Response to the Maine Child Welfare Ombudsman's 2022 Annual Report

December 30, 2022

Maine Department of Health and Human Services

Office of Child and Family Services

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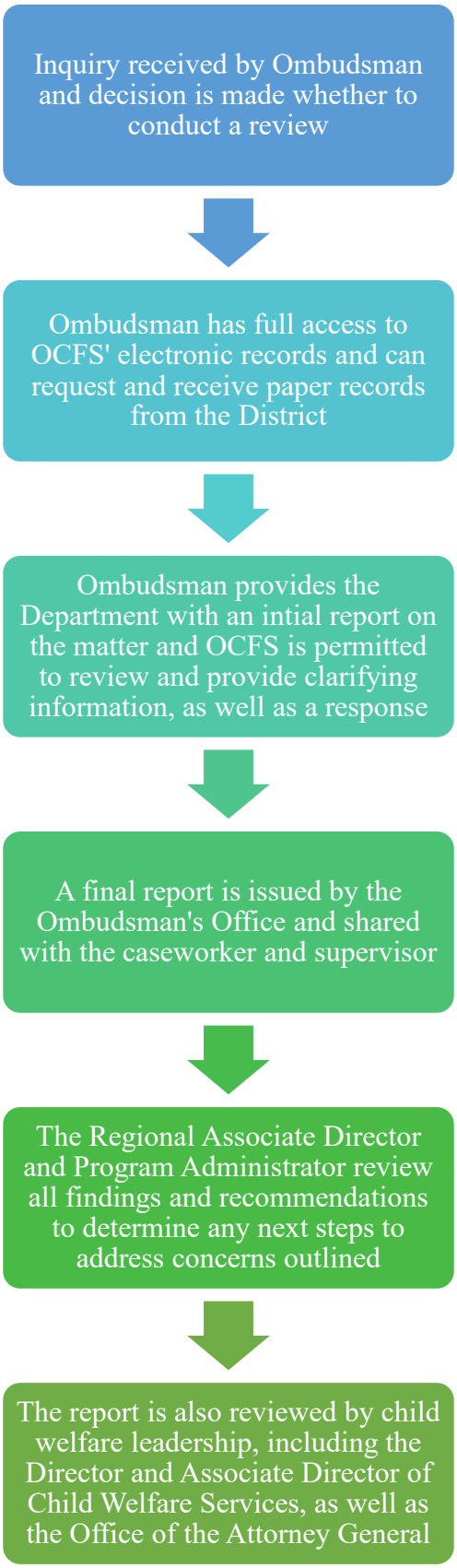

The Office of Child and Family Services (OCFS) offers this response to the Maine Child Welfare Ombudsman's annual report for fiscal year 2022. OCFS appreciates the Ombudsman's analysis of the 85 cases reviewed this year. This number represents less than one percent of over 11,000 reports and cases OCFS assigned for assessment, which involved an average of 2,336 children in care, during the same period. The information from the Ombudsman's case reviews and Report have benefited OCFS in understanding strengths and challenges related to policy and practice and helped to guide overall strategic priorities.

The Ombudsman recognizes the complex work undertaken by frontline staff. OCFS staff have dedicated their careers to the safety of children and strengthening families to ensure children can grow up in safe, stable, happy, and healthy homes. Over the last year, these staff have continued to dedicate themselves to this challenging work to improve the lives of individuals, families, and communities within our state despite workforce challenges prevalent locally and nationally across all employment sectors.

In the last year, OCFS and the Ombudsman have continued to partner through the case review process. Additionally, the OCFS Director and Associate Director of Child Welfare Services meet regularly with the Child Welfare Ombudsman and the Chief of the Child Protection Division within the Office of the Attorney General.

OCFS is in general agreement with the Ombudsman's findings in approximately 60% of cases (including both those in which the Ombudsman agreed with the Department's actions and those in which the Ombudsman did not agree with the Department's actions). In any review where the Ombudsman disagreed with the Department's decisions and where the case was still open, action was taken to review the investigation or case internally and address any ongoing concerns. It is encouraging that the reports that closed during this time indicate a higher percentage of positive findings/general agreement than in previous reports. The Department continues to use feedback from these case reviews to inform wider systemic changes.

In approximately 40% of cases, differences existed between the Department and the Ombudsman with regard to the findings or recommendations specific to the timing of bringing children into state custody or reunifying them with their parents. Each child welfare investigation and case is unique and involves a wide variety of individual, family, and systemic factors that must be explored, considered, and carefully weighed when deciding whether to seek court approval to remove a child from the care and custody of their parents or whether it is appropriate to reunify. The decision to remove or reunify has life-altering consequences for the child and the family. Evidence demonstrates that when removed from the home, children's trauma can be significant even when removal is the best course of action.

