STATE OF MAINE
OFFICE OF THE GOVERNOR
1 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0001

Paul R. LePage
GOVERNOR

May 30, 2018

Government Oversight Committee
Cross Office Building, Room 214
100 State House Station
Augusta, ME 04330-0100

Dear Members of the Government Oversight Committee:

We have received your invitation for a representative of the Department of Health and Human Services to address the Government Oversight Committee during its public hearing on Thursday, May 31.

Given the restrictions in state and federal law regarding what can be discussed in a public forum due to the need to protect confidentiality and the ongoing prosecutions where we seek justice for the deaths of two children, it is inappropriate at this time to have a representative of DHHS at any level address questions without first being able to be advised by counsel as to what can and cannot be said. It would be awkward at best and potentially jeopardize the criminal proceedings if an official were to inadvertently reveal confidential information in their attempt to answer the questions being raised by the committee. Unscripted, off-the-cuff questions and answers would jeopardize the careful work that has been done so far by DHHS, DOE, DPS, the Attorney General's Office, and the Office of Program Evaluation and Government Accountability (OPEGA).

To that end, therefore, we will continue to answer OPEGA's questions in writing, as we have been, so the answers can undergo the appropriate confidentiality review by the Attorney General's Office.

I have enclosed a copy of a report with DHHS's initial findings as to what can be improved in operations and management of the Child Welfare System. DHHS has already implemented several of these reforms; these are identified in the report. Many of these reforms can be implemented with policy changes and do not require legislation. Others, including position reclassification and improved communication and management systems may require additional funding. Some reforms will require legislation.

First, we will be recommending that Maine's statutes are revised so that the priority is on what is best for the child, not family reunification. Placing the priority on family reunification forces the system and the courts to try to keep vulnerable children in a family when the best thing would be to remove the child from the situation. Parents who are unable or refuse to effectively take on the challenge of parenting should not be forced by government to remain with a child, leaving the child vulnerable to neglect and abuse.

Second, we must replace the outdated computer system with a modern system that will provide better communication and access to case histories. More information made available in a way that makes it actionable in a timely manner will improve staff and system-wide effectiveness, producing better outcomes for the children under our care. This is an investment in our children.

Third, we will request that the Legislature—for the second time in my administration—criminalize the failure to comply with the mandatory reporting statute. Mandatory reporters must not hesitate or second-guess whether they should report something that gives them any reason to suspect that a child is being abused. Making the failure to report a class E crime provides an additional incentive to ensure that mandatory reporters act promptly, potentially saving a child's life.

As we continue our review of the child welfare system, additional statutory changes may be recommended. The overarching priority in our review is what is best for the child.

I agree with many of the frustrations expressed that the statutes governing Maine's child welfare system have misplaced priorities and created circumstances that make it difficult to have a full and frank discussion. However, we must proceed in a manner that does not jeopardize any pending prosecution so that justice is served for the children who so tragically lost their lives.

As a person who has personally experienced the trauma of growing up in an abusive home, I take the responsibility of ensuring these reforms are implemented and the system improved so that the people of Maine can be assured not only that a child in a crisis is provided the utmost protection but also that abusers are held accountable.

Sincerely,

Paul R. LePage

Paul R. LePage
Governor

cc: Beth Ashcroft, Director, Office of Program Evaluation and Government Accountability

CHILD WELFARE OVERVIEW

2018

Contents

SUMMARY OF THE DEPARTMENT'S PROCESS FOR REPORTS OF ABUSE

When the Department receives information that a child may be abused or neglected, the Department's first step is to decide whether the child may be in danger. If the Department believes the child may be in danger, then the Department meets with the family and gathers more information about the circumstances of the danger. To do this work, the Department either uses a trained Office of Child and Family Services (OCFS) Child Protection Services caseworker (state employee) or a trained Alternative Response Program caseworker (contractor).

In circumstances where a child cannot be safely parented within his or her home, the Department works with the parents/caregivers to provide services and supports to increase their ability to safely raise their children. This assistance sometimes includes supporting the child within his or her home, while other times it is necessary to temporarily or permanently remove the child from the home.

Throughout this process, the Department must balance numerous factors, including the rights and responsibilities of parents, statutory priorities, and the foremost priority of child safety. Ensuring the safety of children requires the Department and the community to work together to identify and support children at risk.

Child Welfare Reports of Abuse: Intake Procedure

Processing Child Welfare Reports of Abuse
When a report is made to the Department, information is gathered from OCFS Intake staff regarding demographics of the referent and family information. This information includes who is in the home, the abuse allegations, and past child protective history. After gathering such information, the OCFS Intake staff determine whether the allegation is "Appropriate" or "Inappropriate" for Child Protective Services intervention.

When a report contains allegations of abuse or neglect per Title 22:

- The report is marked as "Appropriate" for intervention.
- The necessary response timeframe is determined:
    - 24 hours for high severity risk: allegations include imminent safety concerns exist, including potential occurrences of sexual abuse and/or physical abuse with injury.
    - 72 hours for low-to-moderate safety risk: allegations include safety concerns, such as the potential for physical abuse and neglect to occur.
- The report becomes an open assessment and is sent to the local OCFS District Office for assignment according to the following guidelines:
    - If the severity of the case is high, the case will *always* be assigned to an OCFS Child Protective Services Caseworker.
    - If the severity is low to moderate, the case may be assigned to the local Alternative Response Program provider. Alternative Response Program providers are private agencies contracted by the Department to provide services similar to those of OCFS Child Protective Services.

When a report does *not* contain allegations of abuse or neglect as described in Title 22:

- First, the report is marked as "Inappropriate" for intervention, meaning the intervention methods described in the immediately preceding bullet for "Appropriate" (note that this does not mean that no action is taken).
- A determination is then made regarding whether the report warrants referrals to other voluntary community intervention or prevention service providers.

Child Welfare Reports of Abuse: Assessment Procedure

Conducting Child Welfare Assessments of Reports of Abuse
After a report is marked as "Appropriate" for intervention and assigned to an OCFS Child Protective Services caseworker or Alternative Response Program caseworker as an open assessment:

1. The caseworker initiates contact with the family and then conducts interviews with every member of the family individually within the assigned timeframe. The caseworker also gathers information from others involved with the family, to include such individuals as extended-family members, friends, neighbors, police, school personnel, and medical professionals).
2. Within 35 days of the assessment being opened, the caseworker determines whether the allegations are "Substantiated," "Indicated," or "Unsubstantiated."
   - A "Substantiated" allegation is a finding of high severity abuse or neglect that results in an open case. It may result in a closed case in those instances where the "Substantiated" abuser no longer has access to the child, such as when an abuser has been incarcerated.
   - An "Indicated" allegation is a finding of low-to-moderate severity abuse or neglect that results in an open case. It may result in a closed case in instances where the safety concerns regarding the child have been adequately addressed.
   - An "Unsubstantiated" allegation is no finding of abuse/neglect. This finding results in closing the assessment, although potential referrals may be made to voluntary community intervention or prevention service providers.

Child Welfare Reports of Abuse: Open Case Procedure

Open Cases with Court Involvement
After an assessment results in an open case, the Department requests court intervention when a child cannot be safely maintained in his or her home. The Department will advocate for the Court to either:

- Remove the child from the home and make the Department the legal guardian of the child when safety concerns still exist within the current family home. This process includes working with the family on rehabilitation and reunification with the child, as mandated under Title 22, except when there are aggravating factors (i.e., heinous or abhorrent treatment) as described under Title 22.

  OR

- Order the parent/caregiver to participate in rehabilitative services, as mandated under Title 22, for purposes of mitigating the child-safety concerns. In such instances, the child remains in the parent's/caregiver's custody.

The Department consults and collaborates with the Attorney General's Office throughout the course of a case, particularly during the time the Department is determining whether to file court action.

Open Cases without Court Involvement

After an assessment results in an open case, the Department will work with the family to create a plan to address child-safety concerns. Such plans will either opt to leave the child in his or her current home or to place the child with agreed-upon informal family supports on a voluntary basis.

SUMMARY OF STRATEGIC INITIATIVES

The Office of Child and Family Services completed an extensive review of the internal Child Welfare System during the late winter and early spring of 2018. This review entailed a detailed look at specific cases as well as the resulting evaluation of overall Child Welfare practice and policy decisions. As a result of this internal review, the Office of Child and Family Services has initiated several strategic initiatives as detailed below.

Initiative 1: Improve Service of Contracted Alternative Response Providers (ARP)

Objective: Ensure all ARP cases in a certain district are appropriately served and increase monitoring and oversight of ARP service providers and referrals in all districts to ensure high quality work. This effort included monitoring reassignment practices to ensure that no "Appropriate" reports are closed by the ARP provider before an assessment of child safety is completed.

Status: This objective was initiated in March 2018 and has been completed.

Initiative 2: Ensure Consistent, High-Quality Casework Practice for Child Welfare Services

Quality Improvement Objectives

- *Objective:* Increase quality review of casework practice statewide through implementation of the Quality Improvement Program. This program increases oversight of casework practice through continuous, real-time review of Child Welfare caseworker documentation.

  Status: This objective was initiated in July 2017 and will continue to be an ongoing focus of OCFS work.

- *Objective:* Obtain consistent statewide practice through implementation of the Structured Decision Making tool to strengthen consistent, research and evidence-based decision making across Child Welfare practice. This tool provides a structured guideline against which caseworkers can benchmark their decision-making and determine next steps.

  Status: This objective was initiated in the spring of 2016 and will continue to be an ongoing focus of OCFS work.

Intervention Objectives

- *Objective*: Increase high quality statewide practice through continued implementation of the Family Teaming Practice. Family Teaming Practice increases engagement of caregivers and their informal supports—which are such non-paid supports as relatives and neighbors. This "teaming" works to create a plan to meet the safety needs of children involved with Child Welfare interventions.

  Status: This objective was initiated in June 2016 and will continue to be an ongoing focus of OCFS work.

- *Objective:* Increase child safety-focused interventions by transitioning from the use of contracted providers (ARP) for assessments of Reports of Abuse. This action increases safety of children involved with child welfare interventions by having only Child Welfare caseworkers conduct assessments related to reports of abuse.

  Status: This objective was initiated in the summer of 2017 and will continue to be an ongoing focus of OCFS work.

- *Objective:* Strengthen consistent statewide practice and reduce permanency timeframes by discontinuing Out of Home Safety Plans. This action mitigates risk related to the practice of agreeing to place a child outside of their parents' home(s) with another caretaker, without a court directive and court oversight.

  Status: This objective was initiated in February 2018 and will continue to be an ongoing focus of OCFS work.

Personnel, Management and Training Objectives

- *Objective*: Complete personnel investigation of two recent cases to review and make recommendations for improvement in Child Welfare practice.

  Status: This objective was implemented in December 2017 and expanded in February 2018. This has been completed.

- *Objective*: Implement the supervision "case review toolkit." Caseworker supervisors will use the toolkit to strengthen high quality, consistent casework practice across all districts. This toolkit also increases oversight and improves caseworker supervision.

  Status: This objective was initiated in January 2018 and will continue to be an ongoing focus of OCFS work.

- *Objective:* Create two additional Child Welfare Regional Director Positions and implement the Chief Operating Officer model to increase oversight of the work in each of the eight districts, including intake practice and statewide operations.

  Status: This objective was initiated in May 2018 and is still in the process of being completed.

- *Objective*: Re-class Intake and Assessment Child Welfare Human Services caseworker lines. This action increases the training requirements and expectations related to these positions, with a focus on investigation of child abuse and neglect.

  Status: This objective was initiated in April 2018 and is still in the process of being completed.

- *Objective*: Increase training requirements for all Child Welfare caseworkers and supervisors. This action improves practice within Child Welfare and therefore creates increased child safety.

  Status: This objective was initiated in April 2018 and is still in the process of being completed.

- *Objective:* Increase Child Welfare oversight and case review at the District level through adding clinical supervision by a clinical psychologist, which increases high quality casework practice. This objective was initiated in April 2018 and has been partially implemented.

  Status: This will continue to be an ongoing focus of OCFS work.

- *Objective*: Increase caseworker retention and performance by implementation of trauma debriefing and a semi-annual psychological evaluation of staff. A similar system is employed by the Department of Public Safety to ensure the psychological wellbeing of workers.

  Status: This objective was initiated in April 2018 and is still in the process of being completed.

- *Objective*: Review, plan and implement a Field Instruction Unit (an internship and training program created in partnership with University and College systems) for recruitment of high quality Child Welfare staff.

  Status: This objective was initiated in April 2018 and is still in the process of being completed.

Statutory, Regulatory, and Policy Objectives

- *Objective*: Increase focus on the "Child's Best Interest" through a full review of relevant statutes and policies and the implementation of the resulting recommended changes. This action strengthens the statewide approach to Child Welfare intervention by prioritizing the best interests of the children.

