Report of the Government Oversight Committee

131st Maine State Legislature

Second Regular Session

Frontline Perspectives in Child Protection as Catalysts for Reform

February 2024

SEN. CRAIG V. HICKMAN, SENATE CHAIR

REP. JESSICA L. FAY, HOUSE CHAIR

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SEN. RICHARD BENNETT
SEN. JILL C. DUSON
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REP. ANNE-MARIE MASTRACCIO
REP. H. SAWIN MILLETT, JR.

MAINE STATE LEGISLATURE
GOVERNMENT OVERSIGHT COMMITTEE

March 1, 2024

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Members of the 131st Maine Senate
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Augusta, Maine 04333

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Members of the 131st Maine House of Representatives
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The Honorable Joseph P. Baldacci, Senate Chair
The Honorable Michele Meyer, House Chair
Members of the 131st Committee on Health and Human Services
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The Honorable Jill Duson, Senate Chair
The Honorable Margaret Craven, House Chair
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Director Bobbi Johnson
Office of Child and Family Services
Maine Department of Health and Human Services
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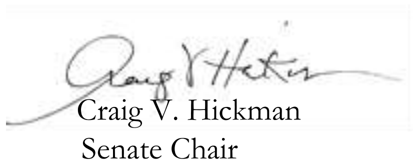
Augusta, Maine 04330

Dear Senators, Representatives, Health and Human Services Committee Chairs and Members, Blue Ribbon Study Commission Chairs and Members, Commissioner Lambrew, and Director Johnson:

On behalf of all of our colleagues on the Committee on Government Oversight of the 131st Maine State Legislature, we are pleased to transmit the following report: "Frontline Perspectives in Child Protection as Catalysts for Reform" (February 2024), which was adopted by a unanimous vote of those Members present on February 23, 2024. We offer this report for your consideration in the context of pending and future legislation, as well as internal Department reform initiatives. This report was developed following committee work sessions held since November 2023. For your reference, an Executive Summary may be found on page 5 of this report. We wish to emphasize that most of our recommendations received unanimous or nearly unanimous support among our Committee members, and we were greatly informed by those on the frontlines who were able to share with us their real-world experiences and vital perspectives.

Thank you for your attention to these matters.

Very truly yours,



Craig V. Hickman
Senate Chair

Jessica L. Fay
House Chair

cc: Members of the 131st Committee on Appropriations and Financial Affairs
Members of the 131st Committee on Judiciary
Members of the 131st Committee on Government Oversight

Enclosure: "Frontline Perspectives in Child Protection as Catalysts for Reform", A Report of the Committee on Government Oversight of the 131st Maine State Legislature (February 2024)

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Executive Summary

To those on the frontlines of child protection in Maine: We See You and We Hear You.

The Government Oversight Committee of the 131st Maine State Legislature conducted a series of work sessions from November 2023 to January 2024, with the goal of understanding from those on the frontlines of child protection in Maine the extent and nature of needed reforms. The Committee heard from case workers, Guardians ad Litem, resource (foster) families, biological parents, mandated reporters, and others. **It became clear that many in key roles are simply overwhelmed, and that the general state of Department staff burnout, turnover, and vacancies increases the risks of potential negative consequences for the safety and well-being of vulnerable Maine children.**

From the work sessions, the Committee coalesced around certain key conceptual goals for reform and then reached consensus on specific relevant recommendations (see page 6 for a summary list, and page 8 for brief narratives). Most of our recommendations received unanimous or nearly unanimous support from Members.

Stabilizing and supporting the child protection workforce is a critical and urgent need, and other needed reforms are unlikely to succeed or be sustainable otherwise.

Many if not most of our recommendations may be pursued by Department leadership without additional legislation. We encourage Department leaders to carefully consider the extent to which such action may be taken, if not already underway, with the benefit of their expertise and experience. The Committee is also mindful of pending legislation that may address some of these matters, directly or indirectly, and which are summarized beginning on page 38 of this report.

We further welcome progress updates from the responsible Department at regular and reasonable intervals. **The Legislature is in a better position to perform its independent role and provide needed assistance when there is complete candor by the responsible Department as to the nature and extent of conditions and challenges. We anticipate a renewed commitment to collaboration and consistent communication about implementation of improvements.**

The Committee welcomes and appreciates the attention to these matters by Members of the Maine State Legislature, the Committee on Health and Human Services, and Department leadership.

Recommendations of the Committee sorted by degree of consensus

Item		Current Bills	Vote of Committee[1]
Unanimous Recommendations			
Category: Front Line Staff			
A1	Recruit and retain more case aides.	LD 2097	Unanimous
A2	Address burnout, turnover, vacancies, and workload.		Unanimous
A3	Provide specific coaching/mentoring opportunities.		Unanimous
A4	Increase and enhance ongoing training opportunities, including job shadowing.		Unanimous
A5	Create special teams to deal with complex cases.		Unanimous
Category: Services for Families			
B2	Improve family team meetings.	LD 857	
Category: Resource Families and Other-Placement Support (Relative; Non-Relative; Other)			
D1	Ensure placement options exist other than in hotels or hospital emergency departments.		Unanimous
D2	Improve home-based therapeutic and other resource family (foster care) resources and supports.		Unanimous
D3	Expand financial support to resource (foster) families and ensure timely reimbursements for appropriate expenditures.		Unanimous
Category: Department Management, Plans, and Reporting			
E1	Task the new Department director with an improvement plan containing short, medium, and long-term strategies and metrics, with regular public updates on progress and challenges.		Unanimous
E2	Require outcomes data.	LD 50	Unanimous
E3	Require specific public reporting on any hospital, hotel, or Department office stays (age, length of stay, district).		Unanimous
E4	Improve culture and job satisfaction.		Unanimous
Category: The Courts			
F1	Improve Access to Courts for Children and Families.		Unanimous
F2	Improve Child and Family Access to Legal Services.		Unanimous
Category: Statute			
G1	Initiate a Review of Statutes Relevant to Child Protection.		Unanimous
Category: Technology			
H1	Fix issues with critical Department technology (Katahdin).		Unanimous
Category: Child Safety			
I3	Address Department struggles to determine the safety of children 1) at the beginning of involvement during child protective investigations and 2) when deciding whether or not to reunify children with their parents.		Unanimous
I4	Share Safety Science recommendations with stakeholders and implement systemic recommendations.		Unanimous
Recommendations with Bipartisan Majority			
Category: Child Safety			
I2	Make consultation with child abuse pediatricians more routine in the child protective intake process and investigations.		11 in support
I5	Join the National Center for Fatality Review and Prevention's Case Reporting System.		11 in support

[1] Votes are of those members present for the specific vote. The GOC is a 12-member, bipartisan, bicameral Committee with equal representation between the two major political parties. All affirmative votes are bipartisan by nature of the Committee's structure.

Item		Current Bills	Vote of Committee[1]
I1	Support the current child abuse pediatricians and hire more child abuse pediatricians through appropriate financial support from the state in addition to the pre-existing contract with the Department.		10 in support
Category: Department Management, Plans, and Reporting			
E5	Review and assess informal policies and practices.		10 in support
Category: Services for Families			
B3	Conduct an outside evaluation of the family team meeting model and create a structure for ongoing quality assurance monitoring.		10 in support
B1	Increase access to mental health, behavioral health, substance use disorder, domestic violence, and other services for families, as well as housing and transportation.	LD 50; LD 353; LD 907; LD 1236; LD 1494; LD 1506	9 in support
B4	Greater supports for new mothers with substance use disorder.		8 in support
B7	Implement the Nurse Family Partnership model of public health nursing to prevent child maltreatment.		8 in support
Category: Separate Office of Child and Family Services from the Department of Health and Human Services (or study this idea)			
C2	The Department should conduct a cost-benefit analysis and present a plan to committees of oversight with their position on Department restructuring.		8 in support

Items Considered that are not Recommendations of the Committee

Items Considered that are not Recommendations of the Committee			
Item		**Current Bills**	**Vote of Committee[2]**
Category: Services for Families			
B5	Increase access to low-barrier wraparound services, with peer support and flex funds		6 in support
B6	Expand financial assistance to low-income families		6 in support
Category: Separate Office of Child and Family Services from the Department of Health and Human Services (or study this idea)			
C1	Proceed to separation	LD 779	6 in support

[2] Votes are of those members present for the specific vote. The GOC is a 12-member, bipartisan, bicameral Committee with equal representation between the two major political parties. All affirmative votes are bipartisan by nature of the Committee's structure.

Recommendations in Detail

On January 26, 2024, the Committee took a series of "straw" votes to indicate the extent of conceptual Member support for the recommendations listed below, after some preliminary action to refine the list.[3]

These recommendations may be pursued through legislation or Department action. Legislation pending in the Second Regular Session of the 131st Legislature, relating directly or indirectly to child protective services, is summarized in Appendix A, and referenced at times by LD No. throughout Part I.[4]

A. Front Line Staff

With regard to stabilizing and supporting staff, the Committee recognizes that this is inherently a Department management function, and that it will be up to Department leadership to leverage existing authorized funds within appropriate procedures. Within that context, the Committee nevertheless urges that the following recommendations be pursued:

1. **Recruit and retain more case aides.**[5]
   (Unanimous Support of those Members Present) (See LD 2097)

   - The Committee heard consistently from case workers that they were required by necessity to handle a range of tasks which took vital time away from social work. These tasks included preparing certain documents for court, providing transportation for parents and children, and supervising children in hotels and emergency departments when other placement options were not available. The Committee also

[3] A recording of the January 26, 2024, GOC meeting may be found here: January 26, 2024 Committee Meeting. Specifically, from a list of proposed recommendations, one of the Chairs or another Member moved each "in" or "out", and offered amendments at times, which was then followed by Committee discussion and action. The recommendations listed in this report were those that were moved "in", including as amended, and then received a "straw" vote of the Committee to reflect relative support.

[4] Some Committee Members have sponsored or co-sponsored legislation currently pending. The vote tallies indicating conceptual support for the recommendations in this report are not intended to imply or represent final Member agreement with the terms of any legislation pending, which will be subject to the regular legislative process.

[5] One Member indicated he would extend this to case workers (increasing their numbers).

heard that the level of compensation offered case aides may be limiting interest in those positions.

2. **Address burnout, turnover, vacancies, and workload.**
(Unanimous Support of those Members Present)

- The Committee heard consistently from case workers that the workload was overwhelming and that this was continuing to be aggravated by frequent staff turnover, and the inability to recruit and retain additional workers for existing positions. As case workers continue to leave, those remaining are bearing an ever-increasing load, with negative cascading and compounding effects. It was also apparent that the minimal tenure and corresponding experience of so many existing caseworkers was far from ideal in confronting and addressing complex family situations.

3. **Provide specific coaching/mentoring opportunities.**[6]
(Unanimous Support of those Members Present)

- The Committee heard from case workers that guidance and assistance from others with more experience, including managers, was seen as vital, and was in shorter supply than it should be, including due to workloads.

4. **Increase and enhance ongoing training opportunities, including job shadowing.**
(Unanimous Support of those Members Present)

- The Committee heard that new case worker training was unrealistic and needed improvement and that there was a desire for more job shadowing early in the tenure of a case worker. Other initiatives should be pursued, as necessary and deemed appropriate.

5. **Create special teams to deal with complex cases.**
(Unanimous Support of those Members Present)

- The Committee urges the Department to increase and enhance multi-functional and cross-functional expertise in a manner best designed to engage in comprehensive and appropriate case management tailored to the needs of a child.

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[6] Two Members generally supported dedicating positions to this role, whether or not that required an increase in authorized positions. A number of Members emphasized that this should be addressed within existing authorized staffing levels.

B. Services for Families

1. **Increase access to mental health, behavioral health, substance use disorder, domestic violence, and other services for families, as well as housing and transportation.**
   (9 Members Support) (See LD 50; LD 353; LD 907; LD 1236; LD 1494; LD 1506)

   - The Committee heard from many on the frontlines that the availability of services and supports for families was falling short of the need, including at times when parents were subject to mandated timelines to take steps to address the very conditions resulting in the removal of children from the home, and to avoid potential termination of parental rights.

2. **Improve family team meetings.**
   (Unanimous Support of those Members Present) (See LD 857)

   - It was clear from the Committee work sessions that the family team meeting is an essential element of measuring and guiding progress toward family rehabilitation, and the Committee supports efforts to better ensure that this critical element functions effectively and meaningfully.

3. **Conduct an outside evaluation of the family team meeting model and create a structure for ongoing quality assurance monitoring.**
   (10 Members Support)

   - Please see the narrative under B.2., above.

4. **Greater supports for new mothers with substance use disorder.**
   (8 Members Support)

   - A number of the cases involving child fatalities under review by the Committee involved babies born (or even multiple babies born in succession) affected by substances. The Committee supports greater efforts to provide support to new mothers in this context.

5. **Increase access to low-barrier wraparound services, with peer support and flex funds.** (High-Fidelity Wraparound)
   (6 Members Support. **As such, this is <u>not</u> a recommendation of the Committee**).

   Please see: Intensive Care Coordination Using High Fidelity Wraparound (hhs.gov)

6. **Expand financial assistance to low-income families.**
   (6 Members Support. **As such, this is <u>not</u> a recommendation of the Committee**).
   (See LD 1877)

   - The Committee was divided on whether this was beyond the scope of the Committee's work. Among those in support, it was believed that this is an essential element of prevention to help avoid more families falling into crisis.

7. **Implement the Nurse Family Partnership model of public health nursing to prevent child maltreatment.**
   (8 Members Support)

   Please see, e.g.: Home Visiting Evidence of Effectiveness (hhs.gov)

C. Separate the Office of Child and Family Services from the Department of Health and Human Services (or study this idea)

1. **Proceed to separation.**
   (6 Members Support. **As such, this is not a recommendation of the Committee.**
   (See LD 779)

   - Among the points made by Members in support were the asserted futility and near-term inaction of waiting for yet another study, the lack of accountability, candor, and cooperation by responsible Department officials which forced the Committee to go to extraordinary lengths to demand accountability, that such an action would be seen as elevating the status and importance of child welfare as a priority, and that structural reform is vital and overdue.

- Among those in opposition, it was seen as an inefficient deployment of resources away from meeting immediate family needs and not fairly raised by the frontline perspectives received.

2. **The Department should conduct a cost-benefit analysis and present a plan to committees of oversight with their position on Department restructuring.**
(8 Members Support)

   - Following Committee Member discussion, this recommendation was revised to specify that the Department itself come forward with a plan describing the costs and benefits of taking or not taking such an action. Two Members suggested that their support was not intended to convey a lack of support for separation now.

D. Resource Families and Other-Placement Support (Relative; Non-Relative; Other)

1. **Ensure placement options exist other than in hotels or hospital emergency departments.**
(Unanimous Support of those Members Present)

   - The extent to which case workers and children were suffering from such placements was described vividly by many frontline workers, and was consistently cited as a key factor in staff burnout, turnover, and vacancies. The Committee believes it will be difficult if not impossible to achieve success with other reforms unless and until this situation is addressed.

