare Philosophy and the Pendulum Swing" is devoted to making the false claim that:

Shifts in child welfare policy and practice over time have often been described as a "pendulum swing" ... between a priority on family preservation (preventing the removal of children and increasing reunification) and a priority on protecting child safety (even if that indicates removal of a child from the family).

This framing appears at least seven times in the report. OPEGA was so committed to it that when they surveyed "stakeholders" they stacked the deck when posing this question:

We asked CPS staff and mandated reporters about their perceptions of the balance between child safety and family preservation by CPS ... Survey respondents who disagreed that the balance is appropriate had the opportunity to provide comments. In these comments we observed that CPS staff who disagreed more often indicated that child safety is too heavily weighted over family preservation, while the mandated reporters more often indicated that family preservation is too heavily weighted relative to child safety.

For OPEGA, the possibility that family preservation *increases* child safety was not even on the table.

At one point the report does say the two are not mutually exclusive – but only in the sense that there are laws mentioning both. The idea that they are opposites that need to be balanced is never questioned – so the false framing that contributed to the death of Logan Marr is reinforced.

OPEGA also gives an incomplete list of the reasons why people hold contrasting views. According to the report:

These beliefs and opinions are shaped by individual experiences, perspectives, risk tolerance, and their role in the system.

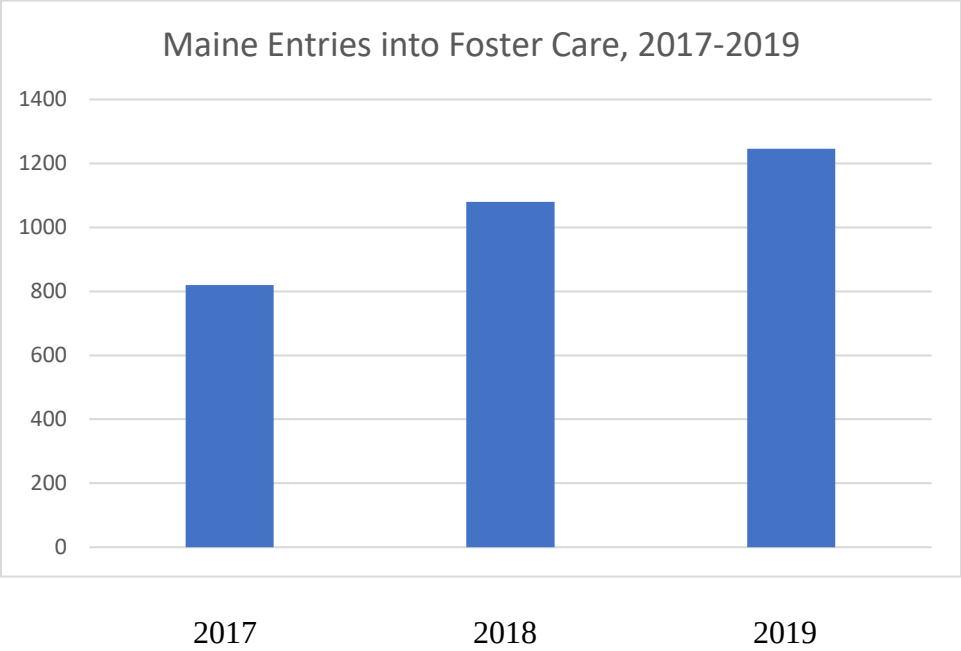
But one factor is left out: Those of us who support family preservation – because it's safer for children – base it on research: the studies showing that, because typical cases are nothing like the horror stories, in such cases children left in their own homes typically do better even than comparably-maltreated children placed in foster care, and the studies showing the high rate of abuse in foster care itself.

In a story about the report, *Portland Press-Herald* reporter Randy Billings shows he understands the real debate. Ironically, his excellent framing gives OPEGA more credit than it deserves. He writes:

There also is a lack of consensus about whether it is more important to emphasize child safety through removal from a family or through family preservation, the report says.

Underestimating foster care panic

In discussing the response to high-profile child abuse fatalities at the end of 2017 and the beginning of 2018, OPEGA acknowledges that staff at OCFS said they were "working from a place of fear…" But the report underestimates the impact of that fear, looking only at increases in reports and investigations and not mentioning the huge increase in children torn from their homes. As the state data tables available here show, in Maine, entries into foster care skyrocketed more than 50% between 2017 and 2019.