  Status: This objective was initiated in April 2018 and will require statutory changes to complete.

- *Objective*: Change Mandated Reporting Statute to create a penalty for failure to report. This action ensures that the professionals required to make mandated reports do so.

  Status: This objective was initiated in April 2018 and will take legislative action to complete.

- *Objective*: Review current Child Welfare policies of a 35-day timeframe for assessments and a 72-hour response timeframe for suggested changes in practice. This action increases child safety focused practice to increase the information available to Child Welfare caseworkers as they make decisions regarding child safety.

  Status: This objective was initiated in April 2018 and is still in the process of being completed.

Initiative 3: Strengthen the Intake Process Related to Reports of Abuse

- *Objective*: Increase ability to holistically review Reports of Abuse by updating the Intake process to make all Reports of Abuse separate reports. This action increases high quality practice in the review of Reports of Abuse and ensures that the gravity of repeat reports is easily noticed and assessed within decision making for dispositions of incoming reports of abuse.

Status: This objective was initiated in March 2018 and will continue to be an ongoing focus of OCFS work.

- *Objective:* Increase the ability to recognize risk as demonstrated through multiple Reports of Abuse by implementation of an automatic Child Welfare Assessment. Circumstances where three "Inappropriate" reports have been filed within six months—in other words, when there are three alleged abuse reports that did not meet the threshold for Child Welfare intervention—a Child Welfare Assessment will automatically be triggered. The Child Welfare Assessment will be conducted in addition to the review of any Report of Abuse for appropriateness of Child Welfare Intervention.

  The triggering of an automatic Child Welfare Assessment increases high quality practice in the review of reports of abuse – ensuring that patterns revealed via repeated reports will be assessed within the decision-making protocols for dispositions of reports of abuse.

  Status: This objective was implemented in March 2018 and will continue to be an ongoing focus of OCFS work.

- *Objective*: Decrease the wait time for calls related to Reports of Abuse received by the Child Welfare Intake staff. This action increases high quality practice in the receipt and review of reports of abuse.

  Status: This objective was initiated in March 2018 and will continue to be an ongoing focus of OCFS work.

Initiative 4: Improve Child Safety Decision-Making Through Improved Access to and Management of Information Available to Caseworkers

- *Objective*: Increase efficiency of caseworker access to state and federal background checks. This action increases the information available to Child Welfare caseworkers as they make decisions regarding child safety.

  Status: This objective was initiated in April 2018 and will continue to be an ongoing focus of OCFS work.

- *Objective*: Change statutes to provide authority to Child Welfare staff to access education records. This action increases the information available to Child Welfare caseworkers as they make decisions regarding child safety.

  Status: This objective was initiated in April 2018 and will take statutory changes to complete.

- *Objective:* Implement a tracking system for cases identified within the Child Death Serious Injury Policy to inform trends and develop a trend report. This report will guide review of cases and make recommendations for improvement in Child Welfare practice.

  Status: This objective was implemented in March 2018 and is still in the process of being completed.

- *Objective*: Change Expungement Practice to increase robustness of Child Welfare records. This action increases the information available to Child Welfare caseworkers as they make decisions regarding child safety.

  Status: This objective was initiated in March 2018 and is in the process of being completed.

Initiative 5: Increase Efficiency and Effectiveness of Casework Practice

- *Objective:* Increase efficiency and effectiveness of the Electronic Data System by implementing a Comprehensive Child Welfare Information System (CCWIS). This action increases the efficiency of documentation and increases thorough oversight and supervision, as well as improves the quality reports and data.

  Status: This objective was initiated in fall 2017 and will continue to be an ongoing focus of OCFS work.

- *Objective:* Implement efficiencies for casework practice by instituting Court Workers for Child Welfare caseworkers. These individuals will be DHHS staff assigned to assist in the preparation of child welfare court cases to increase the efficiency of Child Welfare casework related to court activities.

  Status: This objective was initiated in March 2018 and will continue to be an ongoing focus of OCFS work.

Initiative 6: Strengthen Overall System of Child Welfare Practice
Implementation of New Practices Objectives

- *Objective:* Create and implement a SWOT Team for review of OCFS Child Welfare Practices and Procedures to identify System Strengths and Areas of Need. The SWOT Team will be charged with making recommendations for additional improvements in Child Welfare practice.

  Status: This initiative was implemented in March 2018 and is still in the process of being completed.

- *Objective:* Implement the Community Intervention Program (CIP) to increase services available for families at-risk of child abuse by providing these families assistance in identifying risks and successfully obtaining informal and formal supports aimed at reducing those factors.

  Status: This objective was initiated in summer 2017 and will continue to be an ongoing focus of OCFS work.

- *Objective*: Complete review of Children's Behavioral Health System to improve Child Welfare practice and the availability of Children's Behavioral Health services to meet the needs of children involved with Child Welfare interventions.

  Status: This objective was initiated in March 2018 and will continue to be an ongoing focus of OCFS work.

Implementation of Practices for Populations with Specific Risk Factors

- *Objective*: Implement Plan of Safe Care procedures and policy to ensure that the needs of children who are exposed to substances are addressed appropriately.

  Status: This objective was initiated in April 2018 and will continue to be an ongoing focus of OCFS work.

- *Objective*: Complete review of Child Welfare practice and implement practice changes for cases involving self-injury and medical neglect.

  Status: This objective was initiated in May 2018 and will continue to be an ongoing focus of OCFS work.

- *Objective*: Complete review of Child Welfare practice and implement practice changes for cases involving unexplained injury to children under the age of five. Review of cases by a Child Abuse Physician Expert improves Child Welfare practice.

  Status: This objective was initiated in May 2018 and will continue to be an ongoing focus of OCFS work.

- *Objective*: Complete review of Child Welfare practice and implement practice changes for cases involving children with disabilities.

  Status: This objective was initiated in May 2018 and will continue to be an ongoing focus of OCFS work.

- *Objective*: Complete review of Child Welfare practice and implement practice changes for cases involving parents with disabilities.

  Status: This objective was initiated in May 2018 and will continue to be an ongoing focus of OCFS work.

Conclusion

The Department has undertaken a significant review of the internal child welfare process. Although many of the reforms mentioned herein are in response to recent incidents, several were previously initiated and have been in the process of development and implementation. The Department has been in contact with corresponding agencies in other states to identify best practices for implementation in Maine.

This list of reforms is not exhaustive of all reforms that may be undertaken. Further reforms may be recommended or implemented upon the completion of additional, upcoming reviews. However, the Department can assure the public that these reforms have resulted in a more responsive and protective system. The public should have confidence that the Child Protective Service system can and will take action where appropriate to protect a child in a potentially abusive situation.

HOUSE OF REPRESENTATIVES
2 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0002
(207) 287-1400
TTY: (207) 287-4469

Dale Denno
275 Main Street
Cumberland Center, ME 04021
Phone: (207) 400-1123
dale.denno@legislature.maine.gov

Public Hearing Input, May 31, 2018

Good morning, Sen. Katz, Rep. Mastraccio and members of the Government Oversight Committee.

My name is Dale Denno, and I am the Representative for District 45, Cumberland and part of Gray.

- I am a member of the HHS Committee
- I served as an AAG in the Office of the Attorney General
- I was formerly Director of the Office for Family Independence in DHHS

I attended last week's session and heard the OPEGA presentation to this committee. I have also read the OPEGA report. Frankly, I came away very disappointed with the lack of specific information or specific recommendations. This very possibly reflects my lack of understanding of the process. But I felt very much in sync with Sen. Diamond's frustration with the lack of actions that could be immediately implemented.

I want to briefly state some observations and make recommendations that may or may not be helpful to your efforts. To the extent they're not helpful or they reflect ignorance of the process, please take them in the spirit in which they're being offered.

1. The inability of OPEGA to provide information or answer questions was primarily due to the confidentiality laws we ourselves have written. But those confidentiality rights should not supersede the ability of this Committee to know the facts.

a. I propose the enactment of a statutory override of state confidentiality restrictions for committees meeting in closed session. There should be the opportunity for this committee to hear confidential matters when necessary to its function.

2. The absence of DHHS from these discussions makes it virtually impossible for coordinated efforts to bring about prompt improvements. Having been a Director in DHHS, my experience is that we can't fix systemic problems from the outside in.

a. I don't know what reason exists for DHHS not to participate in this process, but I would suggest that the stakes here are too high for the Executive branch to do other than to join in this effort to assure that we are doing everything we can possibly do to prevent these deaths from happening again.

3. The OPEGA report identifies "potential areas for concern or improvement." But it does not propose a process to objectively evaluate Child Protective Services.

a. I propose that a confidential survey of randomly selected CPS employees at all levels be conducted to determine what is working and what is not working.

i. What is working well, that should continue?

ii. What are the key obstacles to their ability to perform their role?

iii. What improvements would they suggest?

iv. What would make them feel supported and valued in their work?

b. I propose that a review of caseloads, turnover, training, supervision and other critical data points be:

i. Viewed over a 10-year period, to gain historical perspective.

ii. Measured against national averages and against national best practices. I would expect that the agency's Federal counterparts could facilitate the establishment of benchmarks.

4. The movement toward outsourcing is neither good nor bad in itself. However, like a corporation, state government must determine what are its core functions that need to be within its control and oversight.

a. I propose that the Committee look hard at the mission and expectations of CPS, to determine which functions may lend themselves to outsourcing, and which must remain within the direct control of the state.

128th Legislature
Senate of Maine
Senate District 14

Senator Shenna Bellows
3 State House Station
Augusta, ME 04333-0003
Office (207) 287-1515
Cell (207) 776-5404
Shenna.Bellows@legislature.maine.gov

May 31, 2018

Good morning Senator Katz, Representative Mastraccio and distinguished members of the Government Oversight Committee,

My name is Shenna Bellows, and I represent Senate District 14 including the towns of Chelsea, Farmingdale, Hallowell, Gardiner, Manchester, Monmouth, Pittston, Randolph, Readfield, West Gardiner and Winthrop in the Maine Senate. I write to offer comments on the OPEGA report regarding Maine's Child Protection System at the request of several constituents who do not wish to be public at this time. Since your committee wisely decided to proceed with an OPEGA investigation in two parts, I have been contacted by numerous individuals including foster parents and case workers within the system about system problems that may have contributed to the deaths of Marissa Kennedy and Kendall Chick. I would like to share their comments with you in hopes that you will consider them as you make your decisions about the next stage of the investigation.

A whistleblower within the Department reported to me that staff morale among intake workers and case workers is very low. The whistleblower claims that caseloads are too high and further reported that intake was simply not able to review reports within 24 hours of receipt as directed under policy and outlined in the OPEGA report. People are leaving voice mails, and staff members are not necessarily even able to return calls within a 24 hour period because of inadequate staffing levels.

The OPEGA report asserts that the intake supervisor reviews all intake worker decisions, but the whistleblower reports that the reviews are cursory. Intake supervisors have now been directed to read only summary sentences rather than reviewing full content before forwarding the report to district offices because of significant backlogs in review of the reports earlier this year.

The OPEGA report identifies policy changes that the Department has made over the last few years for intake processes and decisions. The whistleblower reports that flaws in new policies have reduced the effectiveness of intake workers and case workers in serving families.

For example, the whistleblower claims that the new policy of creating a new record within the MACWIS system for every complaint has made it harder, not easier to understand the big picture when it comes to a child's safety. The new system of creating new reports is also creating duplicative work. District offices are now directed to conduct separate family visits for each report, even if the reports are duplicative, rather than basing new visits on new content. This is

resulting in visits being more cursory or rushed than might be ideal because of the sheer workload.

As a system, MACWIS is reportedly inadequate for all involved in the child protective response to have a complete picture of the case, and the whistleblower recommends that the legislature appropriate adequate funding for a future DHHS administration to review electronic record-keeping systems that are working well in other states and consider a new system.

The whistleblower expressed further concerns that the new policy of three reports definitely triggering an assessment has led to cases being opened when it's literally one person making multiple calls. Because there has been an increase in the automatic assessments without risk factor categorization, there's less time for cases where there may be only one call but there are significant risk factors.

The whistleblower is concerned that the Structured Decision Making Intake Screening and Response Priority Tool (SDM SCRPT Tool) was implemented without an accompanying Community Intervention Program for adequate prevention work. The SDM SCRPT Tool was created using new definitions advanced in Maine for intervention that created a higher threshold for intervention than Maine had previously used. The impact of the SDM SCRPT Tool was initially prioritizing only cases after abuse had actually happened. For example, the SDM SCRPT Tool definitions direct workers not to be involved in families of drug-affected babies until after drug use by the mother is demonstrated after the child's actual birth. Before the SDM SCRPT Tool, workers were always involved with these families where there was active abuse at the time of delivery. Now, given the problems with the definitions in the SDM SCRPT Tool, workers are being advised to ignore it in these cases until the SDM SCRPT Tool is fixed. The SDM SCRPT Tool needs to be fixed with updated definitions that actually reflect best practices.