2. **Improve home-based therapeutic and other resource family (foster care) resources and supports.**
(Unanimous Support of those Members Present)

   - The Committee heard from many resource (foster) parents, who shared their frustrations with how they were treated by the Department, including when and for what they were reimbursed, how they felt marginalized as a voice for the children in their care, and how the demands placed on them were frequently unreasonable.

3. **Expand financial support to resource (foster) families and ensure timely reimbursements for appropriate expenditures.**
(Unanimous Support of those Members Present)

   - Please see the narrative under D.2., above.

E. Department Management, Plans, and Reporting

1. **Task the new Department director with an improvement plan containing short, medium, and long-term strategies and metrics, with regular public updates on progress and challenges.**
(Unanimous Support of those Members Present)

    - It was well recognized by Committee Members that many of the negative conditions must be addressed by the Department leadership itself. It is vital that there be real, qualitative, and meaningful performance measures established, to drive Department improvement, to promote public confidence, and to permit the Legislative Branch to assist when needed. The Committee looks forward to a renewed commitment for candor, transparency, and accountability.
    - To the same end as the first bullet, the GOC requests that the Department develop a plan to improve child protection in Maine. The structure of this plan should include:
        - developing specific definitions of successful child protection in Maine;
        - detailing the obstacles that are in the way of achieving that success as well as factors that promote that success;
        - developing plans to remove the obstacles and/or enhance the factors that will move toward the definition of success.
        - It is imperative that the Department also include measurement of key metrics of *outcomes* that reflect the definitions of success rather than simply measuring the activities that are thought to be linked with that success.
        - Rational timeframes within which to expect to see results of the various activities should also be determined. The objective is to use the metrics to determine, as quickly as possible, if an activity is moving the Department toward success or not – and continuing, or scaling up those showing success; and discontinuing or changing the others.
        - The federal CFSR methodology may be a backbone structure for this effort, but the Committee is interested in greater specificity with respect to Maine's issues of child welfare than what may be linked to federal funding.
        - This overall plan should be presented to either the GOC or Committee of Jurisdiction (HHS) in stages – reflecting the development of the definitions of success, activities thought to be linked to that success, and then developing the key metrics with which to measure whether the activities chosen by the experts in the Department are working or not.
        - Once key metrics are decided, the GOC requests these updated measures be included in either the quarterly reports to the HHS Committee or a periodic (to be determined) update to the GOC.

    With this concerted effort, the GOC believes its Members, as well as those of the HHS Committee, will be in a better position to promote legislative changes or secure funding for pilot projects that could aid the Department and the State in achieving greater safety, well-being and permanency for children either involved with the child welfare system, or at risk of becoming involved.

2. **Require outcomes data.**
   (Unanimous Support of those Members Present) (See LD 50)

   - Among those supporting this recommendation it was expressed that obtaining answers on Department performance has been difficult and that better and more presentations of data readily accessible to the Legislature is desired.
   - Also, see narrative under E.1, above.

3. **Require specific public reporting on any hospital, hotel, or Department office stays (age of child, length of stay, district).**
   (Unanimous Support of those Members Present)

   - Please see the narrative under D.1., above.

4. **Improve culture and job satisfaction.**
   (Unanimous Support of those Members Present)

   - The Committee views this as an indispensable element of a management plan for addressing those areas in crisis, and to build a more stable and sustainable model for child protection.

5. **Review and assess informal policies and practices.**
   (10 Members Support)

   - Among those Members supporting this recommendation, it was expressed that an appropriate "Department culture" transformation would logically include an assessment of formal and informal practices, and eliminating those which may be identified as unhelpful. It was also noted here that a recent reply from the Department confirmed a lack of formal policy on whether and when confidential information may be shared with others. To the extent this results in the Department defaulting to less sharing with critical stakeholders in the varying systems of child protection than might be appropriate, that should be carefully assessed and reconsidered.

F. The Courts

1. **Improve Access to Courts for Children and Families.**
   (Unanimous Support of those Members Present)

- The Committee is mindful that it has not yet had an opportunity to obtain the perspectives of Judiciary leadership, itself, during the Committee work sessions held in recent months, but that some feedback was received from others working in child protection. In this vein, the Committee looks forward to further discussions and initiatives by responsible parties.

2. **Improve Child and Family Access to Legal Services.**
   (Unanimous Support of those Members Present)

   - Please see the narrative under F.1., above.

G. Statute

1. **Initiate a Review of Statutes Relevant to Child Protection.**
   (Unanimous Support of those Members Present)

   - Among those supporting this recommendation, it was recognized that this effort may not be feasible in the immediate term, but is nevertheless very important to pursue at some point.

H. Technology

1. **Fix issues with critical Department technology (Katahdin).**
   (Unanimous Support of those Members Present)

   - Quite a number of case workers and others, including the Child Welfare Ombudsman, expressed strong concerns about the Katahdin system's user interface, general ease of use, and/or effectiveness of data merges from the prior system. Some Committee Members also expressed reservations regarding the extent to which additional funds would be sought to fix a system that was not performing as expected, and that further processes would need to be engaged, including whether the contract with the vendor warranted any renegotiation or pursuit of other remedies.

I. Child Safety

1. **Support the current child abuse pediatricians and hire more child abuse pediatricians through appropriate financial support[7] from the state in addition to the pre-existing contract with the Department.**
   (10 Members Support)

   - The Committee heard from two medical professionals who have served as forensic experts in child abuse evaluation. It was clear that this is a vital role in helping to establish, at the earliest possible interval, whether a child is in danger.

2. **Make consultation with child abuse pediatricians more routine in the child protective intake process and investigations.**
   (11 Members Support)

   Please see narrative under I.1., above.

3. **Address Department struggles to determine the safety of children 1) at the beginning of involvement during child protective services investigations and 2) when deciding whether or not to reunify children with their parents.**
   (Unanimous Support of those Members Present)

   - The Committee has heard consistently from the Child Welfare Ombudsman that Department performance in these regards requires significant improvement.

4. **Share Safety Science recommendations with stakeholders and implement systemic recommendations.**
   (Unanimous Support of those Members Present)

   - Please see narrative under I.3., above.

5. **Join the National Center for Fatality Review and Prevention's Case Reporting System.**
   (11 Members Support)

   - Please see [Our Role – The National Center for Fatality Review and Prevention (ncfrp.org)]

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[7] What constitutes "appropriate financial support" will require further exploration through Department and legislative processes including possible MaineCare rate reform.

Summary of Committee Work Sessions[8]

January 5, 2024: Committee Members - Individual Priorities for Reform[9]

The following captures the number of Committee Members who provisionally indicated they were inclined to prioritize a particular reform, followed by their individual priorities as stated at the January 5, 2024, Committee Meeting.

Category Counts

9	Improve recruitment, retention, and support for front line staff
6	Invest more in services for families
5	Separate OCFS from DHHS (or study this idea)
4	Improve support for resource (foster) families
3	Management review of OCFS
3	Improve culture of OCFS
3	Improve / invest more in court system
3	Prioritize best interest of children in family reunification
3	Ensure residential placement options vs. hoteling & ER placements
2	Statute review
2	Review Katahdin

Senator Timberlake

1. Separate OCFS from DHHS and change the leadership
2. Revise Caseworker job description
3. Change OCFS culture/attitude
4. Establish family court system (Kentucky and Virginia examples)

Senator Bennett

1. Separate OCFS from DHHS
2. Fund more Case Aides and make the job more attractive
3. Address OCFS culture and improve communication
4. Family reunification: Address bias favoring mothers

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[8] The Committee also met on November 1, 2023 to plan the approach to the subsequent sessions. The recording of that meeting may be found here: November 1, 2023 Committee Meeting.

[9] The recording of the January 5th meeting may be found at the following link: January 5, 2023 Committee Meeting.

Representative Blier
1. Residential options for children otherwise placed in hotels or hospitals
2. Improve caseworker retention, address job dissatisfaction

Representative Mastraccio
1. Review & assess OCFS policy changes; improve practice & address district office variation
2. Promote retention of Caseworkers and Case Aides
3. Residential housing to eliminate hoteling and ER stays
4. Improve prevention services. Use opioid settlement funds for family intervention services pilot
5. Family court system
6. Put child safety first in family reunification [Later endorsed foster family rights statute review]

Representative Keim
1. Case Aide pilot program (emergency measure bill)
2. Market research on foster family needs, pay rates, etc.
3. Separate OCFS from DHHS, revise organizational structure, analyze administration needs to eliminate redundancy (Lean Six Sigma)
4. Invest upstream in family services, use opioid settlement funds

Representative Millett
1. Support Caseworkers with better training, hiring & retention. Career ladder. Team approach.
2. Improve support for foster families
3. Reunification: make safety of children top priority
4. Address workplace culture at OCFS
5. Put more resources into investigations
6. Further implement Safety Science and learning from tragedies
7. Consider a separate OCFS
8. IT review of Katahdin

Representative O'Neil
1. Invest in more prevention services, address Mental Health and Substance Use service needs
2. Court system investments
3. Support Caseworkers: vehicles, technology, Case Aides, coaching and mentoring
4. Specialization for complex cases

Senator Duson
1. Request that OCFS leadership create a management improvement plan with metrics (with input from Caseworkers and families); GOC to review periodically

Senator Tipping
1. Staffing: improve recruitment and retention

2. Reform Mental Health, Behavioral Health & Substance Use Disorder services systems and education to support families and foster prevention
3. Improve performance at handoff points

Representative Arata

1. Support Caseworkers' quality of life. More case aides.
2. Support residential options, transitional housing
3. Katahdin [OPEGA should look at state software procurement]
4. Study commission about removing OCFS from DHHS, explore administrative bottlenecks
5. Study impact of cannabis on child welfare

Representative Fay

1. Improve Caseworker job quality (training, pay, workload, team approach)
2. Support families with services before there's immediate risk of harm
3. More respect for Caseworkers and casework

Senator Hickman

1. Improve support for foster families
2. Review child welfare statutes, including for foster parent rights and child's best interest

December 13, 2023: The Committee heard from a range of frontline professionals, individual biological parents, and resource (foster) families[10]

Professionals

Mark Moran, LCSW, Chair of Maine Child Death and Serious Injury Review Panel

Opportunities to Improve Child Welfare Communication

1. Continue Family Team Meetings (FTMs) that include extended family members and service providers consistently throughout cases.
2. OCFS should proactively share information about children with education personnel (administrators, counselors, teachers) who are best positioned to monitor and support a child's safety.
3. Maine should join the National Center for Fatality Review and Prevention's Case Reporting System.

Recommended changes from the medical system perspective

1. Develop residential Behavioral Health Services for minors in emergency departments whose parents are unable or unwilling to care for them at home (but are not in OCFS custody).
2. Maine needs more child abuse pediatricians to accurately diagnose or exclude child maltreatment.
3. Maine should implement the Nurse Family Partnership model of public health nursing to prevent child maltreatment.

Top recommendations:

1. Address culture, workload, and staff turnover issues with OCFS frontline staff. Biggest issue is lack of work-life balance.
2. Improve consistency and quality of child safety investigations. Acknowledge that prevention is not always possible, and it is sometimes necessary to remove children from their parents.
3. Support case-specific and systemic child welfare reviews by various multidisciplinary groups in various settings to identify opportunities for improvement.

Dr. Amanda Brownell, Child Abuse Pediatrician and Medical Director at Spurwink Center for Safe & Healthy Families

1. Support the current child abuse pediatricians and hire more child abuse pediatricians through appropriate financial support from the state in addition to the pre-existing contract with DHHS.

[10] Written testimony may be found at the following link: December 13, 2023 Written Testimony. The recording of this meeting may be reviewed here: December 13, 2023 Committee Meeting.

2. Make consultation with child abuse pediatricians more routine in the child protective intake process and investigations.
3. Increase payment rates for child abuse evaluations.

Christine Alberi, Child Welfare Ombudsman

1. Address OCFS struggles to determine the safety of children 1) at the beginning of involvement during child protective investigations and 2) when deciding whether or not to reunify children with their parents.
2. Improve the availability of mental health services, substance abuse treatment, trauma informed services, domestic violence services, housing, and transportation.
3. Share Safety Science recommendations with all stakeholders and implement systemic recommendations.
4. Address Katahdin, the new child welfare database, which is difficult and time-consuming to use, especially for looking up family history.
5. Prioritize recruitment and retention of foster homes, both relative and non-relative resource homes.

Melissa Hackett, Maine Child Welfare Action Network

1. Strengthen and support the child protective workforce. Embed strategic consultation within the administration. Increase specialized office support staff, including dedicated positions for coaching and mentoring, legal secretaries, family team meeting facilitation, kinship and foster family support, visitation and transportation, and community services.
2. Expand low-barrier supportive services for families. Cash assistance, home visiting/public health nursing, aftercare services to prevent recurrence, behavioral health services, domestic violence services, substance use disorder treatment, peer support and flex funds.
3. Develop alternatives to hoteling and stays in offices. Identify kinship and resource families to provide respite for children coming into care.
4. Create a special unit in each district to review and manage complex cases with an interdisciplinary team approach.

Andrea Mancuso, Co-Chair of Maine Child Welfare Advisory Panel

1. Create an Office of Parent Counsel to strengthen the quality of representation appointed to parents in child welfare cases and ensure these legal professionals have the tools and resources they need to help their clients be successful and safe parents.
2. Offer the "Child Welfare Law Specialist" training and certification for attorneys, judicial officers and Guardians Ad Litem from the National Association of Counsel for Children and provide scholarships to interested attorneys.
3. Amend Title 22 to require the assignment of client directed attorneys to children age 10 and above in addition to Guardians Ad Litem (GALs).
4. OCFS should report quarterly on the number of children in custody who have stayed in hotels and in DHHS offices for more than six hours (age, length of stay, district).

5. Review the implementation of the Home Builders Program.
6. Align economic supports for parents, foster placements, and uncompensated visit supervisors. Update formal and informal policies and practices.
7. Conduct an outside evaluation of Maine's Family Team Meeting model and create a structure for ongoing quality assurance monitoring.

Ariel Piers-Gamble, Assistant Attorney General and Chief, Child Protection Division (did not make recommendations in her role)

1. Provided an overview of her office's structure and role in providing legal services in the realm of child protective services in Maine.
2. Noted that per statute, reunification efforts are mandatory for the Department but "cease reunification" decisions are discretionary for the Courts.
3. Described her office's representation on relevant panels, availability to provide relevant trainings, and participation in stakeholder groups in the context of policy development.
4. Observed the balances struck in current statute between the interests of children and parents.
5. Provided additional context to the Ombudsman's recent observation on the rate of judicial denial of preliminary protection orders, specifically, the lack of data on the extent to which any are amended or dismissed after a summary preliminary hearing, or how many requests are contemplated and not brought to Court.
6. Shared the challenges, found in other realms but also those distinct to this type of work, in maintaining necessary legal staffing, and that this extends to a range of court personnel and resources (e.g., trial time), as well.
7. Generally described her office's role in advising the Department on potential disclosures of child protection information to authorized recipients.

