Testimony of Beth White
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In Support of LD 2065, An Act to Provide One-time Funds to Support the Construction of a Psychiatric Residential Treatment Facility for At-risk Youth
Sponsored by Senator Henry Ingwersen

Before the Joint Standing Committee on Health and Human Services
10am Thursday, January 29, 2026, Cross Building Room 209 and Electronically

Senator Ingwersen, Representative Meyer, and members of the Joint Standing Committee on Health and Human Services, I'm Beth White, Director of Politics & Legislation for the Maine Service Employees Association, Local 1989 of the Service Employees International Union. We are a labor union representing over 13,000 Maine workers, including workers at the Department of Health and Human Services (DHHS) and the Department of Corrections (DOC).

We're here today in support of LD 2065, which would provide one-time funding for the construction of a psychiatric residential treatment facility for at-risk youth. We want to thank the sponsor, cosponsors and members of this Committee for the work you all have been doing to address the challenges at the Office of Children and Family Services (OCFS).

As you are aware, there has been an ongoing crisis at OCFS with children being placed in hotel rooms or hospital emergency rooms for extended periods of time, mainly due to a lack of alternative placements and foster homes for them. As MSEA member Bernice "Bunny" Wermenchuk said in testimony on the budget last session, "Hoteling is not in the best interest of any child. Hoteling offers no stability, structure, or security. There is no privacy or a sense of belonging. Without a place to cook and refrigerate food, meals provide no nutritional benefits or offers no ability to learn life skills. The cost to the state to hotel for one night: 1 hotel room, roughly $25 for food and drinks for the child, overtime pay for staffing....And lastly, travel expenses to and from the hotel for the staff. And that is for 1 child in 1 county. Currently some counties are hoteling multiple children for multiple nights. Hoteling and ED covering is the number one cause of burnout amongst OCFS staff along with high case load."

This legislation will help address the issues of children being placed in hotels and emergency departments, which often stems from the lack of long-term placements and solutions for children. Currently, our members are concerned about the wait times between when some children are discharged from acute care, such as a hospital emergency department, to when a bed is available in a Psychiatric Residential Treatment Facility (PRTF). There simply are not

enough PRTF beds to meet current needs, which exacerbates the situation. Passing and funding this legislation to build a new Psychiatric Residential Treatment Facility in Maine would make significant progress on this issue.

While we are supportive of this legislation and thankful for its introduction, it's important to note that more needs to be done in the immediate term to address the hoteling crisis. Frontline workers have consistently indicated a solution needs to be developed which addresses the trauma of having children placed in hotels due to lack of resource homes. They have identified two additional needs outside of building a new PRTF:

1. The need to increase the number of enhanced therapeutic foster homes for children with behavioral health needs. There are many examples that could demonstrate this need; one is when a child has severe behavioral health needs, including non-verbal and self-harm behaviors. In these cases, there is concern about the wait time between when the child is discharged from acute care, such as a hospital emergency department, to when a bed is available in a Psychiatric Residential Treatment Facility (PRTF). While addressing the need for a new PRTF would help significantly, more licensed intensive therapeutic homes are needed for these interim situations between acute care discharge and long term PRTF placements. More needs to be done to increase the number of licensed intensive therapeutic homes for children in these situations.

2. The need for placement of children waiting for permanent placements in a residence (such as a bridge home) which offers structure for education, nutrition, socialization, etc. Children can be discharged from an acute treatment facility (generally a hospital) and their condition is considered stable and not needing treatment beyond outpatient therapy and possible community support. However, these children may remain without a residence, as a home is not available. A hotel setting is not structured for a child's emotional growth as there is no dedicated staff.

That being said, we strongly support LD 2065 and our members are eager to see more details about the proposed facility and how it would be operated. We would encourage this committee to pass this legislation and advocate for its funding.

At the bottom of this document, I have also included "Our vision for Child and Family Services", which was written by our members in 2019 and updated in 2023. It includes numerous recommendations for improvements at OCFS. I'm also more than happy to connect you all with workers at OCFS if desired.

Thank you and I would be happy to answer any questions.

Our vision for Child and Family Services, updated 2023

All children deserve safe childhoods. We do this work because we care deeply about Maine children. We are determined to protect them, support them and build families that also can protect and support them. We believe that to do this effectively, serious changes need to be made to Maine DHHS policies, practices and programs. We must recruit and retain staff to stabilize quality public services for Maine children and families. The people who do the front-line work must be empowered to shape the policies and program they implement each day.

Recommendations from frontline workers on how we get there

Provide the necessary resources for support programming, including public health nurses and housing, mental health and addiction resources. Caseworkers need these types of services fully resourced and staffed so Maine families can get the support they need.

> OCFS caseworkers and support staff are first responders, similar to firefighters and police personnel. Resources have been focused on assessing the immediate evidence of abuse and neglect versus the promotion of healthy family dynamics. The focus needs to be on prevention, including economic factors, housing, physical and mental health services, education and other community supports.
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> In simplistic terms, a call to intake regarding neglect because a family is living in a shanty or car, is not poor parenting; it is an economic and affordable housing issue. There also is a lack of awareness by the public of the devastating impact of a government investigation on a family. This is evident by the predictability of the cycle of increased reports of abuse and neglect to the intake units just prior to school breaks – time periods where children are perceived as potentially at risk because schools and other similar providers are not in a position to have a consistent "eyes on the situation." During those time periods, mandated reporters or others may believe they are providing a safeguard but there is no corresponding increase in OCFS staffing for that vacation week or summer break.

