Reviewing the death of Jaden Harding

Senator Hickman, Representative Faye, and the distinguished members of the Government Oversight Committee:

Thank you for the opportunity to share testimony regarding the death of Jaden Harding. My name is Melanie Blair, and I reside in Lisbon. I am a parent of 25 years, a special education and behavioral assistant of 15 years, a foster parent of eight years, and an advocate for the safety and wellbeing of children. As well, a regular attendee of GOC meetings regarding child welfare.

The directors' report outlines many issues relating to unsound safety decisions as well as practice deficiencies made by OCFS. These are, in summary:

- Multiple substance exposed infants
- A lengthy history of unsafe relationships, domestic violence, substance abuse, and mental health issues.
- Caseloads that are too high
- Incomplete investigations with a lack of collateral contacts being followed up on or investigated properly
- Safety plans either not made, or not followed

The impact of the last three factors when the first two conditions are present is ultimately what lead to Jadens death. So how did we get here ...again, and how do we stop the cycle of this continuing.

I would like to point out from page two of the Opega report, under Child Welfare Philosophy and Law. "child welfare decisions made by OCFS are governed by federal and state law, guided by DHHS policy and rules....Together this framework largely emphasizes the rights of parents and family preservation...."

In other words, federal and state laws drive state statutes which in turn drive OCFS policy, which we are to believe is either a safe policy, or one that is even followed.

Federal Law, for example, The Family First Act signed into law in 2018, turned the focus, and the federal funding that goes with it, of the child welfare system toward keeping children safe in their homes.

In doing this, families are supposed to have greater access to services through the Title IV-E Prevention Services Clearinghouse. As a result, these funds are now used to prevent the disruption of families.

-Childwelfare.gov/topics/systemwide/laws_policies /federal/family-first/

The problem? The purse strings and policy is now expressly emphasizing remaining in, or being returned to a questionably safe-at best home in the name of family preservation. All of which is assuming that the services are available, provided, and satisfactorily completed by a parent with significant issues while being enforced, monitored and followed up by a caseworker that has little experience and unmanageable caseloads that make it next to impossible to truly make a complete and thorough investigation and assessment, or follow up on an appropriate safety plan that may or may not even exist.

In addition, OCFS policy (22 MRSA SS 4052-) regarding cumulative CPS involvement: 'reviewing the families prior CPS history is a key part of the first step...' however, the practice model also states, "we believe that people can change. Their past does not necessarily define their potential." The problem here? Historically, history in fact does often repeat itself.

Not mentioned in The Opega Report, but in my own experience and observation, the departments lack of utelizing statute already in place, for example, (Title 22 SS4041) 'Aggravating Factors', as well as disregarding disclosed sexual abuse, are huge contributing factors for children remaining in unsafe homes.

In conclusion, I believe the department should have had a preponderance of evidence, based on Title 22 SS4002 10 B and C to remove Ms Hartley's other children prior to her becoming pregnant with Jaden. In Consideration going forward, I would hope the above mentioned would be considered as you evaluate and determine future recommendations.

Shawn Yardley
Testimony to the Government Oversight Committee
November 29, 2023

Senator Hickman, Representative Fay, and esteemed members of the Government Oversight Committee, my name is Shawn Yardley. I am a founding member of the Maine Child Welfare Action Network. I am also a former CPS caseworker, supervisor and regional administrator in Maine for nearly 20 years. My wife and I have 7 children, including three sisters my wife and I adopted from DHHS nearly 20 years ago.

During my time at then-DHS, I was involved in many efforts to attract, train and retain child welfare professionals. I was part of the 8-member leadership team from UMaine, USM, the Muskie Center and DHS that established the Field Instruction Unit (FIU), intended to recruit and identify undergraduate social work students to build a pipeline of trained and dedicated child welfare professionals. This included establishing a university-based child welfare curriculum that was required of FIU participants and open to the general student body, that focused on a multidisciplinary approach to child welfare. Many of the non-FIU students from other disciplines included child development, journalism, law enforcement, education and foster parenting, to name just a few. We are fortunate to have these people still engaged in various aspects of the work of protecting Maine's children.

I was also involved in several other initiatives to attract, and more importantly, retain qualified and committed staff, as well as to implement new strategies to improve the delivery of critical child welfare services to ensure supports for Maine families experiencing stress were available. This included Family Support for lower risk situations, to prevent family challenges from devolving into jeopardy situations in the mid 80's; Alternative Response services, which allowed for lower risk cases and overflow referrals to be outsourced to contracted providers, eliminating the need to request additional caseworker positions, and including contracted services to supervise children in State custody in hotels and emergency rooms waiting for placements, to relieve the workload on caseworkers who had caseloads they were expected to manage during the day. CPPC was another contracted program to mobilize community partners to support families, including utilizing parents with lived experience to support families involved with the child welfare system. We should look back to some of this work the State previously supported, as we consider how to strengthen the current child protection system. This includes workforce supports and services for families. If we can better and earlier address the challenges in families that create risk for child safety, we can divert more families away from the child protective system, which will allow for more capacity to work with families who are truly in crisis.