The whistleblower is concerned that people without a background in child protection had been placed in supervisory and upper management positions and that policies have changed multiple times in the last two years without a foundation in best practices. The whistleblower has worked in child protective services for over ten years and reports that the chaos within the Department is at this high point because of a lack of cohesive management and direction. The whistleblower reports that the work is being directed more on paper management and checking boxes on policies and time frames rather than doing good social work that actually helps children. *Intake workers and case workers alike do not have enough time with each case because of inadequate staffing levels and policy changes that have led to increased documentation requirements but less time with the actual cases.* The whistleblower reported "When it become more about the policies and the government than the families, it gets hard."

Foster parents, current and former, report a system without adequate follow through or responsiveness to their concerns about child welfare. Of particular note, there is one ombudsman for the entire state, and foster parents feel strongly that isn't sufficient to investigate individual and systemic problems. Too often the ombudsman is able only to review paper files and speak with DHHS employees rather than talking to the guardian ad litems and other concerned adults involved with the child's care. The whistleblower believes that the legislature should seriously

consider a robust investment to allow the ombudsman's office to bring on additional staff for adequate oversight and investigation.

Foster parents expressed the following systemic concerns:

- **The safety and wellbeing of children sometimes seems secondary to a policy goal of reunification of children with their biological parents**
- **Inadequate oversight and accountability.** Foster parents feel that sometimes their concerns do not rise above mid-level supervision and that there is sometimes retaliation for raising concerns about case worker performance or a child's situation.
- **Inconsistency of application of law and policy.** Foster parents report that laws and policies do not appear to be consistently applied. For example, they report a system where biological parents may lose one or more children but other children stay in the home.
- **Turnover rates and lack of consistency of care among case workers.** Children are seeing multiple case workers, sometimes for only a few visits because of turnover, so there is often no one within the system who has seen the child consistently and knows the situation over a long period of time.

In talking to my constituents, there is clear consensus around three potential areas for concern or improvement in planning for a broader review identified by OPEGA on page 8 of the report. Those include:

- Timeliness of answering phone calls regarding potential child abuse
- Timeliness and comprehensiveness of OCFS and ARP assessments
- Appropriateness of caseloads and adequacy of supervision and training

In addition, my constituents recommend that the broader review include:

- An evaluation of whether new policies are correlated with best practice in the field
- An evaluation of the role of the ombudsman and how that office may be strengthened
- An evaluation of MACWIS and whether its helping or hindering communication and information exchange

Thank you for your consideration.

PUBLIC COMMENT

Government Oversight Committee
Maine's Child Protection System:
A Study of How the System Functioned in Two Cases of Child Death by Abuse in the Home

Emily M. Douglas, Ph.D. | Professor/Department Head
Social Science & Policy Studies | Worcester Polytechnic Institute

My name is Emily Douglas. I'm a full professor and head of the Department of Social Science & Policy Studies at Worcester Polytechnic Institute in Massachusetts. I grew up in Maine and lived here for 35 years before leaving for employment outside the state. I am a national expert on children who die from abuse or neglect. I have published more academic papers on this one dark topic, than anyone else in the country and my last book focused on the policy, program, and professional responses to child fatalities. I have testified before the Congressionally-created National Commission to End Child Abuse and Neglect Fatalities and last year I was a Congressional fellow, working in Washington for the U.S. Senate Finance Committee on child welfare policy. But, I got started studying children and their welfare right here in Augusta, Maine, when as a graduate student, I worked for the Maine Child Death & Serious Injury Review Panel. It's where I first learned how compromised families can be, how well-intentioned service providers can miss opportunities to take protective action, and how children can fall through the cracks. For me, my interest and expertise in this topic started here in Augusta and I have been studying this tragedy now for close to two decades. Today I want to briefly comment on the report issued by the Office of Program Evaluation & Government Accountability concerning the deaths of Kendall Chick and Marissa Kennedy.

Official statistics from the U.S. Department of Health & Human Services tell us that annually 1,500 - 2,000 children die from maltreatment every year. [1, 2] We know that these statistics are undercounted and that it is likely many more. A death related to abuse or neglect is more than a tragedy. It is incomprehensible and can leave us feeling enraged and hopeless. Nevertheless, Maine usually performs relatively well in this area, with one to three children dying each year. [3] And, even though it is cases of physical abuse that bring us all together today, across the nation, more children die from physical neglect than physical abuse. [3] Abuse is more lethal, but less common, thus fewer children die this way. [4] What else do we know about children who die from abuse or neglect? We know that there are categories of risk – in the areas of child risk factors (e.g., age), parent/caregiver risk factors (e.g., unemployment, mental health concerns, low knowledge of child development), the parent-child relationship (e.g., parents who see their children as difficult), and household risk factors (e.g., being especially mobile, having non-family members residing in the home). [3-7]

I have worked with child welfare professionals in trainings, as a CASA guardian *ad litem,* taught countless current and future child welfare workers, and still today conduct reviews on cases where children in Massachusetts live in foster care. I am a friend of the child welfare workforce. But, my research shows that we do not adequately prepare them for their jobs. In two studies that I conducted, with over 1,000 child welfare workers participating from across the country, I found that there are serious deficits in their knowledge of risk factors for maltreatment fatalities. [8, 9] I asked workers about their knowledge of the type of risk factors that I just mentioned. Specifically, I asked about nine or ten risk factors and in four or five instances only 50% or more were able to accurately identify a risk. That's right, for half of the question, half of the participants got the answers wrong. To make matters worse, about 70% of the participants reported that they had received training

about risk factors, but it rarely made a difference in their level of knowledge. At the same time, the vast, vast majority, above 90%, said that they worry that a child on their caseloads will die, that they look for what they think are risk factors for death when they work with children and families, and that they want more training. Can you imagine working in such a high-stakes profession and not having the best knowledge and research tools to adequately do your jobs? Child welfare workers can. Ask them what it's like.

I've made this the central focus of my statement here today, because I noted in the report by OPEGA that there was no specific mention or discussion about workforce training, knowledge, or skillset for recognizing risk factors for maltreatment death. There are several references to supervision of workers, which is excellent. It's not enough to train a workforce. They need regular and ongoing supervision. [10] Training may be perceived as a dichotomous entity – trained or not trained. But, in truth, knowledge retention is achieved when it is incorporated in daily work skills and referenced in supervision on a regular basis.

All states suffer the tragedy, outrage, and embarrassment of a child maltreatment death. One doesn't have to look too far to see that many other states are grappling with these same events and that truly, no state escapes. Or, no state has escaped so far. The pressure to do something immediate, to produce results, and to show the public that the outrage is shared at all levels of government is crushing, for all. Sometimes this results in substantive changes, such as new assessment techniques or collaborations between different agencies or professional groups. Other times it results in surface level changes, like the change of an agency name. But, it always results in tremendous pressure on the child welfare workforce. [11, 12] They question their decisions, skill set, and motives – desperate not to appear in the next round of headlines. If a child dies in foster care, suddenly more children will remain with their birth parents. And, if a child dies at the hands of their parents, suddenly more children will be removed and placed in foster care. [13] The scramble to do the right thing is panic-inducing. I'm not suggesting that these informal practice changes can be completely avoided. But, what I am saying is that workers across the nation have deficits in their knowledge of risk factors and an overwhelming percent of worker want training. My guess is that the same thing is true of workers here in Maine. So, I recommend that as part of the investigation into the deaths of Kendall and Marissa, that the entities who are empowered to do so determine the level of training that workers have received around fatal child maltreatment and their knowledge in this domain. And, ultimately, yes, that the State of Maine gives workers what they want around training. Help them develop a "child maltreatment fatality lens." Be a national leader. Give workers research-based training in risk factors for child maltreatment fatalities and then incorporate that into their daily child welfare practice skills.

Thank you for giving me the opportunity to speak today.

References Cited

1. Herman-Giddens, M.E., et al., *Underascertainment of child abuse mortality in the United States.* JAMA, 1999. **282**(5): p. 463-467.
2. Ewigman, B., C. Kivlahan, and G. Land, *The Missouri fatality study: Underreporting of maltreatment fatalities among children younger than five years of age, 1983 through 1986.* Pediatrics, 1993. **91**(2): p. 330.
3. U.S. Department of Health & Human Services, *Child maltreatment 2015: Reports from the States to the National Child Abuse and Neglect Data Systems - National statistics on child abuse and neglect*. 2017, Administration for Children & Families, U.S. Department of Health & Human Services: Washington, D.C.

4. Douglas, E.M., *Child maltreatment fatalities in the United States: Four decades of policy, program, and professional responses*. 2016, New York: Springer.
5. Korbin, J.E., *Incarcerated mothers' perceptions and interpretations of their fatally maltreated children.* Child Abuse & Neglect, 1987. **11**: p. 397-407.
6. Chance, T.C. and M. Scannapieco, *Ecological correlates of child maltreatment: Similarities and differences between child fatality and nonfatality cases.* Child and Adolescent Social Work Journal, 2002. **19**(2): p. 139-161.
7. Fein, L.G., *Can child fatalities, end product child abuse, be prevented?* Children and Youth Services Review, 1979. **1**: p. 31-53.
8. Douglas, E.M., *Child welfare workers' training, knowledge, and practice concerns regarding child maltreatment fatalities: An exploratory, multi-state analysis.* Journal of Public Child Welfare, 2012. **6**(5): p. 659-677.
9. Douglas, E.M. and M.K. Gushwa, *Child welfare workers' knowledge of risk factors for child maltreatment fatalities: A second multi-state assessment.* Human Service Organizations: Management, Leadership & Governance, In Review.
10. Frey, L., et al., *The pivotal role of child welfare supervisors in implementing an agency's practice model.* Children & Youth Services Review, 2012. **34**(7): p. 1273-1282.
11. Regehr, C. *Public inquiries into deaths in care: Effects on emergency responders*. The Australasian Journal of Disaster and Trauma Studies, 2003. **2003-1**.
12. Regehr, C., et al., *Inquiries into deaths of children in care: the impact on child welfare workers and their organization.* Children and Youth Services Review, 2002. **24**(12): p. 885-902.
13. Gelles, R.J., *The book of David: How preserving families can cost children's lives*. 1996, New York: Basic Books.

Testimony before the Government Oversight Committee

Dr. Lawrence Ricci

May 31, 2018

Senator Katz, Representative Mastraccio and members of the Government Oversight Committee

SPUR WINK
going the distance

SPURWINK SERVICES
207.879.6160 phone
207.871.5668 fax
778 Main Street
South Portland, ME | 04106

www.spurwink.org

My name is Doctor Lawrence Ricci. I am a board certified child abuse pediatrician, medical director of the Spurwink Child Abuse Program, clinical professor of pediatrics at TUFTS University School of Medicine, and consulting child abuse pediatrician at Barbara Bush Children's Hospital and at Eastern Maine Medical Center. I am also a current member and former chair of the Maine Child Death and Serious Injury Review Panel (CDSIRP). I have practiced child abuse pediatrics in Maine for the past 30 year and have evaluated many thousands of children for abuse and neglect. During that time I have also unfortunately seen many children die from abuse and neglect.

For every child who dies in Maine from abuse and neglect (averaging 2-3 per year) at least 50 sustain potentially life threatening injuries and several hundred sustain some form of harm. According to the 4th National Incidence Study on Child Abuse and Neglect by the time a child reaches age 18, well more than half will have experienced some form of abuse or neglect. We also know that more than a quarter of children in our country will have at some point in their childhood been involved with the child welfare system.

The deaths of Kendall Chick and Marissa Kennedy were unbearably tragic but more than that they were likely preventable. Although the details of these two deaths are not available I can say with absolute certainty from my 30 years as a child abuse pediatrician in Maine that these and other children who die or who are seriously injured from abuse and neglect should not have died, should not had sustained life threatening injuries, and should be alive and well today.

The Spurwink Child Abuse Program now 25 years old is a multidisciplinary child abuse evaluation program. The purpose of the program is to offer an accurate diagnosis of abuse and neglect if it has occurred. We have on staff three medical providers and will be adding a second child abuse pediatrician in July. We also have psychologists and interviewers. Our medical providers frequently consult with other medical providers, child protective workers and other on child abuse cases. We also have satellite clinics in Lewiston, Augusta, and Bangor.

Child Abuse Pediatrics, a subspecialty of Pediatrics, was formally recognized by the Board of Pediatrics in 2006. Approximately 200 of us became board certified in 2009 and there are close to 400 board

certified child abuse pediatricians in the United States today. We are not only experts in the diagnosis of all forms of abuse but routinely participate in prevention, education, and advocacy. Many of us are researchers, most are clinicians who evaluate children every day. As illustrated in my recently released book What Happened in the Woodshed, Child abuse pediatricians have emerged as a new and important force for child safety in the United States.