Biological Parents

Jamie Brooks

Shared her history:

Undiagnosed mental health issues.
Untreated substance use disorders.
Power and control dynamics.
Multi-generational conditions.

Suggested breaking the cycle is done with adequate services and support.
Stressed the importance of well-trained case workers to be "clear and kind".

Karen Tompkins

Karen Tompkins described her experiences as a parent who had received services in the past, and her role subsequently as a peer support for other parents. In addition to highlighting the challenges

associated with mental health and substance use disorders, she cited involvement with the child protective services system itself as a source of stress for families. She also read a letter on behalf of other parents which included the following:

> We collectively had a variety of experiences with child protective staff. Although not the norm, when we experienced positive relationships with caseworkers, there were common practices that made this possible. Most significantly, these caseworkers worked closely with our Family Teams (groups of our service providers and family/friend supports). They listened to the perspectives of other team members, and took those perspectives into consideration when making case decisions. The Family Team members who made the positive impact regularly told us that they wanted us to succeed in bringing our children back home.
>
> Resource parents who shared similar messages of hope also played an important role in successful reunification with our children. Some resource parents went out of their way to encourage and support our own growth and change, as well as caring for our children. A few of our relationships with resource parents were long lasting as they became true extended family. Peer support from other parents who had personally experienced the child protective system was a source of hope for those of us who had this service; those of us who did not have this support recognize it would have been helpful. Collectively, we agree that it is essential that parents are connected to somebody who provides unconditional positive support throughout the process.
>
> Many of the experiences that we did not find helpful were related to communication. Most of us did not understand what would happen next during our case, and when we asked, it was not explained in a way that made it easier to understand. It was hard not knowing what was going to happen, and this made it easier to imagine the worst-case scenario of losing custody of our children forever. While case workers are asked to give all parents a few documents when they first meet them that explains parents' rights and responsibilities, many parents aren't able [to] process what is being said after they are told their children are being removed. This information needs to be reviewed in subsequent visits when there may be more time for a conversation. Caseworkers get seven weeks of training to understand how the system works, but the vast majority of parents don't get any formal training, and they need their rights and responsibilities reviewed as many times as necessary. Expecting parents to learn how the system works on their own can make many issues more challenging, and make reunification less likely. Every parent should have access to training that explains their rights and responsibilities. Investing in peer support and educational services for parents can make a big difference.
>
> We preferred when our family teams were able to have hard conversations, sharing all the information they had with us, and telling the truth even when they thought there might be a strong reaction. We recommend that caseworkers and supervisors take the time to share whatever they can with families, tell them what they will be doing during the time it takes for a decision to be made, and help parents understand what they should be doing. Parents need transparency and to know what is going to happen, and it's important to help them understand the process and their responsibilities.
>
> Collectively, we had a variety of stressors in our lives that brought our families into contact with child protection. These included mental health issues, untreated substance use disorders (SUD), relationships with people who used violence to control us, and generational poverty. Each of our situations was unique and overwhelming, and getting services and support for the stressors in our

lives was critical. We needed care for our physical and mental health, and support to face old traumas from our own childhoods with honesty and courage. Some of us had Family Team members who helped us get resources for our children, addressed our housing situations with vouchers, and supported us as we juggled appointments and made life changes.

Some of the most important resources we received were not just formal services but opportunities: we first needed reliable income to meet our needs, and then a pathway to financial independence. Poverty is often mistaken for neglect, and it takes skill to know the difference. Many states have updated their definitions of neglect to clarify it as withholding a resource parents already have, not one that is absent in their household. We recommend investing in policies and programs that relieve immediate financial stress for families, while helping them build a path forward to new economic opportunities. We also recommend updating statute to clarify neglect as willful withholding, not a lack of financial resources.

It was equally important that everyone working with our families understood the other issues we were facing. Some of us experienced child protective staff or other providers who did not understand depression, and the deep mental obstacles that needed to be overcome in order to do the work. For some of us, our substance use increased initially when our children were removed, as a way to cope with the pain and grief we were experiencing. Some of us worried about how to pay for treatment, or didn't know about Medication Assisted Treatment (MAT). Substance use disorder touches many people, and relapse is not unusual. Things sometimes get worse before they got better, but people can and do change. A study by the U.S. Centers for Disease Control and Prevention showed that 75% of people with a substance use disorder find recovery.

Many parents want help, they just don't know how to ask, or they are fearful or feel shame. Access to mental health and recovery services are essential both during a crisis, and in order to maintain health over a lifetime. The current reality of long waitlists for services is not aligned with federal timelines for family reunification. We recommend developing more SUD and mental health recovery and treatment resources in every community, including more peer support services, and more opportunities to keep families safely together while parents are seeking treatment and making changes. Instead of expecting caseworkers to be experts in all of these topics, we also recommend establishing access for each district office to people who understand the issues of mental health, SUD recovery, domestic violence, and poverty.

Child removal causes lifelong trauma that affects the whole family, including parents, kids grandparents, and extended family, and can last for generations. Families don't have to stay in difficult places in their lives. We didn't stay there. The right support can help more parents make the changes needed to be the parents they want to be.

Thank you for your time and attention.

Resource (Foster) Families

Melanie Blair (See also "Unsupported", presented by Walk A Mile In Their Shoes, December 2023)

Communication – needs to be complete and honest to meet child needs and find correct

placement. This has not been satisfactory in her experience. Had a placement that resulted in violence by the placement toward one of her other children.
Negative Consequences for Challenging the Department.
High caseworker turnover – delays case resolution.
Reunification pursued at all costs.
Ombudsman does a fantastic job, but more ongoing oversight is needed.

Jessica Creedon

High caseworker turnover – who were bullied and mistreated for advocating.
Preservation of biological family is prioritized above foster family always.
More is needed from state above and beyond MaineCare for high needs children.
Adoption means less state support from State.
But if they do not adopt, the Department may place the child in a nursing home.

Deborah Hibbard Brito

Was adopted herself. Has a kinship placement.
Three main issues:

1. Re-traumatization from not following guidelines for parental rights termination.
2. Caseworker works for the parent, not the child. System should be child-centric.
3. Foster parents excluded from family team meetings. Need real information sharing.

Hannah Pelletier

Therapeutically licensed foster parent for 13 years.
Hoteling from the experience of a child and its negative impact.
There should be public data on numbers hoteling.
Lack of services.
Placement disruptions on top of removal from home and the negative consequences.
Not making good placement matches and supporting the available resource parents.
Kids with higher needs qualifying for higher rates and services, yet the home does not qualify for a therapeutic license, if home already has four kids under 16.
"Leveling" challenges. What care level is appropriate and lack of information about true level.
Parent's rights protected at expense of children's rights.
Ombudsman process takes longer than timeline when negative event takes its toll.
Nowhere else to go to challenge Department decisions, as a foster parent.

Ashley Pesek

Most of her kids have reactive attachment disorder.
Kids with dual system involvement (child protective and juvenile criminal)
Real change requires looking through all stakeholders' lenses.
Need to avoid unintended consequences in reform.
A totally overburdened system or series of systems.

Cited a case in which jeopardy was found by court on same day as reunification (trial home placement).
Cited other cases in which there were procedural and substantive shortcomings.
Hoteling children has many negative implications. Wildly inappropriate for child development and caseworker can no longer have neutrality with foster family who had to seek another placement.
Not all kids are prepared immediately to live with a family.
Placement waitlists and refusals.
Services not available in time needed to make a difference.
Cited one case in which there were thirteen placements in approximately as many months.
Need a place outside of a family at times. Understands the difficulties with group homes, but with hoteling and mismatched placements, trauma result.
Believes it is clinically inappropriate to have a child forced to be placed in a home at a time when that is what "sets their brain on fire."
Suggests some other kind of "supportive living."
She exceeds the number of placements to have a therapeutic license. But if children need the therapy, that needs to follow them to wherever they may be.
Permanency not being established timely. Cited one child in placements for nine years.
Caseloads too high.
Foster family attrition when feeling undervalued.
Waiting for court dates. Courts with inadequate trial time directing parties to make more agreements. May not be best outcome.
Systems beyond child welfare need reform.
Need plan for care gaps for foster parents.
More trauma training.

Deborah DeJulio

Foster parent for 23 years.
Has a therapeutic license.
"I'm done."
There is no support for foster families.
"We don't listen to foster parents—you are all biased."
Waiting too long to get into court.
Trauma to children during forced visits with biological parents.
"We know what they need. Can't get the services."
Biological parents need to work with the foster families, but most do not.
Foster Parent Bill of Rights does not really mean anything.
Travel restrictions create difficulties. Cannot take a child to Disney if parent vetoes it.

Stephanie Millette

Provides respite for teens who are in foster placements.
Shortage of foster homes for teenagers.
Uncertainty in placement makes for fragile placement. Child not knowing what is next.
There should be a "market" study of foster needs and foster placements before making a recommendation on what to do.
Resort to emergency rooms where services and placements lacking.

Dayna Pittiglio

Gave up foster license due to adopting child with complex medical needs.
Parents have all the rights and foster parents are seen as having an improper agenda.
Felt coerced and manipulated by the Department which made it hard to obtain services on child's behalf.
If a parent is unable to be safe around animals, they are not fit to be around children.
DHHS and Police information sharing needs improvement.

Ashley Collins

No longer accepting placements.
One placement remains unresolved four years later.
Case worker turnover in this case nine times.
Year long waitlist for services.
Not invited to family team meetings or provided information for first year.
Insufficient GAL visits.
Biological family rights are impacting child's needs and do not adequately consider foster perspectives.

Coreen Jurson

Children leaving system more traumatized than when entering.
Asked for help for a long time, but result was change in placement after 3 ½ years, which felt punitive. Given one hour, supervised "goodbye" visit (not even told it was "goodbye" at that time).
This was followed by an investigation of her.
She did clear her name.
Not sure what needs to change, but changes are needed.

Mary Jean Rumery

Feels she was lied to and abused by the Department.
Eventually was able to adopt children, but it was an ugly and too lengthy a process.
Feared for current placement.
Described differing treatment based on District.
Asserted that top leadership does/did not value foster parents (at least in one district).

Kelly Collins

Certified emergency room nurse.
Struggled to obtain services for foster placements.
Reunification process taking too long—increasing attachment disorder syndrome.
Foster parents need answers.

December 6, 2023: The Committee heard from Commissioner Lambrew and Then-Acting Director Bobbi Johnson[11]

Acting Office of Child and Family Services Director Johnson

Shared her work and personal history.
Intends to prioritize the well-being and empowerment of staff.
Looks forward to continuing to work with community partners and the Committee.

Department of Health and Human Services Commissioner Lambrew

Shares frustration that performance on some key measures has worsened; staff vacancies have increased. Caseworker concerns are being looked into.
There is no place in Department for a supervisor to pressure a worker to work without pay.
Changes in recent years are not keeping pace with new dynamics, including substance use disorder epidemic and high cost of living.
Believes the change in OCFS leadership offers opportunity for a re-set. Will seek empathy and listening skills, in addition to technical capability.
Commits to improving the culture, including to make caseworkers feel valued and supported.
Looks forward to reviewing the recommendations of the Committee.

[11] The recording of this meeting may be found at the following link: December 6, 2023 Committee Meeting.

November 29, 2023: The Committee heard from Former DHHS Child Protection Leader Peter Walsh[12]

Vision: Eliminate child abuse and neglect in three years

Double the resources including federal, state, private, and other sources.

Prioritize child welfare in all other human services agencies.

Greatly increase support to frontline staff.

Develop a new category of service provider called Child Safety Specialist.

Send an immediate response person on all calls that come into the hotline.

Double the salaries of frontline staff.

Strengthen the caseworker advisory committee.

Rename DHHS to the Department of Child and Family Services.

Transfer unrelated services to other departments.

Use existing state surplus: whatever is necessary to eliminate child abuse and neglect.

[12] A recording of this meeting may be found here: November 29, 2023 Committee Meeting. Mr. Walsh testified in the afternoon.

November 15, 2023: The Committee heard additional frontline perspectives[13]

Bethany Fournier – Resource Parent, Occupational Therapist and Executive Director of the Nonprofit Nanna's House

Ms. Fournier shared with the Committee her experiences working within a school district, and as a foster parent. She shared information on her nonprofit, Nanna's House, that aims to help ease the transition for children being placed into Foster Care. She hoped to create a home-style environment that a caseworker could bring a child to, and stated the nonprofit has a house ready to go but the Department responded by saying they did not think the idea was something that was needed or valuable.

Marsha Rogers – Retired CASA Guardian Ad Litem

Ms. Rogers shared her experiences with working with families as a Guardian Ad Litem (GAL) and as a Foster Parent. She noted times when a child who was not treated for the trauma of Foster Care had bad behaviors come out years later that affected their schooling abilities. She hoped that there could be plans for these children in the future to give them tools before the change of behavior happens to help prevent a negative outcome.

Sandra Hodge – Founding member of the Child Death and Serious Injury Review Panel, past Program Specialist for the Child Protective Services central office.

Ms. Hodge explained that the Child Death and Serious Injury Review Panel started as a mission to bring together the communities and resources within the state to bear on the issue of Child Abuse and Neglect. She added that there was a wonderful reservoir of information and experience that needs to be tapped.

Kerry Hewson – CASA Guardian Ad Litem and School Nurse

Ms. Hewson shared her experiences as a CASA GAL and a School Nurse. She shared disappointment in Maine for not asking for more grants to fund more resources for children within the schools. She suggested implementing a less complicated system so that it is easier for staff to collect data and easier for people to receive more resources.

[13] The recording of this meeting may be found here: November 15, 2023 Committee Meeting. The additional frontline perspectives were heard in the afternoon.

MaryAnne Spearin – Superintendent of Schools, Washington County

Ms. Spearin shared her experiences with children as a middle and high school principal for 10 years. She stated that the system's inadequate support of the health and wellness of the students and families makes educating those children more difficult when the basic needs of those kids are not being met. She noted families being on wait lists for services for over a years' time. She added that another area of concern would be the lack of communication between the Department and the school systems as it is a disjointed system of services for the greatest at-risk students. She stated that calling the report line sometimes does not bring fast enough results when a child is fearful of going home from school, so the school has started resorting to directly calling known caseworkers to ask for someone to come help. She strongly felt that the Department and the schools should work together in a collaborative way to figure out solutions for these students. She mentioned having responses while reporting stating that the children were too old to be helped and she thought it was wrong to suggest that kids of legal dropout age are past the cutoff for help.