Something I think about often was when I was a supervisor at the department in the 90's, when the referral rate exceeded the caseworker capacity. Appropriate referrals were labeled as such and numbered in the thousands, but there was pressure from central office to label them as inappropriate for CPS due to capacity issues. This is to say, agency capacity and the resulting triaging of family intervention is not a new issue for our state. With differing investments and priorities over time and across administrations, the agency has been well staffed and supported, and at other times, struggling.

I could talk for much longer about many of these programs and efforts over the years to respond to the needs of families referred for child maltreatment, but I want to focus on what I believe is a fundamental issue in having a system that is able to respond to the families identified as at risk for child abuse and neglect – the staffing and retention of caseworkers. Until this is addressed, new policies and programs will not be enough. The Legislature appropriates the funding for personnel lines designed to meet the need, and yet there is a chronic vacancy rate of 25-30%. I believe that children at risk of child abuse and neglect should be entitled to support when it is needed. My #1 recommendation is to develop a plan that will ensure appropriate and effective staffing of child protective services. Until the agency is fully staffed and that is sustained, caseworkers will continue to enter the field overwhelmed with cases and without the experience or robust support needed to navigate the complex challenges they will face in their work. Child protective work requires robust training and ongoing support to ensure we don't burn out the caring and talented workers entering this field, who are critical to ensuring child safety and family well-being.

Testimony of
Mark W. Moran, LCSW
Chair, Maine Child Death and Serious Injury Review Panel
Before the Government Oversight Committee

Public Hearing Date: November 29, 2023

Senator Hickman, Representative Fay, and members of the Government Oversight Committee:

My name is Mark Moran. I am a Licensed Clinical Social Worker and the Chair of Maine's Child Death and Serious Injury Review Panel (CDSIRP)*. After hearing Director Schleck's presentation of the Jaden Harding review and reading the report myself, several themes emerged that I'd like to highlight for the Committee. These are themes that I and the Panel have noted repeatedly over a long period of time.

Many families who come to the attention of OCFS have lengthy histories of involvement with CPS, sometimes spanning multiple generations. This is particularly noteworthy in cases for which there is a child death or significant injury that prompts comprehensive, multidisciplinary review. When such reviews are conducted and the reviewers take a broad, holistic view of the family's circumstances over time, behavioral and cognitive patterns begin to emerge. When examined in relative isolation or with only cursory review of historical records, individual reports and investigations may produce an inadequate understanding of a child's true level of safety and risk. Opportunities to understand familial deficits more accurately and to consider more significant protective interventions are missed. These cases involve families who most often function at a minimally acceptable level. As the OPEGA report stated, Jaden's family "consistently exhibited a number of risk factors that generally hovered near the threshold for Departmental intervention." I think of these families' day to day reality as being a low simmer of safety and risk concerns for their children. Periodically, something raises the temperature such that the simmer will increase to a boil, at which point some OCFS involvement begins anew. That involvement, whether by safety plan, referral to/implementation of a specific community-based service, or some other intervention, may succeed in decreasing the temperature back to a low simmer in the short term, but most frequently this happens without substantive changes in the behavioral and cognitive patterns that make kids unsafe over the long term. These patterns, if accurately identified and understood, should be the target of intervention if improvement in long term child safety and caregiver functioning is the goal. Instead, the family regresses over time until this cycle begins again.

The length and complexity of a family's CPS history and the fairly consistent inability of OCFS staff to adequately review, analyze, and incorporate familial patterns into a current investigation has been an ongoing problem for many years. In fact, this dynamic has been specifically listed as a concern in each of my Panel's last 3 reports. As you know, OPEGA staff reviewed 870 pages of records in the Harding review. While that may seem like a lot- and it is- it is just a small fraction of the 19,743 pages reviewed in the Maddox Williams case. Most recently, in our 2022 report, we recommended that OCFS develop a protocol for in depth review and assessment of chronically maltreating families who repeatedly come to the attention of OCFS over a long period of time. Given the volume of such records and despite our collective desire for a better, more effective child welfare system, expecting OCFS caseworkers to spend the number of hours necessary to meaningfully review case files that are hundreds and thousands of

pages long is simply unreasonable within the existing OCFS structure. This is especially true in the context of existing pressures caseworkers face to meet various policy, timeline, and safety related expectations, some of which were addressed recently by frontline staff.