I laud the work of OCFS and OPEGA in reviewing these two deaths. I am particularly pleased that some important changes have come about from these reviews, changes such as CPS's decision to automatically open for assessment any case after three inappropriate reports. I also am pleased that there will be increased child welfare oversight by adding a clinical psychologist.

I particularly appreciate OPEGAS's recommendations regarding mandated reporter training and its recommendation that there be critical review points where difficult cases receive a comprehensive re-assessment of risk. OPEGA also appropriately recommends that there be communication and information sharing among key entities involved in the welfare of children. My experience with other deaths such as those of Ethan Henderson and Leo Josephs has been that failure to share information among agencies is a primary cause of failure to protect.

I would add the following recommendations:

- That these two cases not only receive internal review but that OCFS constitute a committee within their structure to augment that review. Members of the CDSIRP are eager to help. Internal reviews are fine but insufficient in any analysis by any agency. Fresh eyes particularly eyes with differing skill sets are critical to improvement.
- In addition to a psychologist assisting in case review with OCFS I would recommend one of Spurwink's child abuse medical providers be involved in these discussions. Most if not all serious cases involve a significant medical component and the expertise of these providers would be invaluable in these reviews particularly in that the knowledge base of skilled child abuse medical providers is not common knowledge for child protective workers and supervisors, no matter how well trained.
- I remain concerned about Structured Decision Making (SDM) as an intake tool as it is currently formulated. SDM can be a useful tool particularly in developing consistency but consistency is not accuracy. I am afraid this tool has not been well vetted by important stakeholders such as the CDSIRP and Hospitals. I am also concerned that the goal of the tool has been described as decreasing false positives. Any attempt to use a screening tool in medicine to decrease false positives will by definition increase false negatives meaning more sick patients will be missed. We would never want a screening test in medicine that decreases further testing for cancer if it also means that cases of cancer will be missed. In the case of CPS intake SDM, if the goal is to decrease false positives then cases of abuse will be missed.
- We at Spurwink routinely train child protective workers in the medical aspects of child abuse though many do not get the training. We routinely train medical providers. We rarely train nurses, home visitors, schools, law enforcement, and mental health provider. Training of all mandatory reporters must occur and such training includes the services of a child abuse medical provider.

- It is my firm belief that all children with concerns of child abuse and neglect deserve a skilled medical evaluation. This seems to be working well in Maine for physical abuse where there is close collaboration between Spurwink and CPS. It is working less well for neglect and sexual abuse. Since the advent of children's advocacy centers (CACs), a worthwhile endeavor, fewer than 15% of sexually abused children receive a skilled medical evaluation. The reasons are complex but one simple solution would be to have child protective workers make a medical referral to Spurwink at the same time they make a referral to a CAC. Complex neglect case should be referred to us as well yet apart from failure to thrive this rarely happens. We can assist with such reviews which often involve extensive medical and non-medical record.

Finally I offer my and my agency's services to OPEGA and to the Government Oversight Committee as this valuable review moves forward. I am happy to answer any questions today.

Thank You

Lawrence R. Ricci, MD
Lawrence R Ricci
Spurwink Child Abuse Program

Testimony of Mark W. Moran, LCSW
May 31, 2018

Before the Government Oversight Committee of the Maine Legislature

In response to OPEGA's May 2018 report on Maine's Child Welfare System

Senator Katz, Representative Mastraccio and members of the Government Oversight Committee, my name is Mark Moran. I am a Licensed Clinical Social Worker at Eastern Maine Medical Center, a volunteer Guardian ad Litem for the Maine CASA program, a former Child Protective Services Caseworker and the Chair of Maine's Child Death and Serious Injury Review Panel. I have been involved in Child Welfare work in Maine in one capacity or another for the past 17 years.

As you may or may not know, the existence of the Child Death and Serious Injury Review Panel is authorized in Maine law, with a stated purpose of reviewing cases in which children have died or been seriously injured and using those reviews to recommend to state and local agencies methods of improving the child protection system. The Panel has not yet been able to review either of the two child death cases which prompted the Committee's inquiry. Despite the Panel's desire to offer our expertise for such reviews, after extensive consultation with the Attorney General's office, we were unable to define a process for review that would allow for full panel participation and avoid any potential for interference with the criminal investigation. The Panel does intend to review both of these deaths as soon as the criminal prosecutions are completed and the Attorney General's office gives us approval to proceed. In the meantime, we are eager to assist with any other reviews for which our expertise may be of benefit.

I would like to commend the OPEGA staff for the work they have put into this matter thus far. Navigating the intricacies and complexities of meaningful case review in the context of pending criminal prosecutions and a public demand for information and accountability is incredibly difficult. I would like to use my time today to comment briefly on some of the issues raised in the OPEGA report, to offer some observations of the Child Welfare system as a whole, and to recommend some specific areas of focus as the Committee moves forward with its review process.

The media headlines following the release of OPEGA's report last week predictably focused on the phrases "poor job performance" and "inadequate supervision." While I cannot speak in absolutes, I believe it is important for the Committee to understand that individuals who choose to work in the Child Welfare field do not, in my experience, make the choice to perform poorly. Their supervisors do not seek to be inadequate in their oversight of their staff. There is no epidemic of lazy, uncaring caseworkers reporting to disinterested, indifferent supervisors. That is not the disease. "Poor job performance" and "inadequate supervision" may very well be, however, the symptoms of a larger disease. I am hopeful that the Committee will see fit to examine the factors that lead to such symptoms, including, but not necessarily limited to, staffing levels, caseloads, rates of and reasons for staff turnover, challenges and opportunities for recruitment and retention of high performing staff, and the overall well-being of OCFS staff. It is not unusual for me to hear about OCFS colleagues who have real anxiety about returning to

work after a weekend, a holiday, or a vacation. It is not unusual for me to hear about OCFS colleagues who don't want to go to trainings or take a sick day or schedule a vacation because they are fearful of the work that will pile up in their absence, and it is not unusual for me to observe and interact with OCFS colleagues who are clearly adversely impacted by the work they do.

The OPEGA report cited "greater information sharing" among those parties involved with a family as potentially having prompted further action or reassessment. In my experience in multiple roles, I have consistently seen deficits in information sharing as a barrier to best practice and child safety. The current Maine statute, specifically Title 22 Section 4008, contains provisions that allow for optional or mandatory disclosure of otherwise confidential child protection records. These disclosures are crucial if multiple professionals from multiple disciplines are going to effectively work together to accurately evaluate a child's safety and ultimately protect them from harm when that intervention is warranted. In day to day practice, access to information is often determined by the quality of interpersonal relationships among service providers in local communities. The result, therefore, is inconsistent sharing of information, which creates gaps through which at risk children fall. Confidentiality laws and rules are important, but in many cases, whether correctly or incorrectly, those laws and rules are offered as reasons why information cannot be shared even among professionals, thereby making those laws and rules barriers to child safety.

In their report, OPEGA staff touched on the topic of Structured Decision Making, particularly as used at the intake hotline. To be clear, I applaud the OCFS efforts to be judicious stewards of limited child welfare resources and to more consistently provide the right response for children and families. I also support the notion of having a structured decision support tool available within the Child Welfare system. I am concerned, however, that in the interest of trying to reduce false positives, which is to say, providing an OCFS intervention or response in families who do not truly need it, the OCFS is also increasing their risk of allowing false negatives, which is to say, not providing an OCFS intervention or response in families who do need it. I am also concerned that in the effort to reduce false positives, OCFS may be failing to meet its statutory duty to investigate all abuse and neglect cases (22 MRSA 4004-2-B). I have seen multiple reports over the past year be deemed "inappropriate" because someone has offered a potential explanation for an injury or ingestion. The potential explanation is sometimes simply accepted as the truth of the matter and no further inquiry takes place. From my perspective, both as a hospital Social Worker and Chair of the Child Death and Serious Injury Review Panel, failing to investigate in favor of accepting a potential explanation is a dangerous practice that may very well lead to episodes of repeat maltreatment.

Based on the totality of my experience and in addition to the areas I've already highlighted, I offer the following recommendations for specific areas of focus as the Committee pursues its review of the Child Welfare system in Maine:

- Functioning of the intake hotline unit: When calling to make reports, my staff consistently have to wait 30-45 minutes to speak to a caseworker who can take the information that needs to be reported. This is a significant enough time period to be viewed as a potential barrier to the reporting of child maltreatment.

- Caseworker efficiency: Are we maximizing the use of available technologies to enhance the efficiency and productivity of casework staff? Would this lead to improved retention? Are there inefficiencies in casework practice that could be eliminated or tasks which could be shifted to other, non-caseworker staff? Are we sacrificing the quality and depth of assessments in favor of speed of completion to be able to move on to the next case?
- Acceptance of unqualified forensic opinions with regard to child injuries: To what extent does OCFS staff make decisions about child safety or plausibility of an account of how an injury happened based on the input of nurses, physicians, other professionals or parents who lack the forensic pediatric expertise to reliably opine on such matters?
- The Alternative Response Program system: Are the staff in these programs adequately trained to provide the level of service that is expected of them? Should OCFS be sending ARP reports to assess/investigate at all, or should referrals to these programs only happen after an OCFS assessment/investigation has taken place?

Finally, I strongly recommend that the Committee consider ways in which to capture the input of front line caseworkers and supervisors during this review process. In an effort, in part, to inform my own thinking about the issues involved, I recently attempted to solicit the thoughts of some of my OCFS colleagues as to what they saw as areas in need of improvement from their perspectives. I received a polite but clear response that OCFS staff had been directed to not speak about the OPEGA report or the ongoing review process. While I understand that directive to some degree, I believe the Committee would be remiss if that valuable, front line input was not included in this systemic review. Frontline staff are perhaps the most well-positioned to identify systemic flaws that influence day to day practice.

While the deaths of Marissa Kennedy and Kendall Chick are heartbreaking and tragic, they provide an incredible opportunity for thorough review and improvements to the Child Welfare system in Maine. No other cases that I can recall have garnered such attention by the media, the legislature, or the general public since the death of Logan Marr in 2001. The opportunity to make improvements, however, should be approached cautiously. While I appreciate the desire for quick changes to make kids safer today and tomorrow, recommendations for changes must be developed thoughtfully and with proper attention to detail. Our children's lives depend on it.

Thank you for your time, and I am happy to try to answer any questions you may have.

Mark W. Moran, LCSW

mmoran@emhs.org

Summary of Testimony of Christine E. Alberi
Child Welfare Ombudsman

Regarding OPEGA's Report: *Maine's Child Protection System: A Study of How the System Functioned in Two Cases of Child Death by Abuse in the Home*

Sen. Katz, Rep. Mastraccio and honorable Members of Government Oversight Committee. Thank you for considering my comments today.

1. The Office of the Maine Child Welfare Ombudsman is governed by 22 M.R.S.A. 4087-A. We are an independent non-profit funded by contract through the executive branch to provide statewide ombudsman services for the Department of Health and Human Services, Office of Child and Family Services (OCFS).

The Child Welfare Ombudsman has several different roles, but the two primary functions are 1) to complete case specific reviews in order to resolve complaints about OCFS and 2) to provide information about the child welfare system to callers and to refer individuals to other organizations or sources of information as necessary. Individuals with concerns or complaints call to set up a telephone appointment. During that appointment, the Ombudsman or Associate Ombudsman gathers information to determine whether or not the case should be opened for a review. If the case is opened for a review, the Ombudsman sends the complaint or complaints and a summary of the caller's concerns to the relevant OCFS district office and the district will respond to the complaints and provide any relevant documentation or information as requested by the Ombudsman. The Ombudsman also has access to all of the information in MACWIS, the database where caseworkers generate the case's narrative log, among other data. A draft report is generated and sent to the district office where the program administrator of that district agrees with the report and it is finalized, or disagrees and the report is discussed further. If changes are recommended by the Ombudsman, these generally will occur or will have occurred already, but often in instances where policy or procedure was not followed the actions cannot be undone. Once reports are finalized they are sent to the central office as well as to the district.

In addition to case specific reviews and information services, the Ombudsman also provides more general recommendations to OCFS and the legislature and executive branch based on trends and issues that become evident in surveying case reviews done over a period of time.

2. The Ombudsman's office has completed reviews of the cases for Marissa Kennedy and Kendall Chick, although these reviews have not been finalized with OCFS. I have also read the OPEGA report and agree with the report and the section entitled Potential Areas for Concern or Improvement to Consider in Planning a Broader Review. I would like to highlight the areas that are most important for consideration in the upcoming OPEGA review.

- appropriateness of caseloads and adequacy of supervision and training of OCFS and ARP staff

  In addition to caseworker caseloads, supervisor caseloads should also be carefully considered. Ongoing training in investigation and assessment of the safety of children for caseworkers and supervisors is imperative. Large caseloads could also contribute to

higher risk cases being referred to ARP agencies. Also, OPEGA could consider whether too-high caseloads contribute to high caseworker employment turnover.

