Review Requests for GOC Consideration

March 2018		
Topic Area: Child Protective Services (administered by the Office of Child and Family Services at the Department of Health and Human Services)		
Possible Areas of Focus	**Covered by other OPEGA review topic?**	**Past or current efforts by others in this area?** (See Additional Information)

• Role of DHHS OCFS and any other government agencies in the reporting, handling and response to potential child abuse/neglect of Marissa Kennedy and Kendall Chick.
• Initial responses to potential child abuse/neglect situations
  o Mandatory reporting
  o Intake and screening of reports
  o Child safety assessments and determinations
• Actions on safety assessment findings
  o Provision of child and family supports and services
  o Case management including on-going monitoring of child safety
  o Protective custody actions and proceedings
  o Placements for children in protective custody
• Overall CPS system components
  o Communication, coordination and collaboration
  o Staffing and contracted resources
  o Laws, regulations, policies and procedures
  o Oversight of CPS system and activities and actions on identified areas for improvement
	OPEGA has some understanding of the CPS function and processes from two previous reviews related to this topic:
	• Review of Guardians *ad litem* (GAL) for Children in Child Protection Cases – report issued July 2006
	• Review of Children's Licensing and Investigation Services – report issued March 2017
		Maine Attorney General's Office is currently investigating and/or prosecuting potential crimes committed in recent child deaths.
		
		DHHS is currently conducting a comprehensive internal review of individual case and CPS process stemming from a recent child death.
		
		DHHS Annual Report on Child Protective Services for 2016 was issued in May 2017.
		
		US Department of Health and Human Services Administration for Children and Families issued a 2017 report from its periodic review of Maine Child and Family Services.
		
		Maine Child Welfare Services Ombudsman Program issued its most recent annual report in 2017.
		
		Maine Child Death and Serious Injury Review Panel's most recent report located on the internet is dated January 2015 and covers cases from 2010 – 2013.

Additional Information (OPEGA has conducted very limited research on this topic)

DHHS Child Protective Service (CPS) activities are authorized under Title 22 § 4001-4099-H, The Child and Family Services Protection Act. Section 4011-A addresses the reporting of suspected abuse and neglect to DHHS including specifying mandatory reporters and obligations of those reporters.

OCFS' Child Protective Intake Unit operates a statewide, toll-free hotline to receive reports of alleged child abuse/neglect. At the time of OPEGA's 2017 report on Children's Licensing, the hotline was staffed 24 hours a day, seven days a week by 28 staff that collected information from callers to determine the nature of the complaint and those involved.

OCFS' 2016 CPS Annual Report contains a variety of statistics on reports and child protective assessments for 2016 and prior years by county. According to the report, in calendar year 2016 DHHS received **18,630** referrals for Child Protective Services intervention in a family situation. When reports are received, a decision is made regarding whether or not the report contains allegations of abuse or neglect per Title 22. If not, the report is not assigned (determined "inappropriate") for intervention. During 2016, **7,463** reports were deemed "inappropriate" (screened out). When reports contain allegations that are "appropriate" for intervention, the report may be assigned for a child protective assessment, or assigned to an Alternative Response Program (ARP) if the allegations are considered to be of low to moderate severity. ARP services are provided by contracted private agencies. In 2016, **2,127** reports were assigned to a Contract Agency for alternative **r**esponse at the time of initial report and **8,279** reports involving **11,546** children were assigned to a caseworker for a child protective assessment. Of the **8277** assessments completed in 2016, **2268** resulted in a finding of abuse or neglect (substantiated or indicated). Substantiated findings are high severity, whereas indicated findings are of low/moderate severity.

OPEGA's 2006 report on Guardians *ad litem* for Children in Child Protection Cases includes a general description of the child protection process, particularly as it relates to court proceedings and the role of GALs. To take a child into protective custody, OCFS must get permission from the Court through a petition for a child protective order. In cases of imminent threat of serious harm to children, OCFS or law enforcement may request a Preliminary Protection Order to immediately take the child(ren) into custody. OPEGA noted in its report that it is judges, not OCFS, that make determinations about children entering protective custody. OCFS does not have the authority to take children into custody nor to insist that families accept services to reduce risks to children. Whenever a child is taken into custody, the Court appoints a GAL to independently represent the best interests of the child in the proceedings going forward. Statutory requirements with respect to GALs are covered in Title 22 § 4005.

The DHHS Commissioner told OPEGA the Department is currently conducting an internal case review in accordance with its policy *Child Death and Serious Injury Internal Case Review*. The policy requires that the case review be documented by the applicable Program Administrator within 30 days using a specified assessment tool. The policy allows another 30 days after the assessment tool is completed for the Regional Associate Director to review the case. The Commissioner explained the Department is also concurrently conducting a broader assessment of Department processes. The processes under review are both internal and related to DHHS interactions with community partners, schools, law enforcement, healthcare providers and other mandatory reporters, including, but not limited to, the areas of reporting, screening and assessment, casework and trauma informed practices, responding to fatalities and near fatalities, and collaborative responses to child abuse and neglect. The Commissioner expects to publicly release what he is able, when he is able, and to engage in robust discussion and significant action regarding process improvement.

Additional Information (cont.)

The Children's Bureau, within the U.S. Department of Health and Human Services' Administration for Children and Families, administers periodic reviews of states' child and family services programs under titles IV-B and IV-E of the Social Security Act. The Child and Family Services Reviews (CFSRs) are structured to help states identify strengths and areas needing improvement in their child welfare practices and programs as well as institute systemic changes that will improve child and family outcomes. The 2017 CFSR report for Maine addressed a range of child protective activities and systemic factors. The findings for the CFSR were based on:

- A statewide assessment prepared by Maine's Office of Child and Family Services (OCFS), and submitted to the Children's Bureau on February 8, 2017, analyzing the State's performance on specified outcomes and systemic factors in relation to federal requirements;
- The results of case reviews of 65 cases (40 foster care and 25 in-home cases) conducted via a State Conducted Case Review process across all 8 districts in Maine between April 1, 2017, and September 30, 2017; and
- Interviews and focus groups with a variety of state stakeholders and partners.

Ratings of strength or area needing improvement were assigned to 18 items related to safety, permanency and well-being outcomes and 18 additional systemic factors. Of the 18 items related to safety, permanency and well-being, 16 were rated as areas needing improvement to varying degrees. Of the 18 systemic factors, half were rated as strength and half as areas needing improvement.

The Maine Child Welfare Services Ombudsman Program is authorized by 22 M.R.S.A. § 4087-A, contracted directly with the Governor's Office and overseen by the Department of Administrative and Financial Services. The Ombudsman Program assists citizens with resolving concerns and complaints with Maine CPS and provides "neutral investigations of complaints brought forth against the Maine DHHS Office of Child and Family Services". The Ombudsman's 2017 annual report recommended that DHHS improve assessment practices and safety planning. The report also contained the recommendation that the Department develop clear kinship policies for later placement of children with relatives.

The Maine Child Death and Serious Injury Review Panel is a multidisciplinary team of professionals (medical, social services, law enforcement) established by state law in 1992 to conduct reviews of child fatalities and serious injuries to children, generally after a criminal investigation is completed. The Panel submits periodic reports of their reviews. The most recent publically available report is dated January 20, 2015 and covers cases from 2010-2013.

LEGISLATIVE SPONSOR: Representative Hymanson