The courts have a significant role in the child welfare system related to removal and reunification. A child cannot be removed from their legal custodians without a court order. Once removal is ordered, the case is subject to judicial oversight, that includes decisions on immediate risk of serious harm, jeopardy, placement and reunification as well as decisions regarding parental unfitness and what is in the child's best interest. These decisions are made through a robust judicial process in which parties have the right to be heard and the court bases its decisions on the evidence before it. The court's involvement ensures the appropriate balance is struck between the constitutional right to parent and the child's right to be free from abuse and neglect.

Over the last year, OCFS has continued to advance policies, training, and support for staff that seeks to aid them in navigating the careful balance of the potential negative and positive impacts of removal and reunification decisions. No policy or training can specifically address every unique circumstance in a single family, let alone the thousands of families OCFS staff interact with on a yearly basis. The Ombudsman mentions the often discussed "pendulum swing" in child welfare and OCFS' level of risk aversion. A pendulum model would indicate that there is an ideal point (in the middle) where OCFS is removing and reunifying an appropriate number of children. OCFS's experience suggests that even if there were such a point, it would shift constantly because of the individuality of each child and family, as well as their circumstances at the time of the child welfare involvement. Rather than strive for a midpoint in the aggregate, OCFS staff work to partner with each family to ensure the safety of their children given case-specific factors.

OCFS continues to implement the Federal Family First Prevention Services Act to increase the infrastructure of supportive services for children and families that may help prevent the need for removal. The Ombudsman takes particular note of situations where children remained with their parents "for too long" before they were ultimately removed. While OCFS understands the Ombudsman's perspective, this characterization runs contrary to the goal of Family First and the general goal of child welfare to ensure that whenever possible, families can remain intact, and parents can raise their children. The Federal Children's Bureau has, through implementation of Family First, expressed a clear preference for the States to attempt to provide supportive evidence-based services to children and families with the goal of preventing the need for removal. Furthermore, OCFS' data does not fully support the Ombudsman's concerns. Current data indicate that for families where an investigation occurred and no findings were made (children are not removed and remain with their parents), there is not a subsequent removal over the next 12 months in 97% of cases.

When removal does occur, it is the responsibility of OCFS to provide rehabilitation and reunification services unless relieved of this obligation by the court. OCFS engages the family and their supports in developing a comprehensive plan, approved by the court, which is the roadmap to ensure safe reunification. The plan is updated based on new information and circumstances and the court monitors progress made by the parents. Parents and their attorneys are given the opportunity through this process to challenge the plan through judicial review if they believe it is inconsistent with the facts of the case and their circumstances. When there is disagreement on how to move forward, the court makes the ultimate decision.

In the Ombudsman's report, two primary areas of concern were identified: Investigations and Reunification. In this response, each of these are addressed and additional context is provided.

Investigations

The Ombudsman's report identified issues related to collecting and analyzing information, and cases in which the Ombudsman found that the Department had sufficient information to determine that a child was unsafe but did not recognize the risk.

OCFS agrees that decisions regarding removal are extremely complex and nuanced and as a result are among the most difficult decisions frontline staff make. Staff continue to face challenges in gathering necessary information to make fully informed decisions regarding child safety. These challenges take several forms, the most basic of which is the refusal of parents and families to provide full and complete information. OCFS field staff sometimes encounter parents that refuse to allow their children to be interviewed, refuse to engage in interviews themselves, and/or deny requests by the Department to sign releases so the caseworker can speak to providers who have experience working with the child and/or family. OCFS has no mechanism to compel a parent's engagement in the investigation process absent a court order. A court order must be based on facts that support it, and without the very information the caseworker is seeking to access, there is often an insufficient basis to seek a court order compelling the parents' engagement in the investigation.

There can also be difficulty coordinating with providers to share information. This issue was identified as a concern in the review conducted by Collaborative Safety and Casey Family Programs at the end of 2021. In response, OCFS, in the Spring of 2022, disseminated an informational brief to mental and behavioral health providers related to working with families involved with child welfare services. OCFS has also met monthly with medical personnel, law enforcement, and legal experts to build more effective communication among these various components of the child welfare system. OCFS is developing legislation for 2023 to improve the statutory framework for information sharing among these specific entities.