Stacey Henson-Drake – Caseworker

Ms. Henson-Drake shared some statistics on her district being high in numbers of cases, crime and child deaths or serious injuries. She noted that there were multiple children within her district that have been housed in hotels for months requiring tons of mandatory overtime to staff the overnight hours. Ms. Henson-Drake stated that the starting pay for case aides is less than that of Burger King and that it was hard to find a qualified workforce at such an abysmal hourly rate. She stated that the pay of the caseworkers is okay but that it is the work life balance that makes it hard to keep the job. Ms. Henson-Drake stated that her local office communication was good, but that she had only met the then-Director Todd Landry twice. She noted there was no communication about what the state planned to alleviate some of the burden. Ms. Henson-Drake answered that she has been in this role since 2021, which makes her a veteran staffer.

Priscilla Girard – Guardian Ad Litem and LCSW

Ms. Girard shared her experiences as a GAL and her expertise of providing clinical assessments and serving as an expert witness for the Department, in processing the trauma that children have gone through.

November 8, 2023: The Committee heard frontline perspectives from a number of caseworkers, and others[14]

Maureen Cote, Caseworker

1. Workloads have continually increased, are not sustainable, and do not allow for adequate service to children and families.
2. Required overtime, especially overnight shifts caring for children in hotels or hospitals, are negatively affecting morale, well-being, and staff retention.
3. Compensation is not adequate to address increases in the cost of living, and staff are currently working without a contract.
4. Field training for new caseworkers is inadequate.

Diane McGonagle, Caseworker

1. Establish field training units in each district office. New caseworkers are guided by supervisors for only their first two investigations, which is not adequate.
2. Develop residential options for high-need children to put an end to hoteling.
3. Reduce mandatory and short-notice overtime.

Mandy Baird, Caseworker

1. Required overtime and hoteling children is a barrier to staff retention.
2. Caseworker workloads are too high.
3. Add staff to assist with administrative and legal tasks.

Sarah Ament, Caseworker

1. Heavy workload is unmanageable.
2. Wait times for services for parents in reunification are counterproductive to the process. Invest in more mental health and substance abuse treatment clinicians.
3. Court delays have a negative impact on ability to meet reunification timelines.
4. Staff should be paid more for mandatory overtime.

[14] The recording of this meeting may be found here: November 8, 2023 Committee Meeting. The written versions of testimony may be found at the following link: November 8, 2023 Written Testimony.

Rochelle Kadema, Caseworker

1. Overtime hoteling shifts are not voluntary.
2. Legal documentation expectations are burdensome; workers need more support.
3. Documenting case work in Katahdin is clunky, disorganized, and inconsistent across workers.

Dean Staffieri, President, Maine Service Employees Association. 28 Year Tenure in OCFS

1. Mandatory overtime expectations are unreasonable.
2. Katahdin, the child welfare information system, does not allow information to be efficiently saved and retrieved.
3. Constant shifting of policies and priorities makes it difficult for caseworkers and supervisors to develop expertise and hinders continuity and efficiency.
4. Lack of reliable transportation services, parent-child visitation supervisors, and residential treatment options for the most vulnerable children are significant obstacles.
5. There are not enough mental health clinicians to meet families' needs.
6. Inadequate staff recruitment and retention contribute to unmanageable workloads.

Former Senator Mike Carpenter (current and longtime Guardian ad Litem)

1. 22 M.R.S. § 4002(10)(B) ("Serious mental or emotional injury or impairment now *or in the future…")* – the "drip drip drip" of harm over time
2. Problems with Katahdin system
3. Whether lack of pre-filing cooperation could be grounds for keeping an investigation open
4. Could a GAL be empowered to check in on a family post-case-closure or other resolution, at some interval in the future, as an added safeguard

Other Perspectives: Summary of representative frontline perspectives shared ith the OPEGA Director confidentially and without attribution[15]

The perspectives provided directly to the OPEGA Director were generally consistent with those provided directly to the Committee, and centered on:

- Hoteling and Emergency Room Coverage
- Availability of Resource (Foster) Family Placements
- Availability of Services (Mental and Behavioral Health, Substance Use, Other)
- Other residential options for some children hard to place or in immediate need following removal
- Case worker burnout, turnover, and vacancies
- Mandatory overtime; pressure to work uncompensated
- New case worker training (more job shadowing desired)
- Katahdin (IT system) functionality, user interface, and data merge from MACWIS
- Leadership support and understanding and consideration of frontline conditions and perspectives
- Support and resources ($) for foster families, reasonable expectations, and a greater voice in a child "best interest"-centered process
- Need for better data on outcomes, not just outputs
- Learn from negative events and share lessons learned with frontline
- Ability of OCFS to meet mission
- Structured Decision Making and whether case workers still have room for discretion and judgment
- More support for transportation, legal paperwork, and other matters freeing case workers to focus on investigation and social work
- After hours (night shift staffing) not yet realized
- Whether foster families may have greater access to information about case plans and statuses
- Better early intervention/prevention

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[15] In an effort to facilitate the Committee's direct review of these matters, the OPEGA Director assisted in identifying and interviewing frontline professionals who later spoke on the record to the Committee or privately with the OPEGA Director. The OPEGA Director provided other facilitation in his role as lead support for the Committee, including in tracking and helping assemble the elements of this report. This report is not the product of any OPEGA analysis or evaluation. The views expressed are those of the Committee, individual Members, or individuals offering perspectives in connection with the Committee's review. Relevant work performed by OPEGA at the direction of the Committee is summarized in Appendix C of this report.

- Better risk assessment
- There are different types of case workers, and at times there are equity concerns over pay incentives for some and not others; there are also times when the Department is competing with itself when case workers are incentivized to take jobs elsewhere in the Department (e.g., Adult Protective).
- Older youth "aging out" without adequate support.
- Ever growing impact of drugs
- More and better coordination with other elements involved in child protection, and interdisciplinary teams
- Court schedules
- Compensation

Some additional observations from those sharing with the OPEGA Director ("Food for Thought")

From a Guardian ad Litem: Beware the false dichotomy that it is "parent's rights versus children's rights." The system needs to protect both. Some of these are Constitutional rights.

From a case worker: No plan of reform will succeed unless and until burnout, turnover, and vacancies are addressed. Hoteling and Emergency Room stays as they are occurring are not fair to kids and not fair to case workers.

From a parent's attorney who has also served as a GAL: The system is built on the false premise that there are services available, including available timely, and this is not the case, especially in more rural areas of the state.

From a number of case workers: Job shadowing is seen as key to better training of new case workers, including to provide realistic expectations about actual conditions to be faced.

From a community service provider: We must be clear about what outcome metrics define success for our child welfare system and the children and families engaged in services. For me, I would like to see a dashboard that outlines outcomes for core goals and operational functions:

- Safety of children referred to OCFS and those already in state custody.

- Wellbeing of children under OCFS custody – especially focused on educational progress, health care access, and psycho-social well-being and sense of safety and belonging for children.
- Permanency – not only the percentage of children that achieve permanency, but the placement history and speed to which permanency is achieved.
- Operational management outcomes for OCFS – metrics related to the structure, financing, management, and personnel outcomes from the Department. It would be helpful to be shown more early information about the financing and expenses, organizational charts, service spectrum and utilization, strategic priorities, and personnel recruitment and retention of staffing outcomes for OCFS.

Data and information should be presented and routinely discussed by the Administration, Legislature, and community stakeholders that allows for identification of system deficits and opportunities for improvements. Reforming a child welfare system cannot be solely based on the most horrific child death cases and should also not accept summaries not backed by specific evaluation metrics.

Appendix A: Legislation of interest as of 2/1/2024

LD #	Title	Summary	Sponsor	Committee Public Hearing/ Work Session
		CPS		
LD 50	An Act to Prevent Child Abuse and Neglect by Developing a System to Ensure Child and Family Well-being	This bill is a concept draft pursuant to Joint Rule 208. This bill, as emergency legislation, proposes to ensure that a forthcoming statewide child abuse and neglect prevention plan is developed and funded in order to provide access to services, develop resources for family stabilization and require outcomes data on the provision of services and resources.	Rep Meyer	HHS Carried Over
LD 500	An Act to Improve the Office of the Child Welfare Services Ombudsman	This bill is a concept draft pursuant to Joint Rule 208. This bill would make changes to the program established to provide ombudsman services to the children and families of the State regarding child welfare services provided by the Department of Health and Human Services.	Sen Keim	HHS Carried Over Public Hearing **1/31/24 ONTP**
LD 779	An Act to Create a Separate Department of Child and Family Services	This bill creates a new Department of Child and Family Services and transfers the functions of the Department of Health and Human Services that relate to child and family services and child welfare to the new department. The Department of Child and Family Services will have a commissioner appointed by the Governor and confirmed by the Legislature as is the current Commissioner of Health and Human Services. The bill also establishes provisions for transferring functions to the new department.	Sen Timberlake	HHS Carried Over Public Hearing 1/11/24
LD 857	An Act to Improve Family Team Meetings in Child Welfare Cases to Ensure Better Outcomes for Children by Providing Adequate Funding	This bill is a concept draft pursuant to Joint Rule 208. This bill proposes to enact measures to improve family team meetings in child welfare cases to ensure better outcomes for children by providing adequate funding to support the full implementation of family team meetings, including neutral facilitation at critical case points and training and coaching for all staff.	Sen Bailey	HHS Carried Over Public Hearing 1/16/24
LD 878	An Act to Improve Child Welfare	This bill is a concept draft pursuant to Joint Rule 208. This bill would improve child welfare by making changes to the child welfare system.	Sen Keim	HHS Carried Over
LD 1725	An Act to Strengthen Legislative Oversight of Government Agencies and Programs by Providing the GOC Access to Confidential Records.	This bill provides that the Government Oversight Committee may receive information and records that are privileged and confidential and that that information and those records are exempt from public disclosure.	Sen Hickman	State and Local Carried Over
LD 1788	An Act to Establish the Office of the Inspector General of Maine Child Protection	This bill establishes the Office of the Inspector General to investigate cases of death, serious injury and abuse or neglect of children in state custody or receiving child welfare or juvenile justice services.	Sen Baldacci	HHS Carried Over Public Hearing 1/11/24
LD 2049	An Act to Increase Safety for Child Welfare Services Workers	This bill exempts certain motor vehicles used regularly for work protecting the welfare of children from the requirement that state-owned vehicles display special registration plates.	Rep Stover	Transportation Public Hearing 2/1/24
LD 2095	An Act to Require Reporting of Child Abuse and Neglect to Military Family Advocacy	If an allegation of abuse or neglect of a child against a parent or legal guardian of a child is investigated, this bill requires the Department of Health and Human Services to	Sen Jackson	HHS Public Hearing **1/31/24 OTP-AM**

LD #	Title	Summary	Sponsor	Committee Public Hearing/ Work Session
	Programs	collect information concerning the military status of the parent or legal guardian and share information about the allegation with the appropriate military authorities. It also directs the department to negotiate a memorandum of understanding with family advocacy programs at military installations.		
LD 2097	Resolve, to Establish a Pilot Project to Alleviate the Staffing Crisis in the Child Protective Services System	This resolve directs the Department of Health and Human Services to increase staffing in the department's Office of Child and Family Services by developing and implementing a pilot project in the office for the recruitment and employment of case aides in the child protective services system for those areas of the child protective services system where there is the greatest need for assistance, as determined by the department. The pilot project must include a public recruitment campaign that targets retirees and other persons not in the workforce. The department is directed to submit a report addressing the implementation and effectiveness of the pilot project and making recommendations regarding further recruitment and employment efforts to the joint standing committee of the Legislature having jurisdiction over health and human services matters, which may submit legislation to the 132nd Legislature in 2025 to continue or expand the pilot project.	Sen Keim	HHS Public Hearing 1/31/24
		CPS Related		
LD 353	An Act Concerning Substance Use Disorder, Treatment, Recovery, Prevention and Education	This bill is a concept draft pursuant to Joint Rule 208. This bill would improve and expand treatment and recovery services for persons with substance use disorder, strengthen prevention efforts and modernize education requirements for clinicians.	Sen Farrin	HHS Carried Over Public Hearing 1/24/24
LD 653	An Act to Support Constitutionally Required Public Defense by Creating the Maine Office of Public Defense Services	This bill creates under the supervision of the Maine Commission on Indigent Legal Services the Maine Office of Public Defense Services, transfers the duties relating to the provision of legal services from the commission to the office and changes references to the executive director of the commission to the director of the office.	Sen Keim	Judiciary Carried Over
LD 907	An Act to Meet the Needs of Individuals with Severe Behavioral Health Diagnoses	This bill is a concept draft pursuant to Joint Rule 208. C-A (H-496): This amendment replaces the bill, which is a concept draft. It requires DHHS to establish a contingency fund to provide supplemental assistance for children and adults with severe behavioral health diagnoses when those needs are not otherwise met by existing state or federal programs. The fund is a nonlapsing fund, and expenditures are capped at $100,000 per fiscal year. The funds may be used to support additional staffing, enhanced reimbursement rates, physical accommodations or other identified needs. Expenditures from the fund must be used to supplement, not supplant, other departmental expenditures.	Rep Stover	HHS Carried Over
LD 1236	An Act to Increase the Provision of Children's Behavioral Health Services in Rural Areas and to Provide Support for Families of Children	This bill requires the Department of Health and Human Services to expand children's behavioral health services for children in families involved in the child welfare system in rural areas. C-A (H-495): This amendment changes the bill to a resolve. It removes requirements related to faculty team meetings	Rep Medigan	HHS Carried Over Work Session

LD #	Title	Summary	Sponsor	Committee Public Hearing/ Work Session
	Receiving Services	and reimbursement rates for Chapter 101: MaineCare Benefits Manual, Chapter III, Sections 28 and 65 services. It requires the Department of Health and Human Services to offer grants and incentives to providers to expand into rural areas to provide services to children and adults in families involved in the child welfare system. It provides an appropriation of $500,000 in each year of the biennium for this purpose.		
LD 1494	An Act to Help Address the Worker Shortage in Behavioral Health Care Services by Allowing Provisional Licensure and Providing for Reimbursement for Out-of-state Licensees	This bill requires the Board of Counseling Professionals Licensure to grant a provisional license for up to 90 days to a counseling professional licensed in another state or an applicant who has completed the requirements for licensure in this State upon receipt of an application for licensure.	Rep Crafts	HCIFS Carried Over **1/16/24 ONTP**
LD 1506	Resolve, Directing the Department of Health and Human Services to Study the Scarcity of Licensed Clinical Behavioral Health Professionals Across the State	This resolve requires the Department of Health and Human Services to convene a stakeholder group to review issues related to the training and recruitment of clinical behavioral health care professionals. The resolve requires the department to submit a report related to the study to the Joint Standing Committee on Health and Human Services and authorizes the committee to report out a bill relating to the report. C-A (H-209): It adds representatives of the Consumer Council System of Maine, the Department of Labor and the Department of Professional and Financial Regulation as members of the stakeholder group. It authorizes DHHS to contract for services to convene, facilitate and provide research for the stakeholder group. + other changes. S-A (S-185): This amendment removes the emergency preamble and emergency clause.	Rep Sargent	Health Coverage, Insurance & Financial Services Carried Over
LD 1877	An Act to Reduce the Number of Children Living in Deep Poverty by Adjusting Assistance for Low-income Families	This bill changes the policy goal of the provision of assistance to low-income families to allow those families to live with economic stability and secure access to health care, based on reliable market data. The bill adjusts the standard of need for assistance and the maximum amount of monthly assistance to a standard and amount based on the federal poverty level. The bill increases the pass-throughs of child support collections. The bill provides for a clothing allowance and payment for certain transportation support services and sets a lower limit on the amount of the special housing allowance for families receiving assistance under the Temporary Assistance for Needy Families program. The bill prohibits DHHS from requiring verification of the use of payments for support services.	Rep Meyer	HHS Carried Over Public Hearing 2/1/24
LD 1975	An Act to Implement a Statewide Public Health Response to Substance Use and Amend the Laws	This bill establishes the Substance Use, Health and Safety Fund in the Department of Health and Human Services. Money deposited in the fund must be used by the	Rep Crafts	HHS Carried Over Public Hearing