- timeliness and comprehensiveness of OCFS and ARP assessments of risk for a child or family and junctures at which a comprehensive re-assessment of risk could be or should be conducted

  This second area for review is directly related to caseloads and training. If caseworkers do not have time to complete appropriate assessment activities in a thorough manner, inevitably important facts and signs of risk will be missed or minimized.

- compliance with policies and procedures, and consistency and appropriateness of decisions made, by caseworkers and supervisors in OCFS Central Intake and District Offices

- factors that impact OCFS or ARP decision-making on appropriate action to take in response to assessed risk levels, and information received or situations observed with a child or family;

  Recognizing risk to children, both in the short and long term can be a complex process. Determining why OCFS staff sometimes does not recognize risk when the facts support that the children are not safe is an important line of inquiry. The timing of decisions to file a child protective petition in court or to remove a child from a home is important to both child safety and parents' rights.

- effectiveness of the child protection system in identifying and responding to child abuse/neglect risks that are not considered to be imminent physical safety risk, i.e. emotional maltreatment, neglect, truancy

  The Ombudsman has worked with OCFS in the past to improve practice in response to educational neglect. More training and education in this area may be necessary.

Additionally, OPEGA might look into the best role for ARP contract agencies in the future and the best way to integrate ARP into OCFS cases to support caseworkers and families.

3. The Child Welfare Ombudsman fully supports the recent changes made by OCFS as detailed on pages 7 and 8 of the OPEGA report, although this does create concern for further increases in caseload for caseworkers and supervisors without necessary resources.

The Child Welfare Ombudsman fully supports the upcoming comprehensive OPEGA review. OCFS has many, many dedicated caseworkers and supervisors who deserve our help and support so that they may do their jobs effectively in all cases. Finally, there are many resources in the state that support children and families that should be strengthened and expanded, to take some of the burden off of OCFS and prevent child protective intervention from occurring.

May 31, 2018

Maine

CHILD WELFARE SERVICES OMBUDSMAN

15TH ANNUAL REPORT • 2017

CHILDREN'S OMBUDSMAN

Table of Contents

The 2017 Maine Child Welfare Ombudsman Annual Report was written and prepared by:

CHRISTINE E. ALBERI, Esq.
Executive Director, Ombudsman

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

Entering the Ombudsman's sixteenth year of service, we continue to work closely with the Office of Child and Family Services to improve practice and policy to help ensure the best outcomes for children in state custody or those at risk of serious harm. As has been historically true, of the 112 cases that the Ombudsman has reviewed this year, the majority have been handled competently and with no major violations of policy or law and no major practice issues.

The Office of Child and Family Services is staffed with many highly competent, professional and caring social workers who do complex and heartbreaking work on a daily basis and this clearly shows in the many positives found in the cases reviewed by the Ombudsman's office. Maine has developed into a highly regarded state child welfare system and has worked hard to keep children safe and only remove children from parents' care when necessary.

Despite the positives, the Child Welfare Ombudsman has continued to work with the Office of Child and Family Services to identify and remedy both statewide issues as well as problems in individual cases. Every child that the Office of Child and Family Services comes into contact with deserves the highest level of safety, support, compassion and understanding, and the Ombudsman will continue to work towards improvements and remedies for problems that arise, while advocating for children and their needs, whether large or small.

I would like to thank both Governor LePage and the Maine Legislature for continuing to support the Maine Child Welfare Ombudsman as a key component of the many stakeholders that help support Maine's most vulnerable children.

Sincerely,

Christine E Alberi

Christine Alberi
Child Welfare Services Ombudsman

WHAT IS *the Maine Child Welfare Services Ombudsman?*

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

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

MERRIAM-WEBSTER ONLINE defines an *Ombudsman* as:

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

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

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

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

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

1. The primary problem is a custody dispute between parents.
2. The caller is seeking redress for grievances that will not benefit the subject child.

3. There is no specific child involved.

4. The complaint lacks merit.

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

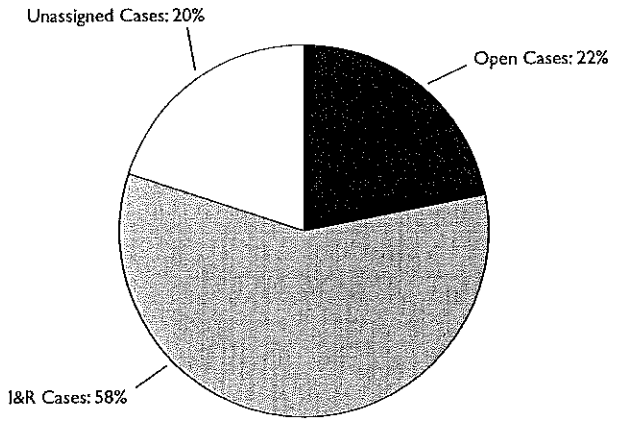
More information about the Ombudsman Program may be found at
http://www.cwombudsman.com

DATA
from the Child Welfare Services Ombudsman

The data in this section of the annual report are from the Child Welfare Services Ombudsman database for the reporting period of October 1, 2016, through September 30, 2017.

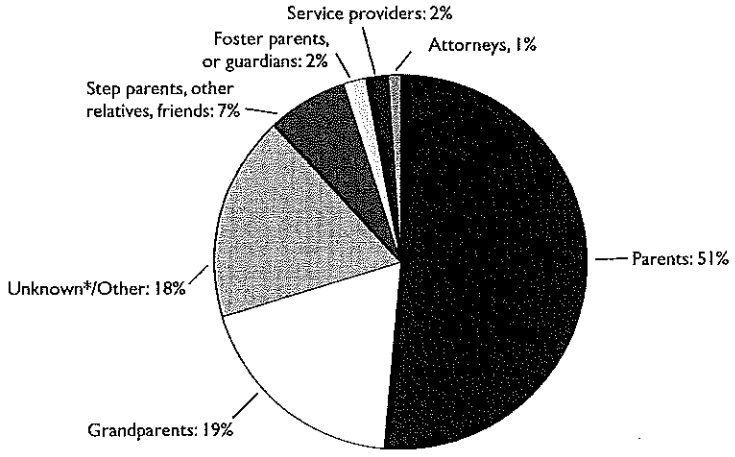
In Fiscal Year 2017, 504 inquiries were made to the Ombudsman Program, a decrease of 8 inquiries from the previous fiscal year. As a result of these inquiries, 112 cases were opened for review (22%), 293 cases were given information or referred for services elsewhere (58%), and 99 cases were unassigned (20%). An unassigned case is the result of an individual who initiated contact with the Ombudsman Program, but who then did not complete the intake process. Our new scheduling protocols allow each caller an opportunity to set up a telephone intake appointment.

HOW DOES THE OMBUDSMAN PROGRAM CATEGORIZE CASES?



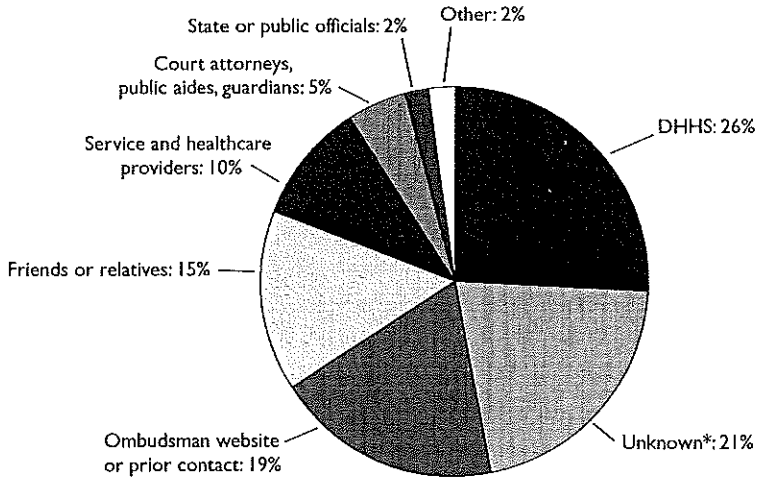
WHO CONTACTED THE OMBUDSMAN PROGRAM?

In Fiscal Year 2017, the highest number of contacts were from parents, followed by grandparents, then other relatives/friends.



HOW DID INDIVIDUALS LEARN ABOUT THE OMBUDSMAN PROGRAM?

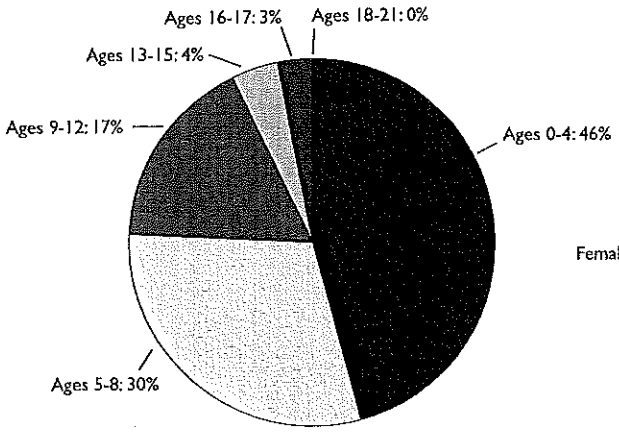
In 2017, nineteen percent of contacts learned about the program through the Ombudsman website or prior contact with the office. Twenty-six percent of contacts learned about the Ombudsman Program through the Department of Health and Human Services.

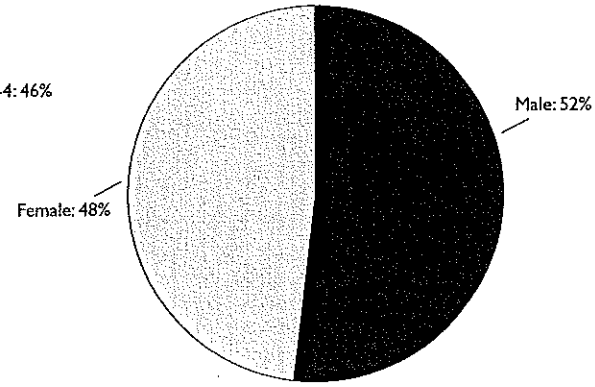


* *Unknown* represents those individuals who initiated contact with the Ombudsman, but who then did not complete the intake process for receiving services, or who were unsure where they obtained the telephone number.

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

The Ombudsman Program collects demographic information on the children involved in cases opened for review. There were 202 children represented in the 112 cases opened for review: 52 percent were male and 48 percent were female. During the reporting period, 76 percent of these children were age 8 and under.





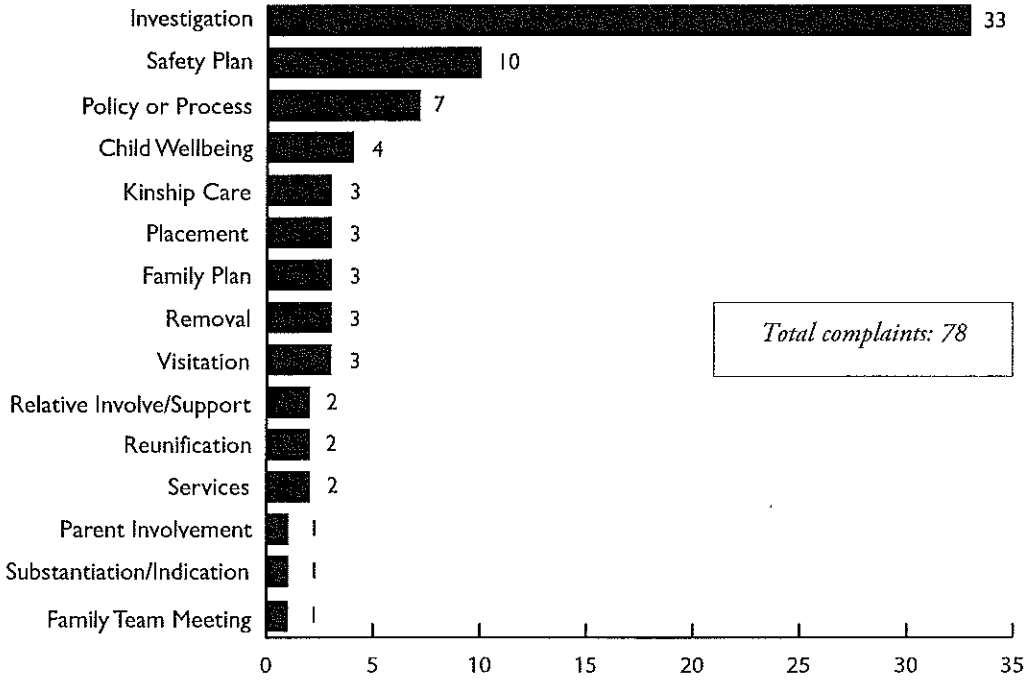
HOW MANY CASES WERE OPENED IN EACH OF THE DEPARTMENT'S DISTRICTS?