Over the last year, OCFS has convened a workgroup of child welfare staff to examine both the current investigation timeframe and the required investigation activities. This workgroup also sought input from national experts including Casey Family Programs and the Child Welfare Capacity Building Center regarding investigation timeframes nationally. The goal of the workgroup was to implement best practices and remove redundancy, while ensuring staff could, to the greatest extent possible, gather information required to make the most informed and factually supported decisions related to child safety. The workgroup presented recommendations to leadership and an implementation plan has been developed to move the recommendations forward by integrating them into policy, practice, and the state's child welfare information system, Katahdin.

The Ombudsman also expressed concern regarding specific issues, including lack of contact with out of home parents and other collaterals; reliance on prior investigations; failure to gather service provider records; lack of engagement of parents in drug screening; insufficient follow-up on new information reported; general lack of a comprehensive investigation; and failure to consider prior child protective history in decision making.
Many of the issues outlined above are directly impacted by the parents' willingness to engage with the Department. OCFS staff are trained to partner with families to help them address child safety concerns, but some parents may not be willing to be forthcoming with the Department for various reasons.

To aid caseworkers in the completion of the investigation, assignment activities provide supervisory support early on in decision making. The caseworker and their supervisor complete the assignment activities in preparation for field work. This process includes determining what information to gather and who the caseworker should interview and speak with regarding the family and allegations, reviewing prior child protective history, and identifying areas to explore throughout the investigation process. Additionally, once initial contacts are made with the children and parents, the caseworker consults with the supervisor to make a preliminary decision about the safety of the children in the home. This decision is modified based on subsequent information gathered throughout the investigation.

The Ombudsman further identified safety planning as an area of particular concern in investigations. Safety plans involve the voluntary, temporary placement of a child outside their home while parents address immediate safety concerns or further investigation activities are completed. OCFS agrees that this practice is inconsistent across the state and has identified it as a focus for child welfare's upcoming strategic plan. The Child Protection Investigation policy is in the process of being revised and provides guidance to staff on criteria for entering into a safety plan, components of the safety planning process, expectations for monitoring the plan, and the process for determining when it is appropriate to develop a short-term alternative care plan. OCFS has also included the expectation that a Family Team Meeting (FTM) be completed as part of the process to engage with families and their supports to develop and monitor the plan. Plans cannot be in effect for longer than 30 days. OCFS had intended to advance this work by implementing the updated policy earlier this year, but implementation was delayed in order to incorporate the recommendations from the Investigation Workgroup. OCFS anticipates that the policy will be finalized in January 2023. Once finalized, staff will be provided with implementation support as part of the policy finalization process.

OCFS expects that the efforts undertaken over the past year, including those in response to Collaborative Safety's recommendations, will result in positive momentum within the investigation process, including the ability of staff to gather and synthesize all available information that may impact child safety.

Ongoing Assessment of Risk in Reunification

While investigation and reunification reflect opposite ends of the spectrum of child welfare involvement, there is significant overlap in these two concerns identified by the Ombudsman. The concerns with investigations and reunification both center around the ability of staff to gather information and analyze that information appropriately, and to weigh the risks and benefits to the child regarding the intensity of the child welfare system's involvement in their lives necessary to ensure their safety. As with removal, child welfare field staff are tasked with making difficult decisions based on complex, unique, and sometimes incomplete information. In both situations, the courts play a significant role. Neither the courts nor OCFS can fully predict what will occur in the lives of children or their families after reunification occurs. Instead, both entities are tasked with considering all available information and making a decision regarding child safety, including weighing the risks associated with the trauma of separation from their parents as well as the risk of child abuse or neglect with reunification.

The Ombudsman's specific concerns included lack of contact with parents and service providers; inadequate assessment of other caregivers, such as a parent's new romantic partner; lack of random drug screens to assess sobriety; failure to fully consider parental capacity; ongoing concerns not adequately investigated; lack of mental health services and evaluations; and failure to fully address parental issues. OCFS has used the specific cases which formed the basis for these concerns, as well as many others over the last year, to monitor the work of staff, including through the Ombudsman's case reviews, quality assurance efforts, federal system improvement work, Safety Science case reviews, and the legal process. As a result, OCFS has addressed case-specific issues where appropriate and is considering systemic changes to support field staff through improvements to policy, practice expectations, and training.

In the 2022 report, the Ombudsman recognizes the important role other stakeholders play in the system of protection for at-risk children, including law enforcement, the courts, service providers, attorneys, Guardians ad Litem (GAL), and school staff. OCFS continues to collaborate with all stakeholders to improve the child welfare system. This includes ongoing work with staff from the Family Division of the Courts on system improvements and participation in the Justice for Children Task Force; meetings with stakeholders, including parents' attorneys and GALs, to discuss systemic issues; and an update to OCFS' Cooperative Agreement with

the University of Southern Maine to add staff with lived experience in the child welfare system who are informing policy and training work.