LD #	Title	Summary	Sponsor	Committee Public Hearing/ Work Session
	Governing Scheduled Drugs	department to oversee, approve and provide grants and funding to agencies, organizations and service providers, including the federally recognized Indian tribes in this State and service providers that are affiliated with federally recognized Indian tribes in this State, to increase voluntary access to community care for persons who need services related to substance use, as set forth in the bill. By June 30, 2024, and annually thereafter, the Legislature must appropriate to the fund an amount sufficient to fully fund the services as set forth in the bill. The bill repeals the laws that make possession of a schedule W, X, Y or Z drug and use of drug paraphernalia a crime. It also repeals the laws governing the civil violation of use of drug paraphernalia and possession with intent to use drug paraphernalia.		1/17/24
LD 2009	An Act to Prevent Abandonment of Children and Adults with Disabilities in Hospitals	This bill requires a hospital to discharge a minor or an adult with a disability who is under guardianship to the care of a parent or guardian no later than 48 hours after the attending physician has determined the minor or the adult with disabilities is safe for discharge, and if a parent or guardian does not take custody of the discharged minor or the discharged adult with a disability within that period, the hospital is required to notify child protective services or adult protective services, as appropriate, which must then take custody of the minor or the adult with a disability.	Rep Stewart	HHS Carried Over Public Hearing 1/16/24 Work Session **1/25/24 OTP-AM**
LD 2050	An Act to Expand Accreditation Options for Laboratories That Conduct Blood-alcohol or Drug Testing	Under current law, a laboratory certified under the federal Clinical Laboratory 14 Improvement Amendments of 1988 may test blood samples to determine blood-alcohol 15 level or the presence of a drug or drug metabolite. This bill adds an additional accreditation 16 option for laboratories	Rep Meyer	HHS Work Session **1/18/24 OTP**
LD 2082	An Act to Ensure the Financial Stability of Behavioral Health Services Providers and Housing Assistance Providers	This bill requires the Department of Health and Human Services to pay administrative expenses and interest charged on lines of credit or loans accessed by behavioral health services providers and housing assistance providers when a delay in department contract award, finalization or payments requires the provider to access the line of credit or loan.	Sen Bennett	HHS Public Hearing 1/24/24 Work Session 2/6/24
LD 2105	Resolve, to Protect and Enhance Access to Behavioral Health Services in Androscoggin County and Surrounding Communities	This resolve directs the Department of Health and Human Services to provide emergency funding to cover operating losses associated with providing acute behavioral health care services provided by St. Mary's Regional Medical Center in Lewiston to ensure that those services can be continued and expanded to meet urgent needs in Androscoggin County and surrounding communities while avoiding curtailment of other critically important health care services in the region. The resolve appropriates $10,000,000 in fiscal year 2024-25 for that purpose. The resolve provides that funds must be disbursed by July 1, 2024.	Sen Rotundo	HHS Public Hearing 1/24/24 Work Session 2/6/24

Appendix B: Supporting Documents

Nov 9, 2023 – Letter from OPEGA Director on behalf of the GOC to Commissioner Lambrew of DHHS on:

- Vehicles;
- Staffing;
- Exit interviews;
- Katahdin database management system; and
- Payments to resource families.
  https://legislature.maine.gov/doc/10753

Dec 6, 2023 – Response from Commissioner Lambrew: https://legislature.maine.gov/doc/10481

Dec 15, 2023 – Letter from OPEGA Director on behalf of the GOC to Acting Director Johnson of OCFS regarding:

- Children in Emergency Departments;
- Standards of information sharing with medical and educational personnel;
- MaineCare's Section 23 relating to child abuse assessment;
- Numbers of resource families;
- Remote work policies and data for OCFS; and
- Children in Hotels.
  https://legislature.maine.gov/doc/10754

Jan 26, 2024 – Response from now Director Johnson: https://legislature.maine.gov/doc/10703

Hotels Placements by Child, Month, and District. https://legislature.maine.gov/doc/10704

Emergency Department Stays by Month based on data required by LD 118.
https://legislature.maine.gov/doc/10705

January 26th Testimony of Direct Johnson: https://legislature.maine.gov/doc/10758

January 26th Testimony of Commissioner Lambrew: https://legislature.maine.gov/doc/10759

Jan 31, 2024 Letter from OPEGA Director on behalf of the GOC to OCFS Director Johnson asking for further detail regarding hospital and hotel stays by children.
https://legislature.maine.gov/doc/10755

Feb 8, 2024 – Response to Jan 31 letter from Commissioner Lambrew
https://legislature.maine.gov/doc/10756

Feb 8, 2024 – Letter from Commissioner Lambrew to Sen Hickman regarding reorganization of the Office of Child and Family Services: https://legislature.maine.gov/doc/10757

Appendix C: A Compendium: Oversight of Child Protection Services, 2018 – Present Conducted at the Direction of the Government Oversight Committee by the Office of Program Evaluation and Government Accountability

Since 2018, at the direction of GOC, OPEGA has undertaken a number of reviews and reported on a broad range of matters in the field of child protection services in Maine. The following pages present a list of OPEGA publications on child protectives services from 2018 – 2023, and include OPEGA's findings, recommendations, and other considerations for OCFS and the GOC. GOC meetings and public hearings to discuss these issues are detailed after each report summary.

2018	**Report regarding the cases of Marissa Kennedy and Kendall Chick**
Information Brief: Maine's Child Protection System – A Study of How the System Functioned in Two Cases of Child Death by Abuse in the Home	

OPEGA reviewed and analyzed records of entities involved with the cases of Marissa Kennedy and Kendall Chick. We also reviewed statutes, rules, policies and procedures, and obtained additional information through interviews.

OPEGA identified a number of potential areas of concern or improvement in the child protection system with the expectation that these observations will help inform the GOC and OPEGA in consideration of potential areas of focus for a broader review of Maine's Child Protection System. The potential areas OPEGA identified in no particular order of priority include:

- guidance and training for mandated reporters, including expectations for what constitutes "reason for suspicion" for those in various roles;
- timeliness of answering phone calls regarding potential child abuse and neglect by OCFS Intake workers via the statewide, toll-free number;
- 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;
- appropriateness of caseloads and adequacy of supervision and training of OCFS and ARP staff;
- compliance with policies and procedures, and consistency and appropriateness of decisions made, by caseworkers and supervisors in OCFS Central Intake and District Offices;
- compliance with contractual obligations, and consistency and appropriateness of decisions made, by ARP caseworkers and supervisors;
- 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;
- extent to which OCFS and ARP monitor whether families are participating in voluntary services intended to reduce the risk of child abuse and neglect and take action when they are not;
- extent to which mandated reporters, OCFS and ARP seek to verify, and can verify, information reported by a child's parents;

- 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; and
- extent and manner of communication and information exchange among the various key entities that are part of the child protection system including schools, law enforcement, health care providers, counselors and therapists, community service providers; OCFS Intake, OCFS Field Offices and ARP providers.

Discussion and GOC Actions:

- GOC Meeting 05-24-2018
    - GOC discussion of Information Brief Presented by OPEGA. https://legislature.maine.gov/doc/2335
- GOC Meeting 05-31-2018.
    - Public Comment on OPEGA Report: Gov LePage, Senators & Representatives from HHS Committee, various experts and members of the public. https://legislature.maine.gov/doc/2352
- GOC Meeting 06-14-2018.
    - Committee Discussion of Information Desired for June 28th Work Session https://legislature.maine.gov/doc/2364
- GOC Work Session 06-28-2018.
    - **GOC Passed motion to subpoena Commissioner of DHHS to appear before GOC. Passed motion to direct OPEGA to add a project to its workplan regarding perspectives of front-line CPS workers.** https://legislature.maine.gov/doc/2381
    - OPEGA's Areas of Concern & Potential Next Steps Document for 06-28-2018 GOC Work Session https://legislature.maine.gov/doc/2354
    - Additional Information Requested by GOC for their 6-28-2018 Work Session https://legislature.maine.gov/doc/2355
- GOC Meeting 07-10-2018.
    - Questioning of Commissioner Hamilton of DHHS appearing due to subpoena. https://legislature.maine.gov/doc/2382
- GOC Meeting 09-27-2018.
    - Review of Summary of legislation enacted during Second Special Session of the 128th Legislation related to child protective services. https://legislature.maine.gov/doc/2517

CPS-Related Legislation Enacted during the 2nd Special Session of the 128th Legislature:

- **LD 1920 – An Act to Modify the Expungement Requirements for Records under the Child and Family Services and Child Protection Act – P.L. 2017, c.472**
    - Current law governing records held by DHHS in connection with the department's child protective activities requires the department to maintain unsubstantiated child protective case records for no more than 18 months (except some unsubstantiated records related to certain persons eligible for Medicaid Services under the federal Social Security Act Title XIX which are retained for 5 years). Public Law 2017, chapter 472 increases that retention period to 5 years.
- **LD 1921 – An Act to Grant the Department of Health and Human Services Access to criminal History Information to Achieve the Purposes of the Child and Family Services and Child Protection Act – P.L. 2017, c.473**

- Current law authorizes DHHS to take appropriate actions to help prevent child abuse and protect the health and safety of children (22 MRSA §§4003 and 4004). Public Law 2017, chapter 473 adds to the list of those appropriate actions, the authority to request and receive certain confidential criminal history record information (and public criminal history information) from the Department of Public Safety as defined under the Criminal History Record Information Act (17 MRSA c. 7).

- **LD 1922 – An Act to Amend the Child and Family Services and Child Protection Act – P.L. 2017 c. 470**
    - Current law lists as a purpose of the Child Protection Act making family rehabilitation and reunification a priority as a means for protecting the welfare of children. Public Law 2017, chapter 470 amends this purpose statement to require DHHS to make reasonable efforts to rehabilitate and reunify families.
- **LD 1923 – An Act to Improve the Child Welfare System – P.L. 2017, c.471**
    - Provides funding to increase the daily reimbursement rates for the various categories of foster homes; 2. Provides funding to create a new Child Welfare Investigator position; 16 Human Services Casework Supervisor positions;
    - Regional Associate Director for Child Welfare positions; 16 Human Services Caseworker positions; and 8 Customer Representative Associate II positions within the Department of Health and Human Services, Office of Child and Family Services;
    - Provides funding for a $5 per wage-hour stipend payment for Caseworkers, Caseworker Supervisors, Assistant Program Administrators and Program Administrator positions;
    - Provides funding for a $1 per wage-hour stipend payment for Caseworkers, Caseworker Supervisors, Services Assistant Program Administrators and Program Administrator positions for those holding or obtaining a relevant master's degree;
    - Provides funding for the procurement of a pilot program to provide supportive visitation, including supervision of court-ordered visitation with the child's relatives and evaluation of parental capacity;
    - Provides funding for the procurement of clinical support and guidance of caseworker practice, including direct consultation with a clinician, training, staff functioning and debriefing;
    - Provides one-time funding for the development of a new comprehensive child welfare information system and directs the Department of Health and Human Services to conduct a needs analysis for its comprehensive child welfare information system, review possible solutions to meet those needs and purchase or develop a new system;
    - Requires the Department of Health and Human Services to contract for a 3rdparty independent rate study to develop a separate rate for MaineCare reimbursement for trauma-focused cognitive behavioral therapy to be billed under rule Chapter 101: MaineCare Benefits Manual, Section 65; and
    - Requires the department to report on the progress of the department in implementing the provisions of the legislation to the joint standing committee of the Legislature having jurisdiction over health and human services matters by January 31, 2019.

2019	Report Regarding OCFS Frontline Worker Perspectives

[Information Brief: Frontline Workers in the State Child Protective System – Perspectives on Factors That Impact Effectiveness and Efficiency of Child Protective Work]

OPEGA was assigned a special project by the GOC which aimed to understand the perspectives of frontline workers in the Office of Child and Family Services (OCFS). OPEGA obtained workers' perspectives in two ways. An online survey was sent to all assessment, permanency and intake caseworkers and supervisors. OPEGA received a total of 191 responses from the survey. After reviewing the responses, OPEGA created follow-up interview questions and interviewed 44 child protective staff. Those interviewed represented each of the eight OCFS districts and involved caseworkers, supervisors, program administrators and assistant program administrators.

The information brief was not designed to contain conclusions or recommendations, but described the perspectives of frontline workers in the following areas:

- The Nature of the Job
  - Off-hours Demands;
  - Work/Life Balance;
  - Secondary Trauma and Health Effects;
  - Worker Safety;
  - Training & Preparedness;
  - Additional Work Components such as Documentation, MACWIS, Court Preparation, Travel, and Administrative Tasks.
- State of Workload for Intake and the Districts
  - External Factors Related to Increased Workload;
  - Internal Factors Related to Increased Workload;
    - Reports previously assigned to ARP
    - Automatic assessments after three inappropriate reports
    - Add-on Reports
    - Structured Decision-Making (SDM) Tools
  - Changes in Practice
    - Out-of-Home Safety Planning no longer permitted
    - Team Decision-Making
    - Changes in the Family Plan / Child Plan
    - Recently implemented Supervisory Tool Kit
    - Supervisors in the Field Requirement
  - Implementation of Changes by the Organization
- Systemic Barriers
  - Lack of Placements for Children
  - Lack of Services
  - The Role of the Courts
- Impacts on the Quality of Work
  - Impact of High Workloads
  - Ability to Do the Work
  - Places for Children in Care (including "hoteling")
  - Policy and Practice Changes
  - Confidence in Decision-making
- Impacts on Frontline Workers
  - Workers Seeking Outside Employment

- Worker-Described Period of High Turnover in 2018
- What Could Help
- What Workers Want Legislators to Know

Discussion and GOC Actions:

- GOC Meeting 02-22-2019.
  - Discussion of Information Brief by OPEGA on Front-Line Worker Perspectives. https://legislature.maine.gov/doc/2870
- GOC Meeting 03-08-2019.
  - Public Comment on OPEGA Report 03-08-2019. Commissioner Lambrew, Charles Bicknell, Amy Cobb – OCFS Caseworker, Pamela Day, Brian Houston, Maine Children's Alliance, Jan Strout. https://legislature.maine.gov/doc/2909
- GOC Meeting 03-22-2019.
  - Potential Next Steps for CPS work: (Options included:
    1) Periodic updates from DHHS to GOC;
    2) Follow-up survey of OCFS Workers after implementation of changes described by DHHS;
    3) OPEGA's project on the workplan to Assess the status of current DHHS initiatives and their impact on previously noted areas of concern or improvement;
    4) OPEGA to review Out-of-Home Placements.)