Another theme that has emerged over time is the inability or unwillingness of OCFS staff to confront caregivers about inconsistencies. This topic was addressed in the Panel's 2020 and 2021 reports and was present again in the Harding case. This is, I think, an important issue because it gets at the core of child protective services work. OCFS hires licensed social workers to conduct child protection investigations. This is a very specific type of social work that, when done well, requires a caseworker to concurrently wear two hats. First, as an investigator, we expect them to approach a case with an element of curiosity and inquiry, to conduct investigative interviews, to look for evidence of child maltreatment, to gather collateral facts and evidence to support or refute allegations, to analyze the totality of information, to reach a well-supported conclusion about whether a caregiver has abused or neglected their child, and to either present a case for intervention to the court (an adversarial process, by definition), prepare a case plan for specific service implementation, or prepare closing documentation outlining why the facts of the case do not support a finding of maltreatment. Second, as a social worker, we expect them to engage families (most often unwilling clients) with a goal of helping them address problems that impact their child's safety, to help parents recognize deficits they have been unable or unwilling to identify, to motivate caregivers to make and maintain positive changes to support their child's well-being, to build enough rapport that the family views the caseworker as a supportive presence, rather than a punitive one, and to refer their clients to additional, appropriate, available, and accessible professional supports. Integrating both skill sets is incredibly challenging and has the potential to lead to problems in practice, such as an inability or unwillingness to confront a caregiver about inconsistencies or untruthful statements. A caseworker might consciously or unconsciously avoid such confrontation in the interest of not damaging a fragile rapport, or they might believe the topic of confrontation to be insignificant to the ultimate determination about the child's safety, or any number of other reasons. Regardless of the reason, to avoid such confrontation is to sacrifice that element of the investigative role, potentially at the child's peril.

The next theme I'd like to highlight is the role of the medical system as part of the broad child welfare system, and there are three elements that stand out from the Harding report, in conjunction with my own experience over many years. First, there has been frequent commentary from former Director Landry and others, including me, that the child welfare system is broader than just OCFS. Certainly, that broad system must include the medical community. Yet, the medical community doesn't have easy access to the information that OCFS has. It is very common for me to see documentation in a medical record that a caseworker called or faxed a brief questionnaire to a primary care provider for a child asking if they have any concerns, or that a caseworker has requested a copy of a child's medical record. Such an inquiry necessarily means OCFS has an open involvement of some sort with the family, but no other information is routinely provided to the primary care provider (PCP). There is never a closing summary for an investigation or case that outlines the allegations, any evidence, and any findings. If a PCP had a concern for a child, they most likely would have reported it already, however, if a PCP knew, for example, that there were allegations of sexual abuse by uncle Joe and a safety plan was implemented in which mom agrees to keep Uncle Joe away, and Uncle Joe accompanies mom to the next well child visit for the child, then the PCP would be well enough informed to make a report.

Otherwise, it's just a note in the medical chart (maybe) that the child was accompanied by mom and Uncle Joe to the visit, with no report to CPS. In an alternate scenario, perhaps a child is removed from a parent's custody and shows up to the next well child visit or has a semi-acute visit due to entering foster care. The foster parent is often under- or uninformed about the specifics of why the child entered foster care. The PCP had no idea anything was happening in the family. The child might benefit from some specific elements of evaluation other than a simple physical exam if the PCP was aware of the circumstances. For example- if there were physical abuse allegations to a child, then the infant sibling who was also removed should likely have a "skeletal series" to look for evidence of acute or healing fractures; or if there was IV drug use in the home, then perhaps the mobile toddler should be tested for hepatitis, HIV, etc. Even when PCPs call to make reports, they very infrequently, if ever, receive information about the outcome of a related investigation- and I'm aware of no protocol or statute that requires OCFS to share that information proactively. Such a practice could enhance the safety net that we expect our broad child welfare system partners to provide.

Second, in the Harding report, there were multiple references to the family not bringing children to the PCP for well child visits. This is also an issue that has been noted by the Panel in multiple other cases, and this was addressed in the Panel's 2022 report. While there is certainly no requirement to attend well child visits, the Panel believes that once the medical team's less intrusive efforts to engage the family have been exhausted and in selected cases where there is a context of additional risk factors, as was the case for Jaden's family, missing well child visits should be viewed by OCFS as sufficient cause to investigate a child's safety more thoroughly. Historically, and as was true for Jaden's siblings, such reports have been deemed "inappropriate" for investigation.

Finally, with respect to the medical system, I noted reference in the Harding report to Spurwink's Center for Safe and Healthy Families (SCSHF), which is the exclusive home of Maine's child abuse pediatrics subspecialty. In September 2023, I spoke with the HHS Committee about this subspecialty (which has historically been called "forensic pediatrics") and two issues the Panel has observed related to it. First, there are two child abuse pediatricians who cover the entire state. They are available during normal business hours and are contacted for consultation by OCFS staff, other medical providers, law enforcement, attorneys, and guardians ad litem, among others. They provide inpatient consultations at Maine Medical Center and testify in court cases all over the state. They operate their primary clinic in South Portland with satellite clinics in Lewiston, Augusta, and Bangor once a month. This means that a family referred for this subspecialist evaluation might have to wait 4-8 weeks and drive up to 4 hours for an appointment. As you may have noted in the Harding report, one such evaluation happened on April 25th and while there was a preliminary opinion given that day to the caseworker and family, no written report was received by the caseworker until July 8. This is strictly a function of workload for these physicians. Maine would do well to enhance its support for this subspecialty service that is essential to the child welfare system. The other notable issue related to child abuse pediatrics is the failure to consult with these providers or to give their opinion appropriate weight in the decision-making process. While this does not appear to be an issue in the Harding case, it has arisen in other cases the Panel has reviewed. As I explained to HHS, at times there appears to be a false equivalency made by OCFS staff; that is, viewing the expert opinion of a child abuse pediatrician as having equal weight as a general pediatrician, family medicine physician, or emergency medicine provider. My colleague and now-retired child abuse pediatrician, Dr. Lawrence Ricci, wrote an op-ed for the Portland Press Herald on November