The Ombudsman specifically notes the need for additional training and support for supervisors as they guide the work of caseworkers. After hearing these concerns and recognizing similar concerns through internal quality improvement efforts, OCFS has undertaken the development of a supervision framework in partnership with the University of Southern Maine (USM) under the Cooperative Agreement. This framework includes the Supervisor Academy training curriculum and additional guidance meant to support the work of supervisors as they navigate policy and practice expectations of their caseworkers. OCFS and USM are working methodically to develop this critically important support for supervisors and expect this initiative to be completed in early 2023.

The Ombudsman notes that "recognition of ongoing risk to the child or children has been difficult when making decisions to move to unsupervised visits, trial home placement, or file for a petition to terminate parents' rights." OCFS recognizes that these are critical decision points in any case and previously implemented Team Decision Making, an internal process that includes the caseworker, supervisor, and PA or APA to analyze all available information and utilize the knowledge and experience of senior staff in decision making. The team can also consult with the OAG, as necessary. October 2022 data on the child welfare dashboard shows that 91% of children who were discharged from the State's custody did not return to care in the following 12 months. The federal aspirational standard for this measure is 91.7%.

As with investigations, OCFS has availed itself of the Ombudsman's case-specific reviews to address concerns and gather additional information that will inform decision making. OCFS believes that current efforts underway to work with providers, including behavioral health providers, hospital staff, and law enforcement will help ensure staff have the fullest possible picture as they are making decisions. This includes decisions regarding reunification, termination of parental rights, and permanency.

Specific Recommendations

The Ombudsman's report included 5 specific recommendations. Below are OCFS' responses:

- *Frontline staff's experiences and opinions are given heavy weight in moving forward with improvements in policy and practice and with child welfare reform*
    - Over the last few years OCFS has dedicated significant resources to transparency and engagement with staff. OCFS staff have the opportunity to comment on and suggest edits to each new and updated policy in the Child and Family Policy Manual before it is finalized and implemented. Frontline staff are included in workgroups to inform specific systemic changes. The many examples include the development of OCFS' new child welfare computer system, known as Katahdin; the Children's Emergency Services Program (after hours coverage) implemented in 2022; and changes to the Child Protection Investigation policy. OCFS leadership has taken particular care to ensure that field staff representation in these forums is diverse both in terms of geography and in role (different types of caseworkers and supervisors). Staff have and will continue to provide invaluable feedback on the challenges they face, as well as the opportunities for growth and improvement.
    - In addition to being reviewed by OCFS staff, all new and updated policies are reviewed by the Maine Child Welfare Advisory Panel (MCWAP) which is made up of citizens including providers, individuals with lived experience in the child welfare system, the Ombudsman, staff of the Office of the Attorney General, and others. MCWAP members provide edits and input that

help to further improve and refine policy to meet the needs of families, providers, and staff. This Panel receives staff support from OCFS, including the Associate Director of Child Welfare Services who engages directly with Panel members in meetings.