			DISTRICT	CHILDREN	
DISTRICT #	OFFICE	CASES	% OF TOTAL	NUMBER	% OF TOTAL
0	Intake	4	4%	9	4%
1	Biddeford	21	19%	39	19%
2	Portland	7	6%	11	5%
3	Lewiston	17	15%	30	15%
4	Rockland	7	6%	12	6%
5	Augusta	20	18%	34	17%
6	Bangor	16	14%	29	14%
7	Ellsworth	10	9%	21	10%
8	Houlton	10	9%	17	8%
TOTAL		**112**	**100%**	**202**	**100%**

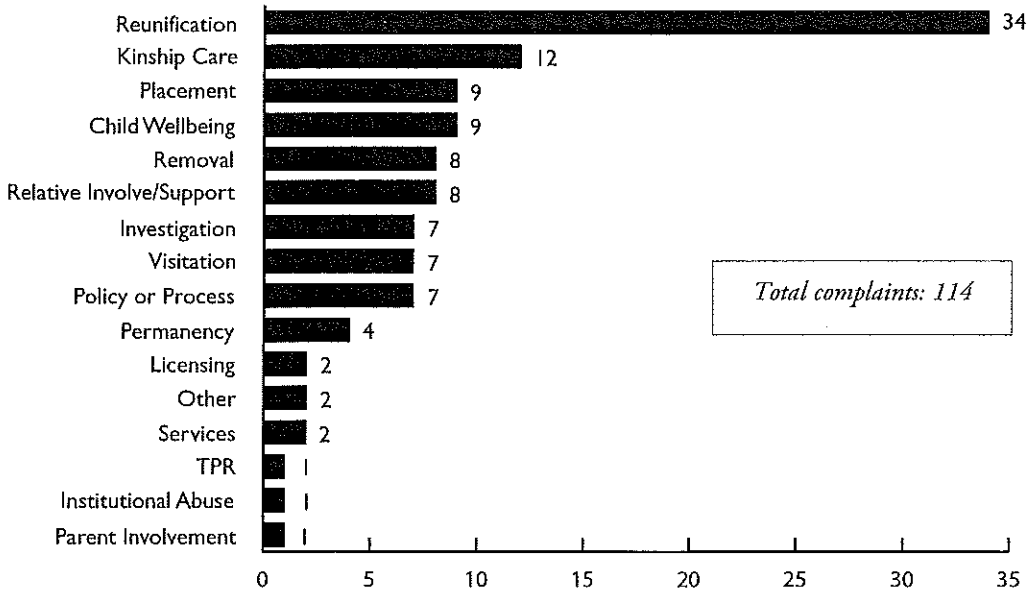
WHAT ARE THE MOST FREQUENTLY IDENTIFIED COMPLAINTS?

During the reporting period, 112 cases were opened with a total of 192 complaints. Each case typically involved more than one complaint. There were 78 complaints regarding Child Protective Services Units or Intakes, 114 complaints regarding Children's Services Units.

Area of Complaint: **CHILD PROTECTIVE SERVICES**



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



HOW MANY CASES WERE CLOSED & HOW WERE THEY RESOLVED?

During the reporting period, the Ombudsman Program closed 107 cases that had been opened for review. These cases included 177 complaints and those are summarized in the table below.

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

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

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

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

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

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

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

RESOLUTION	CHILD PROTECTIVE SERVICES UNITS	CHILDREN'S SERVICES UNITS	TOTAL
Valid/Resolved	4	6	10
Valid/Not Resolved*	21	13	34
1. Action cannot be undone	20	9	
2. Dept. disagrees with Ombudsman	0	1	
3. Lack of Resources	1	3	
Not Valid	47	86	133
TOTAL	**72**	**105**	**177**

* Total of numbers 1, 2, 3

During reviews of the 107 closed cases, the Ombudsman identified 14 additional complaint areas that were not identified by the original complainant. The 14 complaints were found to be valid in the following categories: 5 child well-being, 4 investigation, 2 reunification (one resolved due to changes made by Department), 2 services (unresolved due to lack of resources), 1 kinship involvement, and 1 Policy or Process. Unless otherwise noted the actions were unresolved because they could not be undone.

POLICY AND PRACTICE
Recommendations

The Ombudsman and the Department of Health and Human Services, Office of Child and Family Services (the Department) have had another year in partnership to support improvement in the Department's work in child welfare. The Department has agreed with the Ombudsman's recommendations, specifically in the areas of safety planning, assessment, and later placement of children in relative care.

The Department has continued to sustain improvements in placement of children with appropriate kin at the outset of a case and improvements in kinship involvement in general throughout a case.

During the 2017 fiscal year the following were among the most important recommendations made to the Department:

1. ASSESSMENTS AND SAFETY PLANNING

Assessment Practice and Safety Planning continue to be at the forefront of recommendations made to the Department this year. Multiple cases involved failure to follow assessment policy, failure to follow safety planning policy, or failure to recognize risk to children in their parents' care. Of particular concern were cases involving highly vulnerable children (infants, children with high medical needs, or non-verbal children.)

After opening an initial assessment, the Department and parents will often agree to a safety plan or voluntary care agreement to place children out of the home while an investigation takes place and parents engage in services to increase safety. Sometimes safety plans allow the children to remain with the parents with conditions. Best practice is to quickly complete investigations to determine the risk to the children, and carefully monitor the safety plans, particularly when one or all of the children remain with the parents. Parents also must agree with the safety plan or voluntary care agreement. After the assessment period, if risk to the children is still high, a petition is filed with the court or the children are taken into state custody by emergency petition.

When a safety plan is in effect, by definition, risk to the children may be high. Sometimes an assessment has been completed and the Department has not filed a petition in court but believes that further child protective involvement is warranted. In these cases social workers monitor the level of safety over a period of months, either with the children remaining in the parents' custody or with the children out of the parents' custody under a voluntary care agreement. Social workers make regular contact with children, caregivers, providers and other collateral contacts.

When assessments policy is not followed, either through lack of contact with children, parents, providers, or other collaterals, and safety plan compliance is not monitored, this can put children at risk both in the short and long term.

Department's Response: The Department has an important role in ensuring the safety of children within the families involved with Child Welfare Services. Contacting and assessing critical case members as well as completing monthly face to face contacts is a critical part of the work we do within OCFS to achieve the goal of ensuring child safety and meeting the needs of families. The Department's policy outlines the expectation to interview all critical case members, including out of home parents, face to face monthly. The OCFS acknowledges there is need to strengthen this practice statewide. The OCFS has internal reports that monitor this practice at the caseworker and District levels. The OCFS is actively engaged with staff statewide to monitor quality of this practice and actively work with staff to promote improvements where needed.

Additionally, the District Management Team has had success in collectively reviewing both Family Team Meetings and permanency outcomes per district. This provides the OCFS important oversight into the progress of the case as it directly relates to child safety and reduction of risk within a family. The Department has recently implemented Structured Decision Making within the Intake process and is currently beginning the process to implement Structured Decision Making at the Assessment level. This will strengthen the Department's practice for monitoring cases throughout the Intake and Assessment periods, including safety plans. The Structured Decision Making process addresses both practice and policy to create a consistent response to allegations of child abuse and neglect statewide.

2. KINSHIP POLICY FOR LATER PLACEMENT OF CHILDREN WITH RELATIVES

The Ombudsman has recommended this year that the Department develop clear policies regarding when it is appropriate and in the children's best interests to move children from long term foster homes to out of state (or in state) relative placements that could not take the children during the reunification period. It is not clear in policy whether attachment or bond to a non-kinship foster family, whether or not other attachment issues are present in the children, should outweigh the benefit of being placed with kin for adoption and permanency. The statute is unclear on this, as it gives priority to kinship placements, but does not reference the timing of placement. Whether or not to move a child under these circumstances is decided by determining whether this is in the best interests of the child, but there are no objective legal standards by which to measure this.

The Ombudsman has recommended that the Department should consider a policy where children should always be placed with appropriate kin, including adopted siblings, unless there is a situation where there would be a serious impact on the child and the impact can be measured by evidence based or other objective standards.

Department's Response: The Department prioritizes kinship placements for all children. The OCFS actively monitors the number of children whom are placed within kinship placements. Currently in Maine, we are above national averages for this type of placement. Additionally, the OCFS is actively collaborating with the Attorney General's office to review the current statute in order to provide recommendations

to the Legislature to ensure that statutory language related to kinship placement is congruent and consolidated within the statute and prioritizes kinship placements overall. Additionally, the OCFS has initiated the Kinship Advisory Board which directly addresses issues related to kinship care and also informs the legislature on recommendations related to this type of care.

At the same time, the OCFS utilizes concurrent planning in all cases. This allows the OCFS to ensure child safety and simultaneously plan for long term placement and permanency for all children in care. Within this practice, the OCFS prioritizes strengthening and forming relationships with kin so the child can have additional kinship options that may not have been present during the initial timeframe when the decision was made on where to place the child to ensure the child's immediate safety. These kin resources are continuously engaged in the case process and explored as long term permanency options for the child.

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

The Ombudsman has noted a pattern of cases where children are harmed due to issues with or lack of resources within the children's mental health and behavioral health systems. Children's mental health and behavioral issues have been exacerbated by lack of quick availability and wait lists for in-home counseling services, therapeutic foster homes, and crisis beds. A child who might otherwise have been able to remain in a kinship placement, for example, might have that placement disrupted due to lack of support and might cycle through a crisis placement, a residential treatment center and into a therapeutic foster home. More experienced therapeutic foster homes with full support might prevent placement disruption or entry into residential treatment. Waits for crisis beds have negatively affected children's safety. At least one experienced cognitive behavioral therapist stopped accepting Mainecare payments citing a low Mainecare reimbursement rate.

Best policy and practice would be to make quickly available all possible services for children with serious behavioral and mental health issues so that these children do not need to be hospitalized or in residential treatment. The children involved in the cases that the Ombudsman reviewed this year, where gaps in services harmed children or exacerbated the children's issues, ranged in age from elementary school to late teens; this issue affects children of all ages.

Some children do need residential treatment both for the short and long term. Children in residential treatment are at risk of discharge every 90 days. These cycles are not healthy for many children's mental health and can put pressure on children and providers. Instead of an arbitrary amount of time, better policy would be to allow the child's treatment team to determine when the child is ready for discharge. Additionally, there are few choices for residential treatment in general in Maine, especially for older youth who cannot be placed in a kinship or foster placement due to serious behavioral or mental health issues. The quality of these facilities varies widely. All children in state custody deserve to have the highest quality and most effective treatment available.

Lastly, children continue to be placed in New Beginnings Homeless Shelter due to lack of placement

resources or lack of approval for residential treatment. In one case reviewed this year the child placed at the homeless shelter was 13; and in another case the child was 14.

Department social workers spend a disproportionate amount of time caringly and thoughtfully supporting children with difficult mental health and behavioral issues. In cases reviewed this year, social workers provided excellent service to older youth in care and spent an above average amount of time checking in with older youth, advocating for services, and providing emotional support.

Department's Response: The Department continues to recognize the behavioral health needs of children whom are involved with child welfare services. The OCFS is actively engaged with internal and external stakeholders, including advocacy groups to evaluate and improve practice and services for children with behavioral health needs. Additionally, the Department has created a plan for children who are waiting for behavioral health services that includes a coordinated response from the Children's Behavioral Health and Child Welfare teams as well as the MaineCare Complex Case Unit when appropriate. The OCFS believes this will help children to have more integrated and timely services to address their behavioral health needs. Similarly, the Children's Behavioral Health team is actively reviewing all cases of children waiting to receive services and helping families to identify other supports available to them while they wait for the service.

CONCLUSION

The Ombudsman and Department will continue to collaborate to improve policy and practice in these and all other areas that affect children and families involved with or at risk of being involved with Child Welfare Services.

ACKNOWLEDGMENTS

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

The staff of public and private agencies that provide services to children and families involved in the child welfare system, for their efforts to implement new ideas and provide care and compassion to families at the frontline, where it matters most.

Senior management staff in the Office of Child and Family Services, led by former Director James Martin, and Acting Director, Kirsten Capeless, for their ongoing efforts to make the support of families as the center of child welfare practice, to keep children safe, and to support social workers who work directly with families.

The Program Administrators of the District Offices, as well as the supervisors and social workers, for their openness and willingness to collaborate with the Ombudsman to improve child welfare practice.

The Board of Directors of the Maine Child Welfare Services Ombudsman, Ally Keppel, Allie McCormack, Maureen Boston, Virginia Marriner, and Katherine Knox for their support and dedication to our agency.

Even in cases where the Ombudsman has disagreed with the Department's actions, it is never difficult to find positives in the work of child welfare social workers assigned to work with children and families. Whether it is to remove children from a home, inform parents that their rights are being terminated, or hear stories of horrific abuse directly from a child, social workers perform complex and challenging work every day.