21, 2023, titled "Child abuse exams must be carried out by trained specialists." I've attached that article to my testimony today for your easy reference, because it includes noteworthy research findings supporting the value of child abuse pediatrics, both in terms of appropriately diagnosing child abuse and, just as importantly, making a diagnosis that excludes child abuse.

The next theme is the inadequate conceptualization of risk and safety. I know our Ombudsman has commented and written about this repeatedly and it has also been a focus for the Panel. In the Harding report, I noted two specific examples where this failure was evident.

First, in February 2020 (the investigation of the ear injury), the male in the home lied on at least two occasions to the caseworker regarding his lack of a domestic violence history. Setting aside the failure to confront these falsehoods once more details were obtained, the OCFS staff seemingly accepted the mother's and the man's partner's promise that they would make the man, who allegedly had choked his partner in front of their child, had multiple convictions for domestic violence assault, and had violated a PFA obtained by his partner, leave the home if he became violent again. This plan is simply inadequate because the future protection of the children in the home would be contingent on their being exposed to yet another episode of this man's violence. In short- that protection would be too late. The mother and the man's partner's plan in this regard underscores their inability or unwillingness to view this man as a threat, and the implicit approval of this plan by OCFS demonstrates their failure to adequately conceptualize the risk posed by the man (via his violence) as well as the man's partner and the mother (via their ongoing failure to protect the children). (Harding report p 39-41).

Second, with regard to the incident in which a child was able to leave the home and was found near a roadway, the apparent solution to this problem was for the family to install child safety locks on the doors of the home. Setting aside the lack of follow up regarding the installation of those locks, this purported solution did nothing to address the real problem- that is, the mother's inability to make a safe plan for the care of her children, as well as her apparent choice to otherwise leave an 11 year old in charge of caring for and protecting her kids with another adult in the home who had a known history of domestic violence (the man from the prior investigation). (Harding report p 42-45). This is another example of OCFS staff failing to adequately conceptualize the risks posed by the mother's chronically deficient decision making.

In all three of the cases reviewed by OPEGA thus far, the theme of one or more reports from medical providers to OCFS about substance exposed newborns, sometimes called drug affected babies, has been present. While this may be an area the Committee wishes to explore further, this can be a complex topic on its own, worthy of its own focused discussion to understand the history, purpose, and nuances of the relevant laws, implications for mothers and babies, and best practice recommendations. Having been particularly involved with this topic over the course of my career, I stand ready to assist the Committee in a future discussion, should that be deemed helpful.

Finally, a brief comment on the competing priorities of prevention and family preservation versus investigation and child safety. We often hear about the pendulum in child welfare that swings in one direction in favor of aggressive investigation and removal of children from unsafe situations, and in the other direction in favor of enhanced efforts to prevent child maltreatment, maintaining children in their

homes and preserving family integrity to the greatest degree possible. Make no mistake- I am as big a proponent of preventing child maltreatment as you will find, but I fear that we, as a system, have become too focused on the prevention/family preservation end of the pendulum's arc at the expense of leaving kids in unsafe situations for too long. The largest and most recent examples of this are the federal passage of the Family First Prevention Services Act, Maine's national leadership in being the first state to gain federal approval of their Family First implementation plan, and the joint publication by DHHS and the Maine Child Welfare Action Network of Maine's Child Safety and Family Well-Being Plan (version 1.0) in May 2023. To be clear- all of these are good things that have children's best interests as a driving force, but we, as a system, are not there yet, and we cannot sacrifice the priority of high-quality investigation, sound child protection decision making, and court approved interventions today while we work to reach that prevention promised land. Similarly, we should not sacrifice the efforts toward a future in which all families are strong and well-supported in meeting all their children's needs. We must pursue both simultaneously, guided by the best evidence in both realms. At least for the foreseeable future, the pendulum must hang in the middle, pulled to neither extreme by political forces or visions of ideal social conditions.