Source: U.S. Department of Health and Human Services
Trends in Foster Care and Adoption, FFY 2011-2020

Using the same limited measures, OPEGA suggests that child abuse deaths in June 2021 didn't have much effect, since investigations didn't increase. There are three problems with this:

- It may be too soon to feel the full effects.
- There are no figures at all on entries into care – so we don't know if they went up again.

● Most important: By 2019, Maine was tearing apart families at a record rate – the fanaticism for child removal was worse even than before Logan Marr died. So when you're at your very worst, saying: "Hey look, maybe it didn't get worse still!" isn't reassuring.

Caseworkers themselves understand. Everyone agrees a key problem is that the workers are overloaded. But, as the report itself acknowledges:

In surveys and interviews, some OCFS supervisors and caseworkers indicated that valuable time is spent investigating reports that – in their opinion – did not appear to warrant an investigation. … With a fixed number of caseworkers, if fewer reports are screened in as appropriate for investigation, caseworkers would, in theory, have more time available for each investigation and, in turn, the opportunity to complete a more thorough assessment of risk and safety concerns.

Note the skepticism from OPEGA with qualifiers like "in theory" "—in their opinion—"

In contrast, no such skepticism is expressed for the more commonly suggested alternative: Hire a bunch of additional caseworkers. But that has failed repeatedly. Hiring binges during foster-care panics are likely to lead to even further widening of the net of needless intervention into families. All the new caseworkers -- "working from a place of fear…" -- chase all the new cases and all you get is the same lousy system only bigger.

The funds that would be squandered on a caseworker hiring binge would be far better spent bolstering services for families which, the report admits, range from grossly inadequate to nonexistent.

The Disney version

While perhaps not as damaging, another section of the report may be even more offensive: It confuses myths and facts because it confuses what's on paper with actual practice. Indeed, this section reads as if it was written by the PR department for OCFS back when Logan

Marr died. What OPEGA accepts without question now is what DHS claimed then as it sought to defend itself.

Thus, OPEGA claims it's a "misconception" that "OCFS decides on its own whether a child is removed from their home." They regurgitate the party line you always hear from agencies like OCFS: "A judge has to approve everything we do." That's the Disney Version. But in the real world, not Disney World, OCFS does indeed decide on its own.

For starters, OPEGA repeatedly claims that caseworkers must get a "preliminary protection order" (PPO) signed by a judge before removing a child. But on page 24 of the report, OPEGA admits that's not always true. According to the report:

If a child is determined to be unsafe and time is needed to write and file the petition, the caseworker may collaborate with law enforcement by asking them to invoke a six-hour hold in which law enforcement takes temporary custody of the child.

In addition, Maine law states that

*"Removal of the child from home" means that the department **or** a court has taken a child out of the home of the parent, legal guardian or custodian without the permission of the parent or legal guardian. [Emphasis added].*

But more important, the requirement for a court order is meaningless. There is no real hearing beforehand, no chance for a family to defend itself. A caseworker simply marches into court (or, after hours, calls the judge) and says: "I think we need to take this child right now, here's why." Do you seriously think a judge is going to say no?

OPEGA could have checked. They could have obtained records and determined how often a PPO request is rejected. But, apparently, they didn't.

Also labeled by OPEGA as a misconception: "CPS caseworkers have authority to enter a home and compel parents to cooperate with an investigation."

But that depends on what you mean by "authority." They may not have the authority on paper, but in the real world if you refuse that in itself makes you suspect, so the worker can threaten to call a judge and get authorization to not only enter the home but walk out with your children.

And in one case OPEGA is wrong even about the Disney version. The report claims that parents have the right to refuse to let their children be interviewed. But elsewhere the report specifies that the workers can go to, say, a child's school and interview the child without the parent knowing. (There are times when such action is justified, my point here is only that OPEGA is wrong to suggest this option doesn't exist.)

And, of course, if you don't know about a right, you don't have that right. The report includes this curious statement:

*Over the course of the review, we heard that there is **growing awareness** among families that engagement with CPS is voluntary, and more families are declining to allow access to their homes by DHHS. [Emphasis added.]*

That doesn't sound like caseworkers are actually telling families their rights when they knock on the door.