The Ombudsman would like to take this opportunity to recognize in particular social workers who work with older youth in foster care. In the cases involving older youth reviewed this year, social workers have patiently developed relationships with youth who have serious mental health and behavioral issues and who are often in impossible situations. Social workers have followed children through homelessness, residential treatment, hospitalization, counseling, schools, and family and foster placements that often fail. This work is exhausting and important for these children, many of whom do not have family who can support them. This work is often thankless, and these social workers have given some small hope, friendship and comfort to children who have very little.

CHILD WELFARE OMBUDSMAN

P.O. Box 2057 • Hope, Maine 04847 • 1-866-621-0758 • 207-213-4773
EMAIL: ombudsman@cwombudsman.com • WEB: www.cwombudsman.com

Senator Libby

I had advocated for Sue and her children when DHHS built a case against Sue Wood. I helped her lawyer as best I could. I saw how DHHS operates by enlisting mental health providers as investigators and informants to build their case. Since these mental health providers are paid by DHHS these providers have a conflict of interest as a former director of Kennebec Valley Mental Health explained to me when he said, " Well they provide our funding." Sue's children were always clean, well-nourished with healthy food and did well in school. They were never abused physically or sexually until one of her children was physically abused in placement, but Sue lost her children. They were lovely well behaved and psychologically healthy. I was an LCSW at the time and Child Advocate for the State of Maine employed by the Department of Mental Health and Retardation. I was a mandated reporter and would never even have reported this case in the first place Sue's own therapist who knew the children would attest I'm sure. Sue lost her children supposedly because she was said to "parentified them." I recently mentioned this to a mental health provider who said she never heard of such a concept to remove children to terminate their parental rights. DHHS's handling of this case was a travesty of justice. Sue was not a perfect parent but who is? I was an LCSW and the only Child Advocate working for then DMHR at the time. Linda Breslin, former Director of AMHI knew Sue and her children and too thought this was a grave miscarriage of justice. This was a case that should never have been open. I saw so much worse than Sue's never investigated by DHHS. Resources spent on Sue's case. Instead of concentrating on cases like Sue's they should have concentrated on cases of real child endangerment. Cases I did report report were often ignored. I hope now they have a sense of priority. I suspect this could well be a problem today. Please bring Sue's case to the attention of President Senator Thibodeau.

James P. Breslin

451 Bassett Road Winslow, Maine

207 872 5469

jamesbreslin7843@gmail.com

Statement of James P. Breslin Retired LCSW and Child Advocate for DHHS, Division of Mental Health

I have Maters in Social Work from NYU and worked for 15 years in New York as Assistant Director of Staten Island Court Services doing evaluations and treatment relating to Child Abuse and Neglect as well Child Custody and Visitations, Family Violence, Delinquency. I also worked fifteen years for DHHS as a Child Advocate. I have had hundreds of opportunities to testify in court both in New York and Maine. I also served as a Guardian ad Litum in Maine. So for 30 years I was a mandated provider in 2 states with very similar stands of Child Neglect and Abuse. Sue Wood's Case was the most egregious case of misplaced attention by Child Protection I have ever encountered. I was very familiar with Sue and her children and worked on Sue's behalf to help her maintain custody of her children. Sue was a good mother but DHHS built a case against for emotional neglect based on a mental health fishing expedition that resulted in a finding that she "parentified" her children. I have had many opportunities to work with children and families. At least half of my professional contacts could be described the same way yet they never came to the attention of Child Protection at all. Many of us I venture to add could not withstand such scrutiny. I once talked to the director of as well respected agency who privately confessed when I raised this issue said that the bulk of his funding came from DHHS. Sue was not a perfect parent. Who is? She was a victim of trauma and neglect was but was I believe a good mother. Her children were well-groomed, well-nourished and were always attended to and protected. She helped them with homework and they were successful in school. They were well-behaved in all the many encounters I had with them. If we could learn for this situation I would conclude that DHHS should devote its resources on cases where the physical well-being of the child is most at risk and not on efforts to discover so-called emotional neglect. My wife, former Superintendent of AMHI who we had met by chance at the cinema remarked, when Sue identified herself as one of my clients, on what a conscientious mother Sue as well as a lovely person. She too was an LCSW And mandated provider.

unless tied to risk of physical harm.

James P Breslin

Speech before the GOC

Hello, my name is Sue Wood and I want to thank you for giving me the opportunity to speak before you today. There are two parts of what I want to address. My history relevant to: 1) the issue of immediate jeopardy and 2) the response to call ins and observations of jeopardy.

Child Protective services case was based on mental health issues that interfered with my ability to parent in an acceptable way. They never proved in the judge's final order that the children were physically abused, malnourished, or sexually abused in my care by me or that any past sexual abuse that they may have encountered was due to my negligence. I do believe however, that an extreme amount of state resources was spent to make a case against me. I believe these resources should have been spent not to build a case of emotional neglect but to focus on situations where REAL physical danger is an issue. I also believe Child Protective Services and its' attorney never showed that the children were physically at risk. Instead mental health providers cited history that was based on heresy and unproven history to build the case against me. I believe DHHS Child Protective Services nor the heavily subsidized mental health providers never recognized that I was experiencing trauma from a past marital relationship in which I was emotionally, physically, and sexually abused. In no case did any provider connect any emotional problems that the children may have had were due to this violent marriage. This was a classic case of blaming the victim. I believe it is very important that Child Protective Services focus on real physical endangerment rather than the VAUGE reports of anecdotal and heresy evidence that professionals use to make their case.

I hope the legislature can hold DHHS accountable for not prioritizing the most dangerous cases. If my experience can teach anything, I hope it can teach that.

Investigative Hearing DHS Child Protective Services

My name is B. Sue Wood. I am writing to share my story of what happened to me, in September, 20 years ago. Child Protective services tore my family apart and never reunited it. Instead of following the full letter of the law, the state took it upon themselves including the Judge who signed the order of terminating my rights, to violate federal statutes of reunification.

For the past 20 years not only has this gross error of misjustice destroyed my life forever, it has also affected my ability to financially improve my life. This has followed me and prevented me from gainful employment. I have an associate degree in mental health and human services. More than one job that I applied for has turned me away, due to the past irrevocable harm that the state of Maine has done to me.

My children were taken from me twice. The first time, Sen Libby Mitchell, Chuck Dow, the former attorney for the Attorney General at the time, Steven Rowe, were involved in the swift return of my children. I went through all the requirements that the state asked of me. My children returned home and the case against me was successfully closed.

The second time around, I was as not fortunate to be reunited with my family. Instead, they tore my family apart forever. This was all based upon heresy from a false police report filed by a neighbor as well as a presumption by a worker whose opinion was that I "ran my household like a gestapo camp", based solely on requesting my 7-year-old to make a peanut butter sandwich for me. It is my job as a parent to teach my children to become self-sufficient.

I had gone through a hysterectomy in July of 1998. I was told by my Doctor to have bed rest. The first week after my return from the hospital my children attending a sleep over camp for a week. The following weeks I maintained caring for my children.

I went on two separate occasions to be treated for internal bleeding. The Dr told me that if I returned a third time that I would be admitted having exploratory surgery to discover the cause of the bleeding. The reason I was bleeding was because I was taking care of my children. I could not physically afford to take them to the local YMCA during the summer for swimming, so instead, I carried 5/6-gallon jugs of water from my kitchen to the back porch to cool them off and make sure they enjoyed their summer vacation.

I did everything for my children. Even though, I was unable to work, I received a disability check and did my very best by them. They bathed daily, had clean clothes and nutritious food, as well as assistance with their homework every evening. On weekends we would visit friends as well as attend a local church. I went to food banks every opportunity that I was eligible as well as clothing banks. I went to lawn sales and economized the best I could to see that my children's needs were met.

They were my entire world. My life. I even hand sewed my own underwear and went without my needs to ensure that needs and some of the wants of my children were met.

I even called DHS CPS after my child was assaulted by another child residing at a group home to see if the negligent staff were still employed at the home. The answer I was given was they could not tell me. Also, a staff member of the same Oakland group home for foster children assaulted my daughter, Shera, while she was in state's custody.

My children may not have had a life of luxury, but they were well cared for, their needs were met and most importantly they knew they were loved. Because of one comment that snowballed, my children grew up believing the lies told about me from all the DHS CPS workers, their counselors, and everyone else involved. As a result, to this day, they want nothing to do with me. My first biological grandchild was born in April of 2017. I learned this thanks to Facebook.

I want my story to be told so that no other Mother could ever go through what I went through. Logan Marr was a young child that was killed at the hands of a former social worker for CPS. She was a foster child, that died, just like the recent death of the 10-year-old who was killed by her parents.

Governor Lepage said that we failed. We failed this little girl. The entire department and everyone involved failed. **I am here today to inform you that you ALL failed 20 years ago and you continue to fail.** Unless the laws are changed and people who work in the capacity of helping the children of the state of Maine change not only will more children die, but more families will be destroyed like mine was.

At the very least, I would like my case to be filed and removed permanently from my record. I have suffered enough. I was not allowed to assist a single parent last year by putting her child on and off the bus because of this horrendous error on your part.

I grew and learned from this experience. I have forgiven but never forgotten. There have been many times that I wanted to share my story since this all happened. I truly believe that now is the best time for me to speak. It will not bring my children home. Nor, will it repair the lost years that were stolen from me. My hope is that by being heard today that it will not happen again.

My upstairs neighbor at the time that this happened lived with her boyfriend. They had parties on a regular basis. They smoked pot so much that it reeked all the way downstairs to my front door. Her 2-year-old son who was naked, fell from a 2nd story window. This woman who clearly was not capable to properly care for her child, was able to keep her child.

My children were taken and never returned to me. Where is the justice in all of this? There is none. Just like the numerous reports made on behalf of the 10-year-old child who is no longer here. Something needs to drastically change, and it should have changed a LONG time ago.

I will also like for you to know that the woman who removed my children the first time, Kathryn Dix, refused my advocate, Jim Breslin, and I to review the case file on 3 separate occasions after the case had been closed. My children had already moved out of the state of Maine.

Kate Dix altered a document by adding to it at the bottom after I had signed it and was able to obtain my medical records that had absolutely nothing at all to do with this case. She did this during the time frame that I was going through a divorce with my children's father.

I was a victim of severe domestic violence in this marriage and even my attorney at that time, informed Ms. Dix that he felt she was on a "fishing expedition". He informed her that I was going through enough from the tumultuous marriage where I had been abused in every way as well as terrorized and had my life threatened when I tried to leave the marriage.

On three separate occasions when an appointment had been made to view my case file, upon calling to confirm the appointments, Ms. Dix was either not available by phone or there was some excuse why she could not meet with us. I believe the reason why is because that document was shredded shortly after the medical records were obtained illegally.

My case never should have been allowed to go as far as it did. I pray that one day justice will come for me and my family. Thank you for your time.

Sincerely,

B. Sue Wood

B. Sue Wood

Testimony

Government Oversight Committee

May 31, 2018

My name is Sandra Hodge, a resident of Brunswick, Maine. I retired from the Maine Department of Health and Human services after a 30 plus year career in child welfare, both in and out of State Government. I am testifying today to offer information to the committee on some of what we know and don't know about child maltreatment fatalities, based on research and evidenced base practice, and on what must occur to ensure that the work of the Maine child welfare program is informed by this research and practice knowledge. Child welfare work is as difficult and complex a process as it is critical for the well being of Maine's children. Not having the opportunity to review the two subject cases nor the Department's policies and procedures I cannot offer any opinions about whether the work in those cases reflected good practice but I can present some information on what constitutes good practice. Of note is the lack of good research in some critical areas of child welfare work.

When a child maltreatment fatality occurs there are usually several forums in which the case is reviewed such as internal to the child welfare agency, a legislative committee, the public and the press and in Maine and other states, a Child Death and Serious Injury Review Panel. Research has shown that in many of the cases reviewed there were many obvious risk factors and red flags not identified, understood nor acted upon by staff. The question becomes, if those risk factors and red flags were so obvious after the child died, why were they not so obvious and acted upon before the child died? One possible reason why this happens so frequently emerged from a nationwide study of 450 child welfare caseworkers that found a general lack of knowledge about the risk factors associated with child maltreatment fatalities. Another contributor to the failure to identify risk factors and red flags prior to a child death may be caseworker's and supervisor's own values and biases as they relate to personal views about family. Caseworkers and supervisors must work hard at identifying their values and biases so that they do not interfere with the accurate identification of risk. For example if a caseworker and or supervisor have been raised in a home where male members make all of the family decisions and that is experienced as the correct way for things to be, then the identification of dangerous controlling behavior in a family may not be identified as a risk factor. Both caseworker and supervisor must guard against using their own life experiences when assessing risk in families where child abuse and neglect may be occurring. There may also be the issue of a caseworker and/or supervisor assessing a parent or caregiver as invested in making necessary changes when that parent or caregiver agrees with what the caseworker says and even agrees to accept services but

no behavior changes have been demonstrated. At times it may be difficult for some caseworkers and supervisors to identify significant risk factors in families that look like the caseworker's and supervisor's family. When there are multiple risk factors present, the interactions among them must be determined to accurately assess the increased level of risk posed by such interactions. Failure to accurately identify relevant risk factors and determine the impact of their interaction on a child's level of risk may result in a conceptualization of a case as being less lethal than it is. Critical to the accurate identification of risk is of course, knowledge of what the risk factors are that associated with child maltreatment deaths. There are a variety of of risk assessment tools and processes available to facilitate accurate assessment and conceptualization. There are also specialized training programs for supervisors to identify and control for their own and their caseworker's values resulting in a more accurate identification of risk factors.