In summary, comprehensive review of historical records is essential to high quality child welfare work. The volume of records makes comprehensive review nearly impossible in the current OCFS structure. High quality investigative work must be coupled with high quality social work and the integration of these skill sets is incredibly difficult. Proactive information sharing from OCFS to other major partners in the child welfare system will enhance our children's safety net. Failure to attend well child visits, in select circumstances and in the context of additional known risk factors, should be viewed by OCFS as adequate reason to investigate a child's safety more thoroughly. Child abuse pediatrics services in Maine should be enhanced and their opinion should be given appropriate weight as experts in the diagnosis of child maltreatment. OCFS staff continue to struggle with adequately conceptualizing safety and risk. The issues related to substance exposed newborn reports made by medical providers to OCFS has its own complexities that warrant a dedicated discussion with the appropriate subject matter experts. We cannot allow our child welfare system to lose focus on appropriately high standards for child safety while pursuing an equally important goal of child maltreatment prevention.

Thank you for allowing me the opportunity to address the Committee today. I'm happy to try to answer any questions you might have on these topics or any others with which you think I might be helpful.

**Testimony offered on behalf of the CDSIRP does not necessarily reflect the official opinion of any state, public, or private entity whose employee is a member of the Panel.*

Child abuse exams must be carried out by trained specialists

Recently, the Portland Press Herald and other newspapers around the state reported on the death of 3-year-old Makinzlee Handrahan on Christmas Day 2022. Two months prior to her death, the child was reported to the Department of Health and Human Services by her day care because of bruises. According to her father, she was examined by two different doctors who did not find evidence of abuse.

This raises so many questions. What kind of doctors were they? What injuries were seen on the child? Were pictures taken? Was the child undressed and examined head to toe? Finally and most importantly, was a child abuse pediatrician consulted?

When a child is seen by a medical provider with possible abusive injuries one of three medical diagnoses are possible: injuries consistent with abuse, injuries more consistent with accidental injury, or injuries that do not provide enough information to determine whether they are inflicted or accidental.

The larger question, however, relates to the training and experience of the provider performing the examination. How many abusive injuries have they seen? When and how extensively were they trained in child abuse identification and diagnosis?

I can say from personal experience – first as a board-certified pediatrician, then a board-certified emergency physician, and finally over the past 35 years as a child abuse pediatrician – that few, if any, otherwise highly skilled family physicians, pediatricians and emergency physicians have the training and experience necessary to accurately determine if an injury is inflicted or accidental.

Study after study supports this conclusion. A 2009 paper reviewed children who were reported to child protective services for suspected physical abuse. All were evaluated first by a general pediatrician, family medicine physician, or emergency doctor, then by a child abuse pediatrician.

For 115 children, the first doctor offered a diagnosis of abuse or not abuse. On review by a child abuse pediatrician, 49 of these children had their diagnosis changed. In 80% of these 49 cases, the diagnosis was changed from abuse to not abuse, saving families from unnecessary intervention. In the remaining 20%, the diagnosis was changed from not abuse to abuse, protecting children from further harm.

According to a 2011 paper, 187 children referred to child protective services were compared in terms of diagnosis made by child abuse doctors versus primary care providers (pediatricians, family doctors, emergency physicians). Two independent child abuse pediatricians disagreed with the primary care provider in almost 50% of cases and disagreed with the child protective worker in almost 40% of cases.

Remarkably, the child abuse pediatrician was far more likely to rate a case as not abuse than the primary care physician and the child protective worker. In almost 30% of cases, where the expert thought abuse had not happened and child protective services and the primary physician thought it had, the child had already been removed from the home.

In these studies, a board-certified child abuse pediatrician, who has seen thousands of children for abuse assessment, who has undergone extensive training (usually three years of specialty training after three years of pediatric training and four years of medical school), and who is intimately familiar with the literature on child abuse, is far more skilled at making the correct abuse-related diagnosis than a primary care physician whose child maltreatment training is minimal at best and who might see maybe one case of abuse a year, if that.

In cases like this, where the child is seen specifically for abuse because of a referral by a child protective worker, a child abuse pediatrician must be consulted. If that didn't happen in this case, we should not only ask why, but we should insist that future child protective protocols mandate a child abuse pediatrician consultation. Such a consultation might not have changed the diagnosis in Makinzlee's case. What if it had?

ABOUT THE AUTHOR

Lawrence R. Ricci, M.D., is a retired child abuse pediatrician, former medical director of the Spurwink Child Abuse Program and the author of "What Happened in the Woodshed: The Secret Lives of Battered Children and a New Profession to Protect Them."

Testimony of Christine Alberi, Child Welfare Ombudsman
Government Oversight Committee
Public Comment on OPEGA Report OCFS Case File Review: Jaden Harding
November 29, 2023

Good morning, Senator Hickman, Representative Fay, and members of the Government Oversight Committee. Thank you for having me here today. My name is Christine Alberi, and I am the Child Welfare Ombudsman for Maine. I am here today to make some brief remarks on OPEGA's OCFS Case File Review for the Case of Jaden Harding.