- *Maine should continue to broaden the use of Safety Science to improve systemic issues and waste no time in implementation of recommendations from those reviews, federal reviews, OPEGA reports, and Ombudsman reports.*
    - OCFS strongly agrees with this recommendation and in the last year has implemented Safety Science critical incident reviews within child welfare. Safety Science has been successfully used in other safety-critical industries, including health care, aviation, and nuclear power to understand how decisions, initiatives, resources, and other factors impacted the critical incident. These reviews do not seek to place blame, but instead are intended to determine where systemic improvements can be made to increase the quality of practice in the future. The Ombudsman is part of the Multi Disciplinary Team that determines which cases will move forward in the process for a full review.
    - In addition to the critical incident reviews, the Associate Director of Child Welfare, Regional Associate Directors, Program Administrators, and the Child Welfare Program Manager are part of a cohort participating in leadership labs to more broadly infuse the philosophy of Safety Science into the everyday work of OCFS.
    - OCFS successfully completed all of the key activities and systemic factors items of federal Program Improvement Plan and is now working to meet the metrics of the Measurement Plan. This work will continue through January 2024.
    - OCFS is nearing completion of all activities intended to address the recommendations of the Casey Family Programs and Collaborative Safety report issued in October of 2021. Completion will occur when the recommendations of the Investigation Workgroup are implemented in early 2023 and OCFS advances legislation recommended by the collaborative workgroup consisting of law enforcement, medical, legal, and OCFS representatives.
- *Training for staff and supervisors should be aligned with national best practices.*
    - OCFS agrees and is currently engaged in work with the University of Southern Maine under the Cooperative Agreement to continuously improve training opportunities for staff. This includes not just the number of trainings, but the information provided within them (including inclusion of the voice of parents with lived experience in the child welfare system which is now being incorporated with changes made over the last year to fund positions for parents within the Cooperative Agreement), the logistics of making trainings accessible and engaging for staff statewide, and the manner of training necessary to maximize retention of information. OCFS will continue these efforts in 2023 and has already begun to see the benefits of this work with its New Worker Foundations Training which was updated by the OCFS Policy and Training Team and USM staff in 2021.
    - OCFS also agrees that additional emphasis is needed on guidance for supervisors and, as previously mentioned, is in the process of developing additional training and guidance for supervisors as they guide the work of caseworkers.
- *Stakeholders at all levels have shown understandable concern that the intense focus on child welfare will cause a pendulum swing that will decrease reunification and increase removals of children from parents. Removals of children from parents should never be based on an overall philosophy, but on the specific facts of each child's circumstances. This year's case specific reviews show a pattern of delay in removal of children from families when circumstances for those children are clearly unsafe, and reunification of children with families when parents have not made enough changes to alleviate the jeopardy to the child. Both decisions are characterized by delays in filing court petitions or acting to protect children in other ways, such as through safety plans. These delays do not prevent removals of children from their homes, or prevent reunification; instead, they lack of recognition of risk to children,*

even when all facts are collected, leave children unsafe or delay permanency for the children, or both. A better way to think of the pendulum swing is not to think of the Department's actions causing too many or too few removals, but instead to hope that the Department's practice will become more risk averse. More decisive removals should not affect the overall numbers of children in custody. In fact, in many of the cases below, children were removed eventually, just left in the care of their parents for too long.

- Many factors are considered in child welfare decisions, including (but not limited to) information gathered during an investigation, prior CPS history, and current circumstances that may mitigate child safety concerns. The Department has processes in place to monitor these decisions and ensure factually supported decision making and is always considering opportunities to improve these processes. The key to high-quality investigation and casework is ensuring information is gathered and carefully analyzed to make decisions that balance the risk of potential abuse and/or neglect against the trauma inflicted on children and families when a child is placed in the care of the State for any period of time. In making removal and reunification decisions, the courts rely on OCFS staff to provide information about both the strengths of a family and the specific child safety concerns to guide the level of intervention necessary to increase safety for a child.

- *As stated in the Introduction of this [Ombudsman] report, the Department is the most visible of the many systems that help keep children safe in Maine. Service providers for adults and children, schools, courts, medical professionals, and many other stakeholders all collaborate and have a part in the lives of our children. This report is of necessity focused on the Department due to the nature of the statute that is the basis of the Ombudsman program. Most clearly right now, there is a need for an increase in mental health and substance use services for adults and children in Maine. Lack of strong services can strongly affect the safety of children.*
  - OCFS appreciates the Ombudsman's inclusion of concerns regarding mental health resources for all segments of the population. In addition to child welfare, OCFS oversees Maine's children's behavioral health system. The behavioral health system in Maine and nationally has been challenged as providers struggle to hire and retain staff and address the additional stresses of the pandemic. While these challenges persist, the Department has taken action to mitigate them, including MaineCare rate studies and increases in MaineCare rates for providers, extensive efforts to provide training and technical assistance to providers in delivering evidence-based services to children and families, one-time funding to providers to address the financial implications of the pandemic, and ongoing engagement with providers and other stakeholders to inform system improvement efforts.
  - OCFS recently implemented the second phase of the Resource Parent Portal in Katahdin. This new portal allows resource parents to access information such as medical, behavioral/mental health, school, and Court information in real time.
  - OCFS continues to work collaboratively with both internal and external stakeholders to develop resources to meet the needs of youth, including those in state custody.

Conclusion

OCFS is grateful for the ongoing partnership of the Ombudsman in improving the child welfare system. The Department is also appreciative of the new resources toward the program proposed by the Governor and approved and funded by the Legislature in 2022. The Ombudsman's reports (both case-specific and broader reports) continue to both inform improvements and emphasize the importance of work already underway.

The Office and Department thank the Ombudsman and her staff for their work. As families continue to face challenges, strong collaboration among dedicated stakeholders, including the Ombudsman, will lead to system improvements that better ensure the safety and wellbeing of Maine children, their families, and their communities.