There is debate in the child welfare field about the use of a strength based approach in response to reports of child abuse and neglect. There is no research that demonstrates that this approach is effective in this field. There has been no careful examination or discussion about how this approach allows caseworkers to safely balance the identification of and response to risk factors while providing services seen as supportive by the parents or caretakers. One problem that exists in the approach is the demonstrated practice of some staff to identify any strength of a parent or caregiver as "canceling out" any risk even when the two are not connected in any way. This is an area requiring more research.

Maine's and other states use of alternative response programs to reports of abuse and neglect is another type of program where the impact on child safety has not been the subject of rigorous research.

Again I want to state I do not have information about what actual practice and programs were involved in the two cases or in the Department in general.

Recommendations:

Ensure that all staff training and policies reflect the best research and evidenced based practice in the field.

Ensure that staff training is sufficient to prepare all levels of staff to carryout their responsibilities.

Multi-Disciplinary training should occur on a regular basis involving professionals with a role to play in cases of child abuse and neglect. Delivery of the training should be by a multi-disciplinary team. This includes training for mandated reporters.

Develop and disseminate any needed written protocols between professionals and agencies that share responsibility for responding to chid abuse and neglect.

Assess the adequacy of the casework supervisory function in the Department and address any needed changes to training, management support, and number of supervises.

Conduct an analysis and assessment of the Alternative Response System as it pertains to child safety and risk reduction

Explore and evaluate the implementation of a Child Centered/Child Safety approach in the Child Welfare System

Continue and expand a variety of case review activities with a goal of assessing the adequacy of casework and supervisory practice in order to ensure child safety and effective service delivery.

Review the efficacy of the Structured Decision Making model used at Intake

In any review of individual cases and programs, findings of needed changes are expected. These recommendations can be critical to the safety and well being of children so they carry significant importance and urgency. Of equal importance are the recommendations that ensure that the many dedicated and hard working staff at all levels of the Department have the necessary resources necessary to carry out their critical responsibilities.

Thank you for allowing me to speak with you today. I will be happy to answer any questions you may have.

Testimony to Government Oversight Committee

I am a foster parent and found the remarks and position Governor LePage shared with the GOC on May 31, 2018 to be spot on. I also testified before you that day to share my concerns over DHHS' rush to reunify at any cost. I am submitting this as my written testimony.

My foster daughter is an incredible 15 month old who after all the research I have done, is at high risk for neglect or even worse if she is reunified.

I have been aware from the beginning that this was a reunification case. And I understand and support that goal IF it is in the best interest for the child, however there also needs to be a clear distinction of what happens when this goal is NOT what is best. Some of the basic merits of the reunification process have been heavily abused and undermined.

My foster daughter currently has no control over the following red flags in her environment:

- My foster daughter has been in care for 14 of her 15 months of life and is not at the age where she can speak for herself.
- The birth mother terminated parental rights of two other children
- The birth mother is pregnant again, with twins
- The birth mother uses marijuana, and was allowed to self screen at home before her "random" drug tests for DHHS
- My foster daughter was removed from kinship care secondary to concerns for neglect
- The birth mother has mental health issues with continued poor attendance to mandatory counseling appointments
- A new boyfriend lives in the house with the birth mother (over the past month)
- The birth mother exhibits little to no interest when she leaves her child- no hug or goodbye is shared
- The birth mother cancelled 40% of supervised and unsupervised visits.

However the reunification process continues.

My foster daughter had one overnight visit, before the DHHS recommendation was made for a 3-month trial placement to begin on June 16, 2018. This recommendation was made during a court hearing. I might add, that the birth mother did not even appear at the court hearing; I was there though. Still the reunification plan continues.

At the point of the 3 month trial home placement, my foster daughter will have had only two overnights with her birth mother, 32 hours of supervised visits, and 30 hours of unsupervised visits. Essentially in the 8 months my foster daughter has been with me, she has seen for birth mother for the equivalent of only **4 and a half days**.

My foster daughter has become a part of my family, she is incredibly bonded with me and I with her. In my opinion, reunification is not what is best for her. She has thrived in my care.

I also want to extend my gratitude to Senators Diamond and Gratwick for their correspondence with me prior to the GOC Hearing.

I would be happy to offer any insight that could aid in the work of the GOC and supports the Governor's recommendations that DHHS not look to reunification as the only and ultimate goal in child placement.

Sincerely,
Ruth Lyons, Ph.D.

TESTIMONY OF PEGGY RICE, MAINE STATE EMPLOYEES ASSOCIATION, SEIU LOCAL 1989

BEFORE THE GOVERNMENT OVERSIGHT COMMITTEE

9 A.M. MAY 31, 2018, CROSS OFFICE BUILDING ROOM 220

REGARDING THE OPEGA REPORT "MAINE'S CHILD PROTECTION SYSTEM: A STUDY OF HOW THE SYSTEM FUNCTIONED IN TWO CASES OF CHILD DEATH BY ABUSE IN THE HOME"

Senator Katz, Representative Mastraccio, members of the Government Oversight Committee, my name is Peggy Rice. I am a retired social worker and caseworker for the Maine Department of Health and Human Services. I am speaking on behalf of my union, the Maine State Employees Association, Local 1989 of the Service Employees International Union. My union represents over 12,000 workers and retired workers in Maine, including workers employed by the Maine Department of Health and Human Services.

We are here today in support of a comprehensive investigation into the circumstances surrounding the deaths of Marissa Kennedy and Kendall Chick. The care and safety of all Maine children is our primary concern. As such, we encourage the implementation of high quality standards of practice for all workers, including Maine DHHS workers, contractors and mandated reporters who come into contact with Maine children.

Our members who work at Maine DHHS remain extremely concerned about the department's chronic public employee recruitment and retention problem. The turnover rate among intake workers, assessment workers and permanency workers within in the Office of Child and Family Services (OCFS) within Maine DHHS is high, averaging approximately 60 percent a year, according to our members. Caseloads of OCFS workers and the contracted workers in the Alternative Response Program (ARP) also are high – so high that many DHHS workers we represent say they are completely overwhelmed.

Many of the "potential areas for concern or improvement in the child protection system" listed in the OPEGA report are concerns we share. These areas include, but are not limited to, guidance and training for mandated reporters, a caseload and staffing that allows for timeliness of answering phone calls, timeliness and comprehensiveness of OCFS and ARP assessments of risk, and appropriateness of caseloads and adequacy of supervision and training of OCFS and ARP staff. A revolving staff, coupled with a workforce fractured between public workers and private contractors, can make it difficult to piece together the big picture necessary to keep Maine children safe and to protect them from dangerous situations.

For these reasons, we urge you to do everything within your power to address the public employee recruitment and retention problem at Maine DHHS, and to ensure that all OCFS

workers and all other workers in contact with Maine children have the training, tools and support necessary to provide quality public services. Please also ensure that the voice of OCFS workers is heard in both the ongoing investigations and in related policy making. Many Maine DHHS workers we represent feel as if their voices haven't been heard in management decisions relating to the delivery of child-protective services. They want to ensure high quality standards of practice are implemented at every turn. Thank you.

Maine Children's Alliance

Testimony of Claire Berkowitz,
Executive Director of the Maine Children's Alliance
Public Comment on the OPEGA Report on the Child Protection System: A Study of How the System Functioned in Two Cases of Child Death by Abuse in the Home
May 31, 2018

Senator Katz, Rep. Mastraccio and esteemed members of the Government Oversight Committee, my name is Claire Berkowitz and I am the Executive Director of the Maine Children's Alliance. The mission of our organization is to advocate for sound public policies and promote best practices that improve the lives of Maine children, youth and families. When we learned of the circumstances behind the deaths of Marissa Kennedy and Kendall Chick, we were heartbroken. Everyone in this room and beyond want to know what we can do to improve and strengthen our child welfare system. We all must answer those questions so that collectively we can keep this from happening to other Maine children.

We can honor the lives of Marissa and Kendall by taking an honest, open look into the system within which these girls should have been protected. And without looking for scapegoats or quick fixes that make us feel better in the short term, we can look at the flaws and missed opportunities in order to make policy and practice changes for the long term, so that we will not fail children in the future as we did these two girls. They deserve that commitment from us now, and so do all the other children who may be falling through the gaps as I speak.

However, we cannot wait until a criminal trial to learn from these cases. Children living today deserve to be safe in their homes and their rights should be prioritized over strict adherence to confidentiality laws or the rights of criminal defendants. As it states in the OPEGA report, "knowing some but not all of the details could easily lead to inaccurate perspectives and conclusions about what worked, and what did not, in the child protective system."[1]

In the 2016 Final Report released by the National Commission to Eliminate Child Abuse and Neglect Fatalities it states, "To build a 21st century child welfare system, we need a comprehensive public health approach premised on the importance of strong, integrated, and collective responsibility and coordinated action and measurement across agencies and states

[1] Maine's Child Protection System: A Study of How the System Functions in Two Cases of Child Death by Abuse in the Home. May 2018. Office of Program Evaluation & Government Accountability.

and within our communities."[2] We must ask ourselves, is Maine living up to that standard? I would argue that the answer at this time is sadly, "No."

The heart of child welfare work happens in the interactions between caseworkers, birth parents, foster parents, adoptive parents, relatives, friends, neighbors, court personnel, law enforcement, service providers and the children they all aim to assist. These exchanges have the most immediate and dramatic impact on children and their families. The nature of those interactions is significantly influenced by the laws, policies and cultural norms within which they occur.

While the OPEGA report provides some details about the execution of these policies and laws, the report does not provide a quantifying of the needs of the system to adequately serve our children. We can't just say that poor job performance was a factor in these deaths and move on. Best practice in quality improvement requires a systems analysis. Child protective work is labor intensive and to understand if the system is adequately staffed and resourced and working as it should, we need publicly available data on caseloads for both caseworkers and supervisors – within CPS and the Alternative Response Program contract agencies.

Child protective work is extremely difficult and demanding and essential for the well-being of our families and communities. CPS workers are the first responders to our children in crisis and they must be adequately trained, compensated, and supervised so that they can work to their highest potential. We can have nothing less for our children. But we don't know if a lack of support for these essential personnel, the state staff or the contracted workers performing assessments, contributed in any way to these fatalities. We must know that now so that we can make changes immediately to protect children today.

To bring about positive change, we, the public, need to know more about what happened, how proposed changes will be implemented, how much they will cost. And we need to be made aware of any unintended consequences. We can assume a lot of things from the OPEGA report by reading between the lines of the recommendations, but you can't make effective and informed policy changes based on assumptions.

For example, in the OPEGA report it states that DHHS has already made the following practice and process change, "Discontinuing Out of Home Safety Plans to mitigate risk related to the practice of agreeing to place a child outside of their parents' home(s) and place them with another caretaker without the court's oversight."

To better understand the implications of DHHS eliminating the practice of out of home safety plans, we need to know how many children are in safety plans and how this change would increase workloads in the court and child welfare system. Because if we understand that bullet

---

[2] Commission to Eliminate Child Abuse and Neglect Fatalities. (2016).
Within our reach: A national strategy to eliminate child abuse and neglect fatalities. Washington, DC: Government Printing Office. https://www.acf.hhs.gov/sites/default/files/cb/cecanf_final_report.pdf

point correctly, all of those out of home safety-planned kids will be coming into state custody through a court order. Is the system ready for that type of influx of children into state custody? And, do we have the resources to better support these court appointed placements? So, at MCA we reached out to OCFS staff to find out how many children are currently in a safety plan. Unfortunately, OCFS couldn't provide us with the data we requested because safety plan information is only in the narrative reports for a case and not entered into the trackable information system.

This is a critical time for Maine. We must work together to make changes that will protect our children. To do this, we need transparency from our state government. The rights of children to grow up without being fatally abused at the hands of their caretakers must allow us to find a path to understand what happened and why, despite confidentiality concerns. We need an explanation for the reason for each proposed change and how together this will rebuild the system that has shown itself to be unable to protect vulnerable children. We stand eager to work with state staff and elected officials to make needed changes right away.