The report on Jaden's death and the years leading up to it is comprehensive and accurate, and unfortunately reflects situations that children and families find themselves in every day.

The questions remain, how do we prevent the deaths of children, and how do we give children like Jaden's siblings safety and stability, and help their parents provide that for them?

During the presentation of Jaden's case, there was discussion of the types of reviews that the Department does after a child dies, and whether caseworkers on the individual cases are able to learn from what happened in those cases. The director referenced a review completed by individuals who were not involved in the case, and I believe that was likely the Safety Science review.

The Department has contracted with Collaborative Safety LLC to implement "Safety Science" in Maine for reviews of cases that involve a serious death or injury. This fall the first annual report was released with findings based on both 171 reviews of cases by the safety science team, a small group of department employees, as well as 13 more comprehensive reviews, which is the type of review that occurred in Jaden's case.

In these reviews staff first identified what went wrong in cases, and then focused on *why* things went wrong. The reviews are able to identify patterns and systemic issues that prevent staff from doing the work they want to do and this first report was very illuminating on the specific areas that the Department needs to focus on to improve child welfare practice.

For example, the Ombudsman's office might review a case where we found that there were several times over the course of a year where a petition should have been filed in court. It is easy for us to write in a report, "a petition should have been filed six months before it was" but the real question is, why wasn't the petition filed? The safety science reviews found that in the cases reviewed by the Department decisions would sometimes diverge from practice expectations because of a perception of staff that the courts would deny an emergency petition if reasonable efforts to prevent removal, including safety plans, were not attempted prior to requesting a petition.

My office was able to take the next step in this case: are the courts actually likely to deny a petition? We asked the judicial branch if it was possible to find out how many petitions for preliminary protection orders were denied, and they were able to provide us with data that

petitions are rarely denied, and that the denial rate has not been rising. In thousands of filings considered since 2017, the denial rate was less than one percent, statewide.

This type of analysis is the first step in a system wide change of culture and expectations between the Department and the courts. My past case reviews and this year's coming annual report will reflect that it is usually not a matter of whether petitions are filed, but when petitions are filed. Why did the Department wait to intervene and file in court to protect a child? The Department's own findings show that it is sometimes due to a perception that the courts will not grant a petition. We can take that finding, determine whether the courts are granting petitions, and then move forward with direction to frontline staff about this.

I understand that there may be some skepticism around safety science, a new initiative billed to improve child welfare, but I have found it to be an excellent process and I am hoping that the Department will take the next steps to take the knowledge gathered from these reviews and implement real change where it counts. The question around the courts granting PPOs was relatively easy to answer, and there is no way to know if this contributed to the lack of intervention for Jaden's siblings, but my hope is that we can use this information to help children in cases now.

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

Christine Alberi
Child Welfare Ombudsman
ombudsman@cwombudsman.org
207-215-9591

Date: October 19, 2023
To: Ombudsman Christine Alberi
From: Betsy Boardman, Maine Judicial Branch, Child Protective and Juvenile Process Specialist
Re: Protective Custody Data Request

Request:
A data request was made asking for the number of Preliminary Protection Orders (PPOs) that have been denied by the Court. A summary and analysis of that requested data is below. An additional request was made to provide data on the number of PPOs that were denied/dissolved after the Summary Preliminary Hearing. Due to current data constraints in the case management system, the second inquiry was unattainable.

Method:
The data request asked for the number of Preliminary Protection Orders (PPOs) that were denied upon initial filing. No specific timeframe was requested and therefore, for data reliability purposes, pre-pandemic, pandemic, and post-pandemic data were queried. To obtain this information, a data query was written that narrowed the data population to cases where the following two docket entries were made:

(1) Request for Preliminary Protection Order- Filed; and
(2) Order on Preliminary Protection Order- Denied.