  GOC passed a motion to put option 3 on hold.
  GOC passed a motion to put option 2 on OPEGA's workplan.
  GOC passed a motion to put option 4 on OPEGA's workplan.
  https://legislature.maine.gov/doc/2940
- GOC meeting 05-10-2019.
  - Minutes: https://legislature.maine.gov/doc/3098
  - Testimony from Commissioner Lambrew and Director Landry regarding OCFS' efforts to address concerns raised during system evaluations completed by OPEGA, the Ombudsman, and PCG's (Public Consulting Group) C.A.R.E. Project. https://legislature.maine.gov/doc/2954
  - C.A.R.E. Project recommendations: https://legislature.maine.gov/doc/2955
- GOC Meeting 08-14-2019.
  - Update on Child Protection Legislation from 129th Legislature:
    - **LD 192 – An Act to Require an Annual Report on the Activities of the Maine Child Welfare Advisory Panel – P.L. 2019, c.28**
      - The bill requires DHHS to submit an annual report to the HHS Committee on the activities of the Child Welfare Advisory Panel. The amendment removed a deadline for the annual report.
    - **LD 821 – An Act to Set Case Load Standards for the OCFS – P.L. 2019, c.34**
      - The bill requires DHHS to ensure caseworkers are not assigned cases exceeding a number established by department rule; the number must be recommended by a national organization with expertise in maximum caseloads; the number of caseworkers assigned to support staff must not exceed 8. The amendment replaces the bill and requires DHHS to review case load standards and develop recommendations with input from caseworkers and PCG. Requires

the department to submit a report by October 1, 2019 with findings and recommendations and submit an annual report on staffing in child welfare in relation to the case load recommendations; the reports are submitted to HHS Committee and GOC.

- GOC Meeting 09-23-2019.
  - Minutes: https://legislature.maine.gov/doc/3335
  - Testimony for Director Landry: Includes discussion of OCFS turnover improvement between 2018 and 2019, but at the same time caseloads are not decreasing due to increases in cases. Also includes an update on children in hotels and emergency rooms due to lack of placements. https://legislature.maine.gov/doc/3228
  - Presentation Slides from Director Landry: https://legislature.maine.gov/doc/3229
- GOC Meeting 10-15-2019.
  - Minutes: GOC discussed OPEGA Tracking Document for use in handing off the Child Protection work to the next GOC. **GOC passed a motion to remove from the OPEGA workplan, the project they put on hold on 03-22-2019.** https://legislature.maine.gov/doc/3613
  - OPEGA developed a child protection system improvements - oversight coordination/tracking document. https://legislature.maine.gov/doc/3333
  - OCFS produced a Child Welfare Caseload and Workload Analysis. https://legislature.maine.gov/doc/3332
- GOC Meeting 03-13-2020.
  - Minutes: Committee questions regarding Director Landry's testimony. https://legislature.maine.gov/doc/4630
  - Director Landry Testimony 03-13-2020: Presented recent statistics for New Assessments, Children in Care, Percent Exiting to Some Form of Permanency, Hotel and Emergency Department Stays. https://legislature.maine.gov/doc/4018
  - Presentation Slides from Director Landry: https://legislature.maine.gov/doc/4019

The Committee did not meet until November 2020 due to COVID-19 pandemic.

- GOC Meeting 03-26-2021
  - Minutes: Discussion of OPEGA memo recommending avenues by which the GOC could continue its oversight of CPS should they decide to. https://legislature.maine.gov/doc/6535
    - **GOC passed a motion to direct OPEGA to perform a follow-up survey of frontline child protective service workers, with the understanding the results of that survey may trigger future work related to out-of-home placements or other matters.**
    - OPEGA memo to GOC detailing prior history of CPS work and recommendation of possible avenues to continue oversight. https://legislature.maine.gov/doc/6380
- GOC Meeting 04-23-2021
  - Minutes: Questions for Director Landry after his presentation regarding the status of initiatives and the effect of the pandemic. https://legislature.maine.gov/doc/6707
  - Presentation by Director Landry: https://legislature.maine.gov/doc/6663
- GOC Meeting 07-14-2021
  - OPEGA Compendium of GOC and OPEGA Activities regarding the Child Protective System. https://legislature.maine.gov/doc/6918

- OPEGA Summary of Media reports regarding recent child deaths. https://legislature.maine.gov/doc/6923
- Minutes: https://legislature.maine.gov/doc/6958
  - Director Landry appeared before the Committee and answered questions regarding OCFS processes of assessment, the use of SDM tools, the workload analytic tool from PCG, and the upcoming Casey Family Programs methodology for case review. (Testimony attached to minutes)
  - Assistant Attorney General Lisa Marchese appeared before the Committee and discussed reasons associated with the confidentiality of case files during the adjudication and possible sentencing of prosecuted individuals.
  - Child Welfare Ombudsman Christine Alberi presented testimony to the Committee. (Testimony attached to minutes)
  - Both Senator Curry https://legislature.maine.gov/doc/6921 and Senator Diamond https://legislature.maine.gov/doc/6919 requested reviews of aspects of the Child Protection System. (Testimony attached to minutes)
  - **GOC passed a motion to add an immediate review to OPEGA's workplan for which OPEGA will provide a draft scope to be considered at their next meeting.**

- GOC Meeting 08-11-2021 Minutes: https://legislature.maine.gov/doc/7016
  - OPEGA presented a Proposed Scope of Work for evaluation of OCFS practices regarding investigations, reunification and an overview of the oversight of child protective services within the State. https://legislature.maine.gov/doc/6952
  - **The GOC passed a motion to approve OPEGA's scope with the following adjustments to Reporting items 3 and 4 (See page 3, Table 1,"Reporting):**
    - **3. Information Brief on Scope Area 3 by January 15, 2022,**
    - **4. Initial Evaluation Report on Scope Area 1 by March 15, 2022, and**
    - **5. Final Evaluation Report on, including Scope Area 2, by September 30, 2022.**
    - **The GOC directs OPEGA to prioritize the use of staff and adjust staff assignments to complete the work on the timeline the GOC has laid out.**
- GOC Meeting 09-08-2021 Minutes: https://legislature.maine.gov/doc/7421
  - Citizen Review Panels Bobbi Johnson https://legislature.maine.gov/doc/7024
  - MCWAP Presentation – Debra Dunlap https://legislature.maine.gov/doc/7025
  - CDSIRP Presentation – Mark Moran https://legislature.maine.gov/doc/7023
  - JCTF Presentation – Betsey Boardman (no copy)
- GOC Meeting 11-10-2021 Minutes: https://legislature.maine.gov/doc/7913
  - Presentation – Collaborative Safety, Casey Family Programs and the Office of Child and Family Services
    - Casey Family Programs / Collaborative Safety Report to OCFS https://legislature.maine.gov/doc/7420
    - Collaborative Safety Presentation to GOC https://legislature.maine.gov/doc/7429
    - Director Landry takes questions from the Committee
    - Child Welfare Ombudsman testimony to Committee https://legislature.maine.gov/doc/7425

2022	Report Regarding the System of Oversight of Maine's Child Protective Services

[Information Brief: Oversight of Maine's Child Protective Services]

OPEGA presented facts and background information to describe state and federal oversight of child protective services. There were 10 key lessons and observations highlighted in 5 categories:

1. **Current structure of oversight of DHHS/OCFS and child protective services broadly:**
   a. Child protective services as administered by DHHS/OCFS are subject to in-depth regulatory oversight by the federal government as well as advisory oversight from a network of state-level entities.
   b. Federal oversight is comprehensive and outcomes-oriented with financial penalties for nonconformity.
   c. State-level advisory oversight engages all three branches of government and both public and private sector stakeholders.
2. **Roles and responsibilities of the entities involved in child protective services oversight:**
   a. The roles and responsibilities of the different entities address both macro-level oversight of the system and micro-level review and oversight of specific CPS cases, including cases of death and serious injury.
   b. The four state-level panels and the Ombudsman have distinct missions, but there is a degree of overlap as well as nuanced differences in the scope of their activities.
3. **Information sharing between entities, including barriers or gaps:**
   a. Information is routinely and regularly shared among the state-oversight entities and DHHS/OCFS. This routine information sharing among the panels is often the result of individual panel members and DHHS/OCFS staff being members of more than one oversight entity.
   b. Work is currently being done by several of the state oversight entities to formalize and institutionalize information sharing practices to ensure continuity in information sharing over time.
4. **Best practices and models of oversight of child protective services:**
   a. The state-oversight entities, including the four panels and the Ombudsman, are structured in a manner, and are practicing in a manner, that generally conform to published best practices for entities overseeing child protective services.
   b. Several of the entities have recently made or are in the process of implementing changes to improve alignment with published best practices.
5. **Effectiveness of the structure of child protective services oversight. Without the benefit of a full evaluation, we cannot draw evaluative conclusions about effectiveness. However, based on the limited research for the Information Brief, we can say:**
   a. The oversight structure includes many opportunities for DHHS/OCFS to obtain multiple points of view and draw on the expertise of several professional disciplines engaged in child protection across the private sector and multiple levels and branches of government.

Discussion and GOC Actions:

- GOC Meeting 01-21-2022
  - Presentation Slides – Oversight Info Brief https://legislature.maine.gov/doc/7925
  - Minutes – Questions from the Committee https://legislature.maine.gov/doc/8133
- GOC Meeting 02-11-2022

- Minutes – https://legislature.maine.gov/doc/8371
- Public Comment on OPEGA Info Brief regarding CPS oversight – Betsey Grant, Bill Diamond, Victoria Vose, Christine Alberi, Molly Bogart https://legislature.maine.gov/doc/8139
- OPEGA provided an update on CPS bills in the HHS Committee https://legislature.maine.gov/doc/8137

- GOC Meeting 03-11-2022
  - Minutes https://legislature.maine.gov/doc/8491
  - Memo provided to GOC regarding summary of OPEGA Info Brief and relevant public comment https://legislature.maine.gov/doc/8372
    - Additional CFSR information requested by the Committee https://legislature.maine.gov/doc/8388
    - GOC work session on confidentiality statutes among various CPS oversight organizations https://legislature.maine.gov/doc/8375
  - Update to GOC on HHS Committee timeline from Senator Claxton, Senate Chair https://legislature.maine.gov/doc/8376

2022	Report Regarding Investigations in Child Protection Services

OPEGA Evaluation: Child Protective Services Investigations

OPEGA performed an evaluation of the processes for child welfare investigations at the Office of Child and Family Services with a focus of protecting child safety. Related below are the key takeaways followed by specific issues and recommendations for the agency and policy considerations for the Government Oversight Committee.

Common Misconceptions about Child Welfare

- There are a number of common misconceptions that limit individual and collective understanding of the realities of child welfare, which may lead to unreasonable expectations and missed opportunities for improvement. These misconceptions include the role and authority of OCFS and other key parties; the availability of timely, accurate, and complete information; and the causes and preventability of adverse outcomes. (See page 11.)

Child Welfare Philosophy and the "Pendulum Swing"

- There is a continuum of child welfare philosophies that emphasize child safety and family preservation to varying degrees. Child welfare practice at any given time may vary in response to the prevailing philosophy. Federal and state laws and policies have reflected both family-oriented and child safety principles, and have not substantially changed in several decades. In recent years, demands on the child welfare system have changed periodically as a result of elevated concerns caused by events like high-profile child deaths or unusually high numbers of children in state custody. Regardless of the prevailing child welfare philosophy at any one time, the initial investigation provides the basis for critical child safety decisions. (See page 14.)

Investigation Process Design

- Child abuse and neglect investigations are designed by OCFS to be comprehensive, employing structured tools to guide workers and supervisors to make decisions about child safety at several points throughout the course of the investigation. It is the goal of investigations that all threats to child safety be addressed, planned for, and/or resolved within a 35-day timeframe. The process, however, is lacking in guidance for sufficiency of investigation thoroughness and how to triage multiple cases and priorities. (See page 18.)

Training and Supervision of Caseworkers

- There is wide agreement that the training offered to new caseworkers has been insufficient to prepare them for investigations work. Over the past two years, OCFS has collaborated with the Cutler Institute of the Muskie School of Public Service to restructure the training, and a new course of training took effect in January 2022. (See page 28.)
- Supervisors have significant involvement in the training of new caseworkers, and they support a relatively inexperienced staff of caseworkers in the midst of relatively high turnover. (See page 33.)
- Supervisors are key to the investigations process. Supervisors assign investigations to caseworkers and monitor the whereabouts of caseworkers for safety purposes. They are involved in critical safety decisions at various points, and they provide support, mentoring, and oversight of investigations caseworkers throughout the investigations process. (See page 33.)

Quality Assurance Case Reviews

- OCFS's Quality Assurance Program performs ongoing case reviews. The reviews are conducted based on the federal Child and Family Services Review (CSFR) protocol. OCFS uses case reviews both during the federal CSFR period and on an ongoing basis as a tool for understanding and monitoring the quality of investigations of reported and alleged child abuse or neglect. The standards and expectations of the case review system are very high, and meeting them requires exceptionally thorough and comprehensive work to evaluate risks. (See page 34.)
- The QA case review results indicate a lack of overall thoroughness and completeness in investigations. However, we observed that caseworkers do generally appear to be thorough and complete in the assessment of the most critical and relevant risk and safety concerns, and the most critical and relevant individuals, with respect to the reported allegations. We attribute the lack of thorough and complete investigations to issues related to workload. (See page 36.)
- While infrequent, we observed several practice issues in the conduct of investigations that do not appear to be a function of workload challenges, but rather departures from expected practice. (See page 40.)

Perspectives on Elements Impacting Investigations

- OCFS staff reported that their workloads are unreasonable and that they do not have adequate time to understand risks to the child or the needs of the family. (See page 41.)
- Caseworkers reported that families are usually willing to engage with CPS during investigations, though they are sometimes unwilling to participate in services offered. (See page 45.)
- The sharing of medical and treatment information with OCFS appears to be a barrier to completing thorough and timely investigations. (See page 46.)

Family Perspectives and Service Needs

- Parents and children may experience a variety of reactions during a CPS investigation, including fear and confusion. Organizations that advocate for parents indicate that support for parents to assist in understanding and navigating a CPS investigation would be beneficial. (See page 49.)
- Access, availability, and engagement in services for families were concerns that emerged through interviews with OCFS management and other stakeholders, as well as in our surveys of caseworkers and supervisors, and in the results of the federal oversight of OCFS. (See page 51.)