Reduce caseloads to manageable caseloads that match the national standard of no more than 12 cases per caseworker in the field. This will provide the necessary time with every child and capacity for family plans.

> Every child should be counted as one case. While Governor Mills has added 70 new staff positions, a significant number of those positions remain unfilled. With an ever-revolving door for the hiring of caseworkers, the question becomes: Why is the OCFS unable to keep child protective caseworkers?

In discussion with child protective workers in the field (intake is a separate unit), individual caseloads consistently average over 20 cases and sometimes as high as 30 or more.

Hire more administrative support staff, allowing caseworkers to have the time they need to focus on casework.

Customer Service Representative IIs are considered support staff. When an average person thinks of administrative support staff, the visualization probably is of a person handling the phone calls, filing of paperwork, updating information in databases, etc., not someone who is in direct contact with parents and children. OCFS utilizes Customer Service Representatives to transport children, monitor children during parental visitations and sit with children in hotels and emergency rooms. Community Care Workers' workloads and responsibilities have increased commensurate with the child protective caseworkers' inability to keep up with their increased caseloads. With the decrease in services normally provided by community agencies, OCFS would not function without the Community Care Workers and Customer Services Representatives.

End forced overtime, taking work home and missing work breaks and lunch breaks, all of which are leading to burnout and stress.

Despite the implementation of the overnight CES unit, A majority of OCFS employees (CRA-IIs, Community Care workers, Child Protective Caseworkers and Supervisors) are still facing mandatory overtime, missed lunch breaks, etc. Documentation remains an issue, resulting in missed breaks and working after hours.

Ensure the safety of staff as they work in the field.

Similar to other first responders such as police and fire personnel, always being ready to deal with a crisis is hard on an individual's mental and physical health.

OCFS caseworkers and other staff are often in potentially violent situations with no law enforcement backup.

Due to the lack of therapeutic setting for children with severe mental illness, OCFS staff often are in hotel situations with limited support. Multiple OCFS staff have been treated for assault by children.

Provide the technology that truly functions to meet the needs of the Maine Office of Child and Family Services workers and efficiently integrates into their work. This means investing in the right technology and the right training, not just the least expensive.

While caseworkers applaud the development of a new system, and caseworkers appreciate there was to be a learning curve, Katahdin has not lived up to expectations and in many ways has created more barriers than those experienced with the old system, MacWIS. The Katahdin system does not provide a smooth narrative of a case, a

major obstacle for anyone "picking up" a case as there is no simplified method to access a chronological linear narrative. There is no search function. Instead of reducing the information needed, there are too many screens requiring a check box and, in all honesty, not enough lines in the screen to complete the information required. Basically, Katahdin has clunkier hyperlinks and is less efficient than the old system. As a caseworker is only allowed to read three lines at a time and cannot make the window bigger, the overall result is Katahdin has made it difficult to make timely and accurate decisions. Documentation is difficult in Katahdin as the system is more compartmentalized with more walls. Often depending on the circumstances, accessing one window to pull information for a second window often deletes the information entered. Another issue is the algorithm known as single decision making. The algorithm determines the weight of a reported statement; human experience and knowledge is excluded.

There has been no open and honest review of Katahdin by a panel of caseworkers, supervisors and others who were not a part of the original design. As with any project, those involved with the original development can be biased if changes are suggested by others. Policies and practices continue to be top-down driven, with little to no acceptance of feedback from supervisors or frontline caseworkers.

Reduce unneeded or duplicative paperwork, including making case plans more accessible and usable for families. (See difficulties with Katahdin.)

Give front-line workers a voice in policies, practices and programs so they can meaningfully participate in developing and implementing them.

Policies continue to be top-down driven, with little to no acceptance of feedback from supervisors or frontline caseworkers.

The use of algorithms such as single decision making have multiple drawbacks. Despite the implementation of SDM, the number of tragedies in the past five years has not decreased. Algorithms create more investigations, which delay the documentation of caseworkers' current caseloads, creating a spirally effect: there's not enough time in eight hours to do the investigation, so documentation is frequently done after hours to meet deadlines. A review of deadlines for documentation is needed to determine if a deadline is valid and consistent with national social work ethics and standards ensuring the well-being of the child.

Establish a night shift for coverage across Maine DHHS districts.

Due to hiring delays, the complete rollout of the Children's Emergency Services (CES) Unit is too early for an assessment. Currently many districts are still experiencing having to cover overnights and holidays. There is a concern regarding funding for the CES Unit.

Is there enough staff? Similar to a firehouse situation, there needs to be a recognition that a CES Unit is mainly there for a crisis call.

Intake Unit – This unit experiences a large volume of calls; it's essential to always have the staffing levels necessary to handle a large volume of calls.

Reassess the foster parent certification process, training and support to better build and support Maine's network of foster parents.

Improvements continue to be needed in this area, more so for residential care of children diagnosed with severe autism, trauma syndrome or brain injury. Too often children are languishing in hotels or emergency rooms due to lack of therapeutic placements.