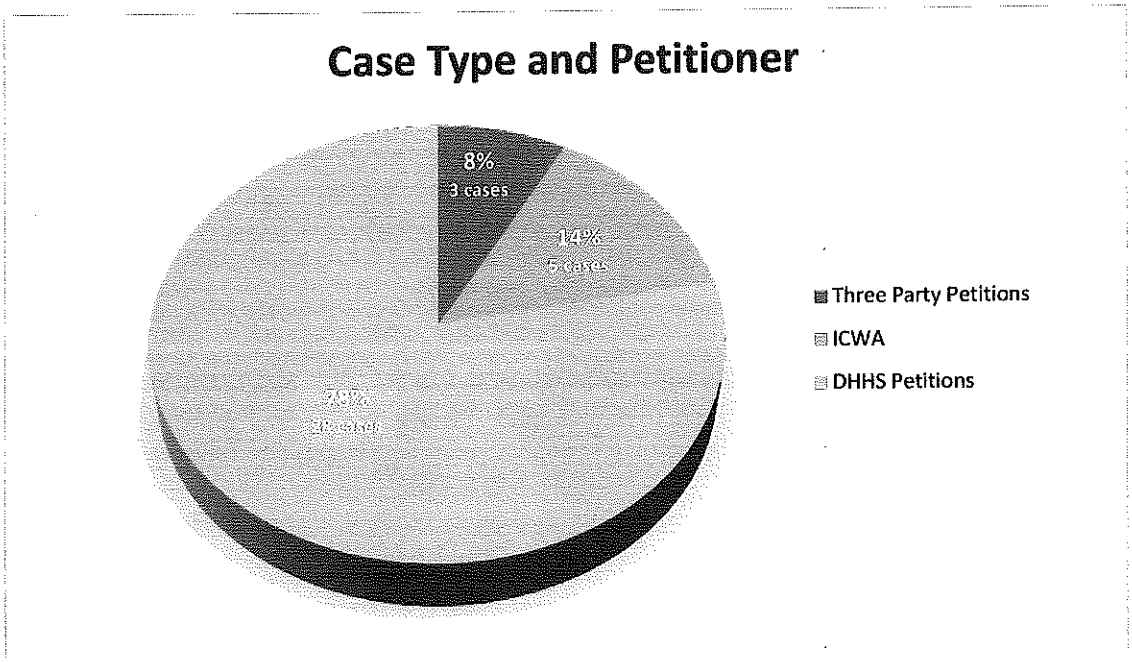
The query date ranges are from January 1, 2017, through September 8, 2023. Another query was run to show the total number of protective custody petitions filed during each calendar year from January 1, 2017 through September 8, 2023.

Data Source:
Only data from the Maine Judicial Information System (MEJIS) was queried. Data from Maine's new electronic case management system (Odyssey) was not queried. Thus, Bangor District Court data is not included.

Total Number of PPO Denial Data
The query returned 40 instances where a Request for PPO was denied. Within the dataset, the following should be noted: *(See **Chart 1**)*

(1) 1 case has three different Requests for a PPO filed by the petitioners on three different occasions throughout the case. Additionally, 2 companion cases were represented twice as the cases were transferred from one court location to another. Therefore, going strictly by the number of distinct docket numbers (cases), the dataset contains 36 denials.
(2) Of the 36 cases, 19 cases are considered companion cases. This means one parent is the same parent in more than one case, thereby generating more than one docket number for that individual. If you were to eliminate companion cases, there would be a total of 25 cases.
(3) 3 of the 36 cases are three-party petition cases that were not initiated by the Department of Health and Human Services.
(4) 5 of the 36 cases are Indian Child Welfare Act cases meaning the court is required to find that "active efforts" were made to prevent removal rather than "reasonable efforts."

Chart 1



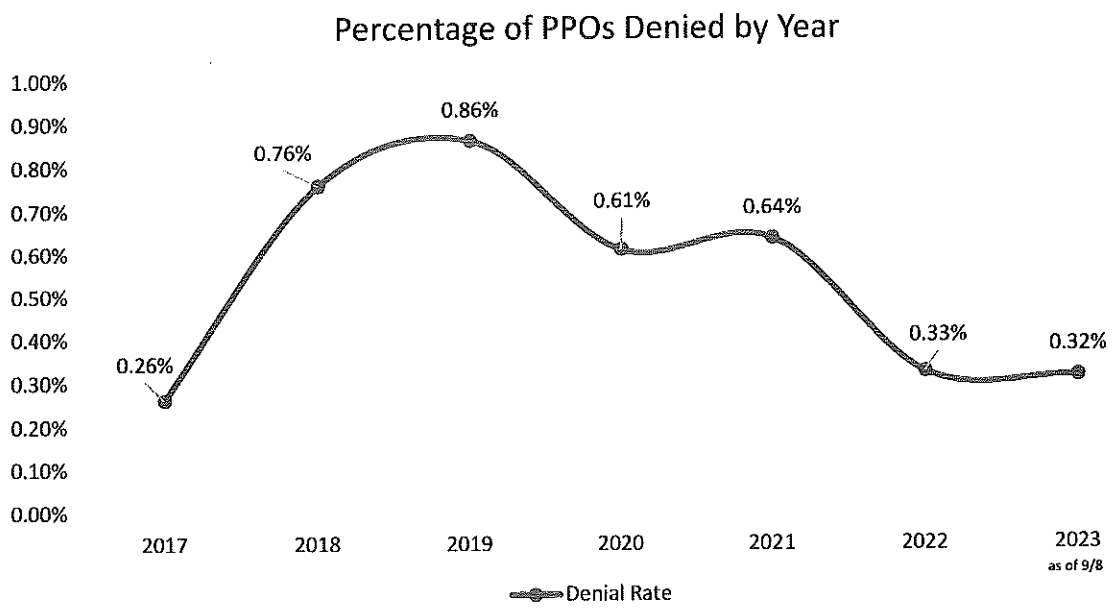
<u>Percentage of PPO Denials by Year</u> *(See **Chart 2**)*