Issues and Recommendations

OPEGA makes three recommendations for OCFS management's consideration. OPEGA recommends that OCFS:

1) Take steps to address the workload issue to ensure that caseworkers and supervisors have the time necessary to conduct thorough investigations and more effectively assess the safety risks to children and the needs of families; (Specifics on page 52.)
2) Evaluate the nature and extent of after-hours work requirements and expectations currently placed on caseworkers, and the risks to caseworker effectiveness and burnout; design and implement policy and program changes to address identified issues and risks; and consider restructuring the delivery of Children's Emergency Services to decreases or even eliminate required overnight shifts for caseworkers and supervisors; (Specifics on page 55.)

3) Build on the foundation of its existing QA system of case reviews to better identify specific practice concerns in a timely manner, within all OCFS districts, and link those concerns to opportunities for supervisor feedback, mentoring, and potentially additional training for individual caseworkers and other district staff. (Specifics on page 56.)

Policy Considerations

OPEGA recommends that OCFS, and the GOC as appropriate, consider the following additional areas noted, but not fully evaluated, in this review:

- **Training of new caseworkers and their transition into the field.** (See page 57.)
- **Caseworker access to medical records and treatment information.** Reluctance of parents' substance use and mental health providers to speak with caseworkers or share medical records can be a barrier to investigations. (See page 58.)
- **Services for children and families in the CPS system.** Mental health, substance use disorder treatment, in-home behavioral health services, and case management services appear to be inadequate in comparison to their need. (See page 59.)
- **Prevention of child abuse and neglect.** Child welfare practitioners describe three levels of prevention: (1) primary prevention, which is directed to the whole population, (2) secondary prevention, which is targeted to families experiencing risk factors, and (3) tertiary prevention, for families in which child abuse or neglect has already occurred. OCFS is primarily engaged at the level of tertiary prevention. Federal and state child welfare experts recommend that states invest in and coordinate efforts at all three levels of prevention. According to the U.S. Centers for Disease Control, the prevention of child abuse and neglect requires a comprehensive focus that crosscuts key sectors of society (for example, public health, education, social services, and the judicial system). (See page 59.)

Discussion and GOC Actions:

- GOC Meeting 03-25-2022
    - Minutes GOC questions regarding the report answered by OPEGA and additional questions to OCFS answered by Director Landry and Bobbi Johnson https://legislature.maine.gov/doc/8530
    - Investigations Report Slides – https://legislature.maine.gov/doc/8494
- GOC Meeting 04-08-2022
    - Public Comment CPS – Investigations: Senator Bill Diamond; Molly Bogart, DHHS; Laura Tomascik, resource parent; Melanie Blair, resource parent; Melissa Hackett Maine Children's Alliance & Maine Child Welfare Action Network; Richard Wexler, National Coalition for Child Protection Reform; Richard Hooks Wayman, resource parent and Volunteers of America Northern New England ; Tonya DiMillo. https://legislature.maine.gov/doc/8536
    - OPEGA summary of report recommendations and related legislation currently proposed. https://legislature.maine.gov/doc/8533
    - LD 960 130th 2nd Regular Session – An Act To Make Changes to the Laws Governing the Child Welfare Services Ombudsman Program P.L. 2021 c.550 https://legislature.maine.gov/doc/8532
    - DHHS/OCFS Responses to Questions posed by the GOC and HHS Committee on 03/25/22 https://legislature.maine.gov/doc/8535

- GOC Meeting 04-13-2022
    - Minutes https://legislature.maine.gov/doc/8631
    - OPEGA summary of Actions Suggested at 04-08-2022 Public Hearing https://legislature.maine.gov/doc/8548
    - USM / OCFS Caseworker Foundations Training document https://legislature.maine.gov/doc/8547
    - DHHS/OCFS Responses to Questions posed by the GOC and HHS Committee on 04/08/22 https://legislature.maine.gov/doc/8546
    - OPEGA update of CPS bills in the 130th Legislature https://legislature.maine.gov/doc/8545
    - Letter from HHS Committee to Director Landry requesting updates to specific questions raised as a result of OPEGA's evaluation of Investigations. https://legislature.maine.gov/doc/8544
    - OPEGA memo to GOC restating report conclusions and providing options to the Committee to address or further define CPS issues. https://legislature.maine.gov/doc/8543
- GOC Meeting 05-18-2022
    - Minutes https://legislature.maine.gov/doc/8632 includes conversation with AAG Chris Taub regarding "what ability the GOC has to meet in executive session to discuss otherwise confidential matters or documents that are not presently available to the committee as public elected officials." The Joint rules and statutes referred to in this discussion are in: https://legislature.maine.gov/doc/8597 .
    - GOC letter to OCFS relaying questions for the Office https://legislature.maine.gov/doc/8595
    - OCFS Response to GOC regarding specific questions (discussion with Bobbi Johnsons and Molly Bogart - in minutes) https://legislature.maine.gov/doc/8598
    - OPEGA provided legislative update on CPS issues to GOC https://legislature.maine.gov/doc/8596
- GOC Meeting 06-15-2022
    - Minutes. The discussion involving CPS was a continuation of the conversation with Bobbi Johnson and Molly Bogart answering GOC questions for OCFS. https://legislature.maine.gov/doc/8679
- GOC Meeting 07-20-2022
    - Minutes https://legislature.maine.gov/doc/9049
    - Second Public Comment Period on OPEGA's CPS – Investigations Evaluation: Melanie Blair; Rachel Grubb; Arleen Sue Carter; Bill Diamond; Jennifer Pieces; Jessica Beck; John and Johnna Morton; Les Cook; Kristine; Mary-Gene Rumery; Stephanie Gaddar; Marcia Rogers; Sarah Sue Wood; Melissa Hackett. Others are recorded in minutes. https://legislature.maine.gov/doc/8689
    - Update to GOC on OPEGA's work regarding "Reunification" Phase 3 of the scope approved in August of 2021. https://legislature.maine.gov/doc/8685
    - After discussion with OCFS, OPEGA provided the GOC with the type of information available in the confidential casefiles from OCFS. https://legislature.maine.gov/doc/8684
    - Memo to GOC from OPEGA providing more detailed information regarding media-reported child deaths where OCFS was involved. https://legislature.maine.gov/doc/8683

- Letter from AAG Gannon to Director Landry stating the opinion that confidential CPS records can be provided to OPEGA as the GOC's investigative arm, but not to the Committee directly. https://legislature.maine.gov/doc/8682
- Letter from OCFS – responses to questions from GOC at 06/15/2022 meeting https://legislature.maine.gov/doc/8681
- Presentation of SDM tools by Evident Change https://legislature.maine.gov/doc/8680
- **GOC passed a motion to have OPEGA continue it evaluation of phase 3 of the CPS scope: Reunification.**
- **GOC passed a motion to request casefiles to review in executive session**

- GOC Meeting 09-21-2022
  - Minutes. Discussion of Current Reunification work. Discussion of potential phase 4 projects. Discussion of OPEGA review of confidential casefiles. Discussion with counsel in executive session regarding response to DHHS refusal to provide confidential records directly to GOC. https://legislature.maine.gov/doc/9143
    - OPEGA future project recommendations in the realm of CPS https://legislature.maine.gov/doc/8940
    - Letter from DHHS Commissioner refusing request for confidential records https://legislature.maine.gov/doc/8939
  - **GOC passed a motion to direct OPEGA to do a "rapid review" of CPS casefiles with respect to 4 specific children's deaths. This put the Reunification work on hold.**
  - **GOC passed a motion to Subpoena the DHHS/CPS records – the casefiles (previously requested and denied) of the 4 children fatalities for the Government Oversight Committee to review in an Executive Session on October 19, 2022.**
  - Subpoena issued by GOC for confidential DHHS records to review in executive session https://legislature.maine.gov/doc/9121
  - DHHS subpoena response https://legislature.maine.gov/doc/9132
- GOC Meeting 01-13-2023
  - Minutes https://legislature.maine.gov/doc/9555
  - Superior Court denied GOC's motion to Compel https://legislature.maine.gov/doc/9464
  - GOC in executive session with counsel to discuss response.
  - **GOC passed a motion to move forward with an appeal of the Superior Court's decision.**
  - **GOC passed a motion to allow chairs and leads to be the liaison to Mr. Taub (counsel for GOC) for the appeal process.**

2023	Report Regarding Case of Hailey Goding

[OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Hailey Goding]

The Government Oversight Committee of the 130th Maine State Legislature directed OPEGA to review certain records generated by the Maine Department of Health and Human Services (DHHS or the Department), Office of Child and Family Services (OCFS) to better understand the safety decisions and actions taken by the Department during its involvement in the lives of four Maine children who died in 2021. This is the first of those four reports.

OPEGA's Overall Conclusion on OCFS Safety Decisions for Hailey Goding
OPEGA did not conclude that any OCFS safety decisions regarding Hailey Goding were unsound within the framework of the records we reviewed, interviews we conducted, agency policy and practice, and legal authority.

Potential Opportunities for Improvement
OPEGA identified two potential opportunities for improvement in the child protection system during our review of this case. The potential areas OPEGA identified, in no particular order of priority, include:

Establish a Central Resource for Substance-related Questions
During our review, we noted a lack of clarity regarding the resources, if any, child protective services workers might consult in an effort to validate or refute the likelihood that exposure to fentanyl in the manners asserted by Ms. Goding in May 2020 on behalf of herself and Hailey were scientifically possible. We believe that establishing such a resource would be beneficial to caseworkers in the future as they encounter various drug-related scenarios and may have questions about certain exposures, interactions, and presentations that may ultimately impact safety decisions.

Improve Service Availability and Enhance OCFS's Ability to Ensure Recommended Services Are Provided
In the wake of Hailey's May 2020 substance ingestion, the Department worked to improve Hailey's safety in the custody of her mother by making a series of initial referrals for mental health and substance use treatment and drug screens for Ms. Goding. Later, additional referrals were made for trauma counseling and case management services. Despite the efforts of the Department, ARP, a case manager, and even Ms. Goding herself, who had demonstrated a willingness to participate in such services, we observed that trauma counseling services were never established nor provided. From our work on this case and other child protective services reviews, we understand that there is a pronounced lack of available services that may vary based on the geographic location or the specific type of service sought.

Discussion and GOC Actions:

- GOC Meeting 02-10-2023
  - Minutes – Questions regarding the report answered by OPEGA. Additional questions to Director Landry of OCFS. https://legislature.maine.gov/doc/9876
  - "Reunification" project is paused. https://legislature.maine.gov/doc/9714
  - 2022 Child Welfare Ombudsman's Report https://legislature.maine.gov/doc/9711
  - OCFS provided its published response letter to the most recent Ombudsman's Report https://legislature.maine.gov/doc/9712

- GOC Meeting 03-10-2023
    - Minutes https://legislature.maine.gov/doc/9938
    - Public Testimony Regarding OPEGA Report: Michelle Ortega; Melanie Blair; Melissa Hackett; Letter from DHHS/OCFS in response to OPEGA report. https://legislature.maine.gov/doc/9929 Additional non-written testimony provided by Betsey Grant; Victoria Vose; Allison Porter; Brian Picciano; and Mark Moran (see minutes above).

2023	Report Regarding Case of Maddox Williams

OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Maddox Williams

The Government Oversight Committee of the 130th Maine State Legislature directed OPEGA to review certain records generated by the Maine Department of Health and Human Services (DHHS or the Department), Office of Child and Family Services (OCFS) to better understand the safety decisions and actions taken by the Department during its involvement in the lives of four Maine children who died in 2021. This is the second of those four reports.

OPEGA's Overall Conclusion on OCFS Safety Decisions for Maddox Williams

Overall, OPEGA concluded that OCFS safety decisions regarding Maddox Williams were not unsound within the legal, policy, and practice frameworks through which the Department must process its information.

OPEGA identified one Legal Issue, one Practice Issue, and one Resource Issue, all with corresponding recommendations; one Public Policy Consideration; and two Potential Opportunities for Improvement.

Legal Issue: Existing Process May Not Adequately Ensure Robust Documentation of Legal Justifications for Not Filing an Otherwise Statutorily Mandated TPR Petition

Recommendation:

OCFS should look to better formalize and more robustly document this specific decision in its process and system to prompt staff to make this decision according to the timeframe specified in statute in an effort to promote permanency for children in foster care.

Practice Issue: Custodial Arrangements Were Not Explored for All Children in the Home

Recommendation:

OCFS should provide guidance to supervisors and caseworkers on the practice of exploring custodial arrangements of the identified children in the household. Understanding the composition of the household, including any out of home parents and the corresponding custodial arrangements (such as when the child will be residing with the other parent), may be a means of obtaining information about the family and the potential risk and safety concerns. It also may be a means of gaining permission to interview or observe children during the course of an investigation, who are otherwise being prevented from being accessed by another parent. OCFS should reinforce this practice through communication and training of staff and amend the investigations policy and pursue any related forms, if necessary, to ensure this investigative task is always completed by caseworkers.

Resource Issue: Staff Vacancies May Impact Casework

Recommendation:

OCFS should conduct a comprehensive examination of CPS caseworker vacancies to identify and propose new strategies to recruit and retain staff. Resulting strategies should be specifically targeted and focused on child protective caseworker positions to address the staffing vacancies within this area of social work. This examination should include the following:

- continue to determine the underlying reasons for CPS caseworker vacancies through exit and stay interviews and how concerns of child protection caseworkers specifically may be alleviated;
- examine the fundamental structure of caseworker and supervisor jobs, and assess whether any restructuring would promote staff retention;
- explore changes to the retirement system and other incentives specific to child protective services casework to promote staff retention and longevity (The Department notes that the

work of OCFS field staff is substantially analogous to that of other first responders, including law enforcement, but these staff do not benefit from the same treatment in statute and policies.);

- examine the Department's current requirement that caseworkers be licensed social workers;
- work with the State Board of Social Worker Licensure to develop a means of getting otherwise qualified applicants the requirements they need to become licensed; and
- report back to the Legislature on the status of these efforts and the current number of vacancies.