Also labeled a "misconception": "Caseworkers alone make child safety decisions." In fact, the report explains, they have to get a supervisor to sign off on them – so there may be all of two people involved - and sometimes they consult with others, too. But the report does not say how often the supervisor actually overrules the caseworker – and whether that is more likely to happen when a worker wants to remove a child or leave the child in the home.

The OPEGA report also notes that workers use a series of checklists known as "Structured Decision Making." The report does not mention that there have been serious questions raised about racial bias in the SDM process.

Logan Marr is missing

And finally, let's note what the report says about Logan Marr, and about how Maine was briefly a national model when, in the aftermath of her death, it rejected the Big Lie and embraced safe, proven alternatives to foster care.

What does the report say about that? It says nothing.

As far as OPEGA is concerned it's as if Logan Marr never existed. Unfortunately, that seems to be the prevailing view in Maine right now. And that, of course, makes the next such tragedy even more likely.

ABOUT NCCPR

The National Coalition for Child Protection Reform www.nccpr.org is a small nonprofit child advocacy organization dedicated to trying to make the child protection system better serve America's most vulnerable children. The group was established at a 1991 Harvard Law School conference by the late Betty Vorenberg, a former member of the National Board of the ACLU. Members of our Board of Directors include Ira Burnim, a former Legal Director of the Children's Defense Fund who now holds that position with the Bazelon Center for Mental Health Law, Prof. Dorothy Roberts of the University of Pennsylvania Law School, author of the definitive book on child welfare and race, Shattered Bonds: The Color of Child Welfare *(Basic Civitas Books, 2002), and Ruth White, former Director of Housing and Homelessness for the Child Welfare League of America. You can read what other child welfare leaders say about us here: http://bit.ly/1mhIl66*

###

Dear Senator Libby, Representative Stover, Senator Claxton, Representative Meyer and members of the Committee on Government Oversight and the Committee on Health and Human Services:

I write offer comments on OPEGA's evaluation of the state child welfare system and its second report to the Legislature focused on child protective investigations. I remain troubled by the lack of data and outcome measures that the Legislature should consider in evaluating the efficacy of our child protective investigation process. (The report can be found at: 8493 (maine.gov)

I am not a child welfare system expert. I am a foster-adoptive father (having helped raise nine foster care children, adopting six of them over the past 25 years). I also have a professional background that intersects with child welfare systems. I served as appointed legal counsel for foster youth, served as legal counsel for parents whose children were in out-of-home placements, served as the CEO of a child welfare/foster care agency in Massachusetts, and formally served as the National Executive Director for the Children's Defense Fund in Washington, DC, which advocates for reforms to federal policies in child welfare. I live with my husband and family in Portland, and currently serve as the President & CEO of Volunteers of America Northern New England (www.voanne.org).

I would like to applaud OPEGA for its thoroughness and assessment of statutory obligations and OCFS policies guiding child protection investigations in Maine. The report provided key details of the practices or actions taken by OCFS caseworkers and supervisors during the investigation stage. Additionally, I appreciated OPEGA's review of the Quality Assurance Case Reviews to determine the state's performance against the Children's Bureau's standards in the federal Children & Families Service Reviews. The OPEGA report highlighted recommendations that I agree should be addressed.

However, I am troubled by the failure to ask the right questions and the absence of performance data on the system's effect on child safety and well-being. The OPEGA report reviewed process and practices within OCFS but did not measure individual or aggregate measurements of child safety and well-being through the CP investigation process.

I would ask this Committee to ask **how the state measures the success of CP investigations in regard to child safety and wellbeing**? Does the state have data on:

(a) the annual percentage of children who remained in their homes and never came back in for another investigation because the investigation either was unsubstantiated or appropriate services were delivered to the family,
(b) the annual percentage of child who experienced repeat episodes of maltreatment either during or after a CP investigation, or
(c) the annual percentage of children was place in out-of-home placement and were successfully reunited with their families because appropriate services helped to mitigate risk factors?

I would also recommend that the Committee receive longitudinal data that evinces Maine's child welfare system outcomes for children over the past decade (2012-2021), which would include the years before and after the critical deaths of several children in 2018. I would suspect that outcomes of investigations changed as a result of this crisis in 2018, but without longitudinal data a proper assessment of the system cannot be determined. It is this level of evaluation that your Committee should be assessing and is missing in this OPEGA report.

I had hoped OPEGA's study of Maine's Child Welfare system would have answered the following data or outcome questions based on the federal Children's Bureau's guidance and framing (https://www.childwelfare.gov/topics/systemwide/assessment/family-assess/id-can/protection/):

Assessment in Child Protection - Child Welfare

State laws provide guidance to child protective services (CPS) agencies regarding identifying and reporting suspected child maltreatment, investigating to determine whether abuse occurred, and providing necessary services for children and youth and their families

www.childwelfare.gov

1. IDENTIFICATION: The first phase of any CP investigation is identifying children who are at risk of maltreatment.
    a. Have the sources of CP complaints (schools, medical professionals, citizens) changed over the past decade?
    b. What are the number of complaints registered with OCFS annually, over the past decade, that may indicate whether communities are appropriately educated on risk factors?
    c.
2. INTAKE: Intake of child protection reports attempt to determine if the complaints or initial reports to Child Protection (CP) meet the statutory and agency guidelines for child maltreatment.
    a. How do we know if OCFS is screening in the proper percentage of cases for assessment and investigation, as compared to other states or national averages, and how have these measures changed over the past decade?
        i. Of the over 26,000 reports in 2021, it was found that 56% were screened out, 37% were referred for investigations and 4% were deemed low-risk and referred to a contract agency for family assessment. How does this compare to national standards or averages from all other states
    b. Has the state's percentage of reports that receive an investigation versus reports that are denied investigation (for inappropriate reports of alleged abuse and neglect) changed over the past decade?

3. INTAKE: The standard of 35 days for completion of an initial assessment can be overridden by the urgency of the complaint.
    a. Have the factors for child safety that OCFS consider urgent, to speed up investigations, changed over the past decade?
    b. Of the annual percentage of cases that are deemed urgent for quicker assessments changed over the past decade, and how do these percentages compare to other states or national averages?
    c.
4. INITIAL ASSESSMENT: After an initial CP complaint, an initial assessment is completed that must answer whether the child is safe and, if not, what type of agency or community response will ensure the child's safety in the least intrusive manner (including out-of-home placements).
    a. What is the percentage of CP cases that result in children being placed out-of-home (into foster care or residential care) and what percentage of children are allowed to remain in their homes, and how have those percentages changed in the past decade?
    b. What has been the state's record (the annual percentage) of children being victimized by maltreatment after an initial assessment over the past decade?
    c. Of all investigated reports, what percentage of cases are found to have substantiated findings and how has this percentage changed in Maine over the past decade?
    d. Of the number of investigated reports, and after findings are compiled through the SDM Safety Assessment and the SDM Risk Assessment tools, what percentage of cases are closed, and how has this percentage changed in Maine over the past decade?
    e. Of the number of cases that involved out-of-home placement of the child, what percentage of cases had children successfully reunited with their families, and how has this percentage changed in Maine over the past decade?
    f.
5. COMPREHENSIVE FAMILY ASSESSMENT: The time granted to CP workers to conduct a comprehensive family assessment (to determine what must change is in order for the effects of maltreatment to be addressed and for the risk of maltreatment to be reduced or eliminated):
    a. Has Maine OCFS's guidance or recommendations for typical changes in family behavior or necessary supports changed over the past decade?

b. What has been the state's record of children being victimized by maltreatment after the completion of the comprehensive family assessment and how have these annual percentages changed over the past decade?
c. Has OCFS ever evaluated whether its recommended family services or parent treatment plans resulted in enhanced safety or failed to ensure child safety (i.e. did they get 'the issue' or 'problem' wrong and assign the wrong response to fix the family)?
d.