Potential Opportunities for Improvement:

1) **Continue OCFS Research into Identifying Risk Factors Related to Targeted Children**
2) **Increase Availability of CODE Resources**

Public Policy Consideration: Persistent Disconnect Between Public Expectations for the CPS System and the Current Legal and Policy Framework and Capabilities of OCFS

Discussion and GOC Actions:

- GOC Meeting 04-14-2023
  - Minutes including questions to OPEGA and to Director Landry of OCFS https://legislature.maine.gov/doc/10043
  - DHHS revised memo regarding the timeline of the Maddox Williams Case https://legislature.maine.gov/doc/10032 Original memo is Appendix A of OPEGA Report (linked above).
- GOC Meeting 05-26-2023
  - Minutes https://legislature.maine.gov/doc/10192
  - Caseworker Table associated with Maddox Williams case: https://legislature.maine.gov/doc/10138
  - Maddox Williams case Visual Timeline: https://legislature.maine.gov/doc/10137
  - Public Comment on OPEGA Report: https://legislature.maine.gov/doc/10132 Christine Alberi; Betsey Grant; Bill Diamond; Melissa Hackett; Melanie Blair. Additional unwritten testimony by Victoria Vose, Maddox Williams' grandmother; and Mark Moran noted in Minutes (above)
- GOC Meeting 07-07-2023
  - Minutes including questions regarding the report to OPEGA and to Director Landry of OCFS https://legislature.maine.gov/doc/10217.
- GOC Meeting 10-18-2023
  - Minutes including discussions with Molly Bogart and Todd Landry regarding Customer Wait Times in DHHS and OCFS (pages 4-8) and further discussion of a media news report regarding Maine's most recent Annual Service & Progress Report (ASPR) and the GOC's desire to intensify their meeting schedule to provide recommendations for the full legislature by January. (pages 8-9) https://legislature.maine.gov/doc/10407 .
- GOC Meeting 11-01-2023
  - Discussion of strategies for the Committee to accomplish its work.
    The discussion revolved around a goal for the GOC to provide recommendations to the full Legislature regarding how to make the system of child protection better. The prevailing view was to hear from frontline workers of the system and use that information to inform further investigation. Prior work regarding frontline perspectives can be found in (Information Brief: Frontline Workers in the State Child

Protective System – Perspectives on Factors That Impact Effectiveness and Efficiency of Child Protective Work and OPEGA Evaluation: Child Protective Services Investigations). (See 11-08-2023 GOC meeting, below, for testimony from frontline workers.) Viewpoints from the courts were also desired by members of the Committee. Discussion continued regarding how to obtain testimony from front-line workers while ensuring their job security and protecting confidential information.

Approaching the problem from two perspectives was suggested: aspects to prevent families from entering the system in the first place along with improving the performance of the system once in it.

There were questions regarding how mandated reporters are responded to by the department. (See OPEGA Evaluation: Child Protective Services Investigations page 43 for survey results of mandated reporters.)

Another topic of conversation included questions regarding how often caseworkers and AAGs disagree on or don't align their opinions in CPS court cases. [OPEGA note: OPEGA interviews with caseworkers and supervisors reveal that CPS cases have numerous decision points which may move the trajectory of the case in one direction or another. Disagreements are common in certain cases but typically move to consensus as the jeopardy petition or TPR is prepared.]

It was noted that drug use is common in the cases studied. Members expressed concerns about the variability and adequacy of testing in the State. Why can some facilities test for fentanyl and others cannot?

There were questions regarding whether parents should be able to keep a caseworker from coming into their home to inspect their children once a parent has been found to have children that are at risk.

The meeting continued with a discussion of the most recent Annual Progress and Services Report (APSR) highlighted in a recent media report. OPEGA produced a compilation of historical APSRs. https://legislature.maine.gov/doc/10377 .

The GOC passed a motion to allow OPEGA to interview CPS staff about their experiences in the department. Minutes: https://legislature.maine.gov/doc/10456

- OPEGA staffing the Committee, provided a discussion power point: https://legislature.maine.gov/doc/10376 .
- OPEGA staffing the Committee, provided an APSR trend report https://legislature.maine.gov/doc/10377 .

- GOC Meeting 11-08-2023
  - Testimony from front-line CPS workers: https://legislature.maine.gov/doc/10439

	Maureen Cote, Diane McGonagle, Mindy Bard, Sara Ament, Sen. Michael Carpenter, Rochelle Kadema plus written testimony from Dean Staffieri (including testimony to HHS Committee 01/25/2022.)

2023	Report Regarding Case of Jaden Harding

[OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Jaden Harding]

Through our review of the larger history of CPS involvement, OPEGA identified:

- two unsound safety decisions in which we conclude that the facts of the case—as known at the time—warranted additional Departmental intervention to ensure the safety of the children in the home prior to Jaden's birth;
  - **Unsound Safety Decision 1:** No Additional Interventions or Safety Planning to Ensure the Safety of the Children (Prior to Jaden's Birth) from the Man Living in Ms. Hartley's Home (February 2020)
  - **Unsound Safety Decision 2:** No Additional Interventions or Safety Planning when Ms. Hartley's Out-of-State Relatives Leave Her Home (June 2020)

- two overarching practice issues that spanned multiple investigations and ultimately prevented the Department from making other necessary and appropriate safety decisions and taking related actions to ensure the safety of the children in the home prior to Jaden's birth;
  - **Overarching Practice Issue 1:** Important Connections Missed by OCFS Across Multiple Investigations Regarding the Risks Posed by Ms. Hartley's Relative (And Alleged Abuser of Her Children)
    - **Recommendation:** OCFS should develop a process and standard for identifying which families' CPS histories should be subject to a more comprehensive review. Additionally, OCFS should ensure that any staff assigned this work have the time and resources needed to conduct them.
  - **Overarching Practice Issue 2:** No Comprehensive Review of the Family's Prior CPS Involvement That Would Have Shown a Pattern of Ms. Hartley Allowing Unsafe Individuals Around Her Children

- eight practice issues that occurred during specific investigations that were both prior to and following the announcement of Ms. Hartley's pregnancy with Jaden;
  - **Practice Issue 1:** Extremely Overdue Investigation with Periods of No Investigative Activity (April 2018)
    - **Recommendation:** Although we did not review data that would enable us to quantify the impact of the 2018 policy changes on workloads, we would still recommend that the Department take a thoughtful, measured approach to future policy changes with a focus on potential workload impacts to avoid similar risks—especially as the Department experiences difficulties in the recruitment and retention of caseworkers
  - **Practice Issue 2:** Inadequate Efforts to Locate the Family (April 2018)
    - **Recommendation:** As the Department continues to update its investigations policy and any related documents, we recommend that the "Activities to Locate" tool continue to be used and caseworkers continue to be trained in its application.
  - **Practice Issue 3:** Incorrect Identification of Alleged Abuser by Intake (March 2019)
    - **Recommendation:** While we do not know the extent to which intake screening errors such as this occur, we do recommend that OCFS consider

implementing a mechanism into their existing process to denote instances in which intake—and not the referent—has identified a critical case member. In denoting these individuals, caseworkers may be more cognizant of the need to verify the accuracy of the identities provided solely by intake.

- **Practice Issue 4:** Reported Allegations and Safety Threats Unexplored by Caseworkers (April 2018, March 2019, and March 2020)
  - **Recommendation:** OCFS should clarify and communicate its expectations for what caseworkers should do when an "FYI report" that would otherwise be screened out is added to an open investigation. For other screened-in reports containing multiple allegations, supervisors should ensure that caseworkers, at a minimum, discuss all allegations with the parents/caregivers.
- **Practice Issue 5:** Inconsistent and Sometimes False Information Unexplored by Caseworker (February 2020 and March 2020)
  - **Recommendation:** OCFS should make efforts to communicate and reinforce its expectation that caseworkers identify and challenge inconsistencies in the information provided to them by families.
- **Practice Issue 6:** Status of Bangor Police Department Investigation Unexplored by Caseworker (February 2020 and March 2020)
  - **Recommendation:** Although we are unsure of the extent to which a scenario like this occurs, we believe that following up on the results and status of earlier criminal investigations can provide valuable information to caseworkers. As such, OCFS should consider developing guidance for closing summaries specifying how caseworkers are to document that there are ongoing criminal investigations at the time the investigation closes, and, also, establish expectations for what subsequent caseworkers are to do when they review that documentation in the future.
- **Practice Issue 7:** Installation of Child Safety Locks Not Verified by Caseworker (March 2020)
  - **Recommendation:** OCFS should consider the development of a process to ensure that any tasks identified as next steps to complete the investigation as part of the preliminary safety decision are revisited by the caseworker and supervisor prior to the closure of the investigation. Any steps that are determined to still be relevant, but not yet performed should be performed before the investigation is closed.
- **Practice Issue 8:** Mr. Harding's Safety Never Assessed (June 2020)
  - Recommendation: OCFS should consider revising its investigations process and related checklists to require caseworkers to confirm a family's living arrangements and all household members have been identified when nearing the end of an investigation to ensure that the safety of all individuals residing in the home with access to the family's children is assessed before the investigation is closed. This is particularly relevant as it appears the living arrangements and household compositions of the families that the Department works with can change often and sporadically.

- <u>one systems issue</u> that contributed to the Department not fully understanding the risk that Ms. Hartley's relative/alleged abuser of her children posed to the children (other than Jaden) at a later point in the timeline;
  - **Systems Issue 1:** Multiple Profiles for the Same Individual

        - **Recommendation:** Even with the improvements offered through the use of Katahdin, OCFS should establish appropriate search guidance to be used by caseworkers to mitigate the risks associated with multiple profiles. This guidance could include more thorough search criteria, such as adding a date of birth or social security number. The Department should also review its current guidance related to screening people into the Department's various systems to ensure that guidance outlines a process that appropriately addresses the risks associated with entering multiple profiles for a single individual.
- three potential opportunities for improvement.
    - Identify and Provide Appropriate Levels of Services for Families
    - Improve Information Sharing Between OCFS, Law Enforcement, and the Courts
    - Improve Feedback and Management Expectations

- GOC Meeting 11/15/2023
    - Presentation of OPEGA Report on the Case of Jaden Harding followed by continued testimony from Bobbi Johnson and Molly Bogart and then select front-line workers: Bethany Fournier – Resource Parent, Occupational Therapist and Executive Director of the Nonprofit Nanna's House; Masha Rogers – Retired CASA Guardian Ad Litem, District 7 + Foster Parent; Sandra Hodge – Founding member of the Child Death and Serious Injury Review Panel, past Program Specialist for the Child Protective Services central office; Kerry Hewson – CASA Guardian Ad Litem + School Nurse; MaryAnne Spearin – Superintendent of Schools, Washington County; Stacey Henson-Drake – Investigations Caseworker, District 3 OCFS; Priscilla Girard – Guardian Ad Litem + LCSW; https://legislature.maine.gov/doc/10479.
    - November 9th Letter from Committee to Commissioner of DHHS https://legislature.maine.gov/doc/10753 .
- GOC Meeting 11/29/2023
    - Public Testimony regarding OPEGA's report on Jaden Harding: Melanie Blair, Shawn Yardley, Mark Moran, Christine Alberi, Melissa Hackett https://legislature.maine.gov/doc/10462 .
    - OPEGA Document: House Composition over time – Mother of Jaden Harding https://legislature.maine.gov/doc/10452 .
    - Sen Hickman invited former child protection services leader, Peter Walsh to address the Committee.
    - Meeting Minutes https://legislature.maine.gov/doc/10748.
- GOC Meeting 12/06/2023
    - DHHS Commissioner's Response to Nov 9th Questions from the Government Oversight Committee: https://legislature.maine.gov/doc/10481 .
    - Discussion with Commissioner Lambrew and Acting Director Bobbi Johnson.
    - Meeting Minutes: https://legislature.maine.gov/doc/10749
- GOC Meeting 12/13/2023
    - The Committee heard from a range of frontline professionals, individual biological parents, and resource (foster) families. Written Testimony: https://legislature.maine.gov/doc/10505 .
    - Meeting Minutes: https://legislature.maine.gov/doc/10750 .
- GOC Meeting 01/05/2024 (Cancelled due to weather)

- GOC Meeting 01/12/2024
    - December 15th Letter from OPEGA Director on behalf of Committee to Acting Director Johnson of OCFS https://legislature.maine.gov/doc/10754 .
    - Handout on LD 779 from Sen Timberlake https://legislature.maine.gov/doc/10629
    - Meeting Minutes unavailable as yet.
- GOC Meeting 01/26/2024
    - OCFS Response to GOC letter from December 15th https://legislature.maine.gov/doc/10703 .
    - Testimony from Commissioner Lambrew https://legislature.maine.gov/doc/10759
    - Testimony from OCFS Director Johnson https://legislature.maine.gov/doc/10758
    - CPS Hotel Placement Info https://legislature.maine.gov/doc/10704
    - Emergency Dept Data required by LD 188 https://legislature.maine.gov/doc/10705
    - Meeting Minutes unavailable as yet.
- GOC Meeting 02/09/2024
    - January 31 Letter to Director Johnson of OCFS https://legislature.maine.gov/doc/10755
    - Memo to Sen Hickman from Commissioner Lambrew on February 8, 2024 https://legislature.maine.gov/doc/10757
    - Follow up information on hospital stays and "hoteling" from Commissioner Lambrew https://legislature.maine.gov/doc/10756 .
    - Meeting Minutes unavailable as yet.

2024	Report Regarding Reunification in Child Protection Services

Information Brief: Child Protective Services Reunification

For this report, OPEGA: (1) examined relevant Maine statutes, federal law, agency rules, and OCFS policies; (2) conducted a total of 58 interviews with OCFS staff members, stakeholders in the court process, biological and resource parent representatives, and others; and (3) assessed OCFS reunification work by analyzing existing quality assurance data. OPEGA examined the 235 case reviews conducted from April 2017 to March 2023 that had reunification as the child's permanency goal.

OPEGA identified four cross-cutting challenges that are prevalent in reunification casework.

1. **Caseworker practices concerns:**
   - Assessment of parent's substance use: Many cases did not meet the federal standard for regularly assessing parents' substance use. OCFS staff named caseworker inexperience and issues with drug screening as challenges contributing to this concern.
   - Caseworker engagement with family: Casework tended to fall short of expectations on assessments of caseworker conversations with parents about their needs and case planning goals, as well as facilitation of family team meetings. Staff said that inadequate training and job shadowing contribute to this deficiency.

2. **High workloads impacting safety, permanency, and well-being outcomes:**
   - Permanency caseworker vacancies: OCFS has struggled with high staff turnover and inability to fill vacant positions, with some district offices experiencing especially high vacancy rates. This causes high workloads and means that staff are relatively inexperienced, which contribute to many of the identified challenges.
   - Lack of support staff: Frontline staff reported that inadequate support with administrative and legal tasks exacerbates the challenge of high workloads and has a negative impact on casework quality.
   - Lack of visitation supervisors and transportation for families: OCFS contracts with agencies to provide supervision for parent and child visits, as well as transportation for families. Staff and parent representatives reported high demand and lack of availability of these crucial services.

3. **Waitlists for evaluations and treatment:**
   Case reviews and staff interviews suggest that progress toward reunification is often hindered by long waitlists for parents' required mental health evaluations, mental health treatment, and for substance use disorder treatment.

4. **Timeliness of termination of parental filings and other legal concerns:**
   Case reviews identified challenges with timeliness of filing termination of parental rights, leading to delays in permanency for children. Several factors may contribute to delays,

including caseworker workload and the backlog of cases in the judicial system delaying hearings necessary for timely reunification.

- GOC Meeting 02/23/2024
    - Committee received the presentation of OPEGA's Information Brief on Child Protective Services – Reunification.
    - Committee finalized their Report : Frontline Perspectives in Child Protection as Catalysts for Reform.