6. EVALUATING FAMILY PROGRESS: Evaluating whether risk conditions or behaviors have changed is critical to case planning.
    a. How does Maine evaluate family protective factors, strengths, or safety factors, and if these factors have changed over the past decade have we seen a corresponding improvement in child safety?
    b. For each year, over the past decade, what has been the average length of time it takes for family dynamics and factors to change to accomplish the elimination of a safety plan? Do we see any trends in the length of time taken to ensure families have built up protective factors or strengths to achieve family reunification?
    c. Have measurements of family progress in relation to protective or risk factors changed over the past decade?
    d.
7. DISPARITIES: Research literature has often noted the disparities in negative outcomes for children and youth from under-resourced (poverty) communities and marginalized groups including youth of color, youth with disabilities, LGBTQ youth, and older adolescents in child welfare systems. This report failed to mention this and gave no finding regarding:
    a. The rate of maltreatment experienced by children after the completion of investigations broken down by race, disability, sexual orientation, gender identity, or age to identify any disparities over the past decade.
    b. The percentage cases resulting in out-of-home placements, the percentage of cases achieving successful family reunification, or the length of time in out-of-home placements broken down by race, disability, sexual orientation, gender identity, or age to identify any disparities over the past decade.
    c.
8. CHILDREN AND FAMILY SERVICES: OPEGA's report also noted concerns regarding the lack of access to services that OCFS refers families.
    a. "*OCFS may refer families to services such as mental health counseling, in-home behavioral health services, substance use treatment, and case management, to help address risk to children. Lack of service availability, including waitlists, along with access barriers such as transportation, child care, and ability to pay, were cited as ongoing concerns.*"
    b. In the report's addendum, OCFS responds with statements that it is committed to improving accessibility to services and mentions increased pay to behavioral health workers, rate studies, and strategic plans for system improvements. However, OCFS also never mentions how they are evaluating their progress.
    c. The Legislature should ask what are their outcome measures and process from which to evaluate real improvements in accessibility to services?

I would suggest that the Legislature has a duty to examine child welfare outcome data focused on child well-being to gain a deeper appreciation and understanding of the system's efficacy. The OPEGA report was a wonderful overview but more information is needed if we hope to identify gaps or deficits in our child welfare system that need to be addressed to ensure child safety and well-being.

Thank you for considering my remarks. I am grateful for the public service and dedication you each show to our Maine communities.

Sincerely,

Rich Hooks Wayman

RICHARD A. HOOKS WAYMAN (Pronouns he, him, his)

President & CEO

Volunteers of America Northern New England
rich.hookswayman@voanne.org
T 207.373.1140 *III* **C** 207.400.6070
www.voanne.org

Great Place to Work-Certified™

Great Place To Work. Certified MAY 2021-MAY 2022 USA ™

Helping America's most vulnerable.®

Tonya DiMillo
A
Testimony
OPEGA Child Protective Services Investigations report
tonya@tonyadimillo.com

April 8, 2022

Good afternoon, thank you Senator Libby, and Representative McDonald, committee members. I would like to express my gratitude for your commitment to save and improve the lives of Maine's children. And, to Senator Diamond, I would like to thank you for your courage and leadership in this time of need, you have honored and championed youth and families in Maine- and I am grateful.

I am appreciative of this opportunity to speak to child safety again. I remain very passionate about a collaborative effort that continues to work toward balance in protection of our children. This is an extraordinary time, requiring extraordinary response and measure. I believe together we can reach our shared goals for youth to safely grow and develop to be who they are meant to be.

The recent OPEGA report and briefing on child protective service investigations confirms much of what we already know. Concerns remain of flawed child safety assessments and/or decision making at critical moments during the investigations. We learned of inadequate training. We learned of the internal decision-making process and an internal quality review process. We learned about of the use of multiple risk and safety assessment and decision-making tools in every step of the investigation. Sometimes, as evidenced by our grave child outcomes, such evidence-based tools and internal processes may not be enough.

I have come to believe, based in research and in my experience, the people missing from the table are the experts in whole child care. Such resources have the wisdom, training and experience that will support each child in their safety, health and well-being. These experts are often far removed from the decision making- yet could be the most supportive.

I believe creating a team of experts ranging from pediatrics, neuro/brain and body, as well as youth champions-coaches etc. may provide a lens that is specific and supportive to each child's safety and care. This team will *see* the whole child, support establishing safety, and support their health and well-being through appropriate assessment and evaluation to understand each child's strengths and needs- especially their safety. In this way, every family system- biological, kinship, foster or community-based care systems will know how to rise in response to each child, establishing safety by meeting their needs, ultimately supporting their growth and development.

I believe this policy measure of creating a team/council can also provide a compassionate space for accountability to such complex issues, to review the various stakeholder reports, recommendations, differences, and how to collectively reach appropriate standards of care and the best possible outcomes for our youth and their families.