The following data calculates the percentage of PPO denials in relation to the total number of new PC filings that occurred during the same time period for each calendar year:

(1) 2017: 2 PPO denials out of 763 PC filings representing a 0.26% denial rate.
(2) 2018: 7 PPO denials out of 923 PC filings representing a 0.76% denial rate.
(3) 2019: 10 PPO denials out of 1,159 PC filings representing a 0.86% denial rate.
(4) 2020: 6 PPO denials out of 983 PC filings representing a 0.61% denial rate.
(5) 2021: 6 PPO denials out of 943 PC filings representing a 0.64% denial rate.
(6) 2022: 3 PPO denials out of 920 PC filings representing a 0.33% denial rate.
(7) 2023: 2 PPO denial out of 633* PC filings representing a 0.32% denial rate.

**Data for 2023 is from 1/1/2023 through 9/8/2023.*

Chart 2



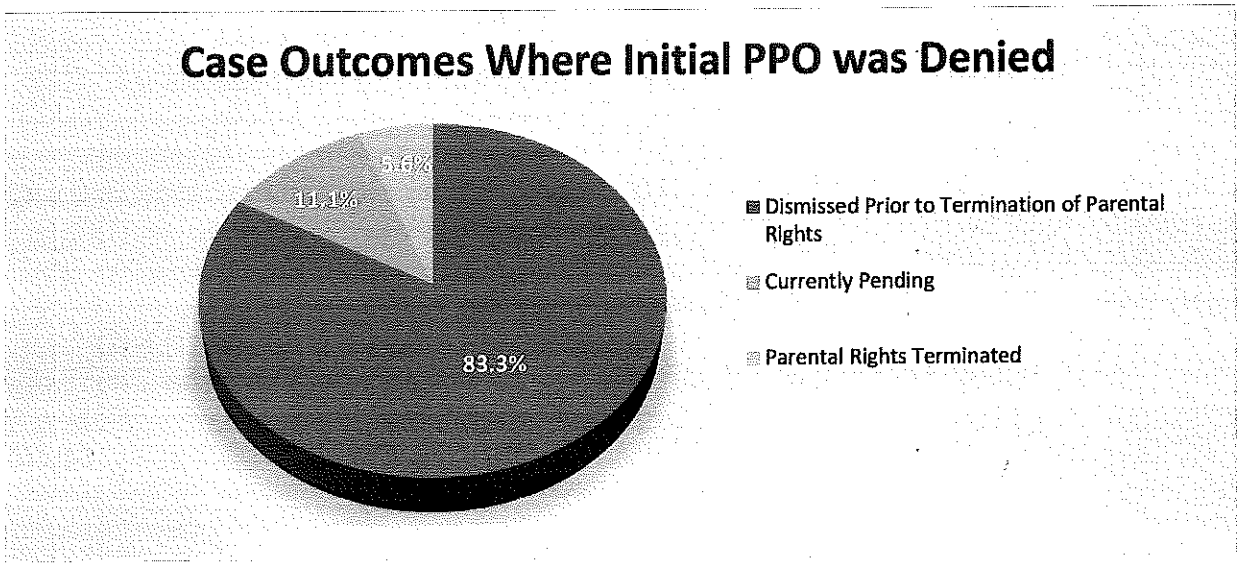
Case Outcomes *(See **Chart 3**)*

(1) 30 cases (83.3%) were dismissed prior to termination of parental rights. Of those 30 cases:
   a. 2 were dismissed with the entry of a permanency guardianship.
   b. 2 were dismissed with the entry of a parental rights and responsibilities order.

(2) 4 (11.1%) cases are currently pending.

(3) 2 cases (5.6%) (companion cases) resulted in the termination of parental rights.

Chart 3



Testimony of Melissa Hackett, Coordinator, Maine Child Welfare Action Network
Government Oversight Committee
November 29, 2023

My name is Melissa Hackett. I am a policy associate with the Maine Children's Alliance. I also serve as the coordinator for the Maine Child Welfare Action Network. I offer testimony today in both capacities.

In opening, it feels important to note that while I am here today, I am here on behalf of the Network leadership team members, who have collective decades of experience and expertise, representing former child protective workers and leaders; foster and adoptive families; and supportive services professionals working directly with children, youth, and families. They are all ready and willing to support this committee in the work ahead to develop the most effective policy proposals to address issues in the system that impact child safety and family well-being.

I would like to speak today to some of the questions and concerns raised both in review of the Jaden Harding case, as well as in the broader review of the state's child protective agency. Overall, we support the findings and recommendations of OPEGA in the report, in terms of practice and systems issues and opportunities for improvement.

History and background of the child welfare system in the United States – why we reunify. The foundation of the child welfare system began with a focus on removing children from homes, rather than financially supporting families deemed "unsuitable". Over time, disparities in this approach became evident. Black and Native children were significantly overrepresented in cases of maltreatment and placement in foster care. Often this resulted in congregate care placements, meaning not in a family- and home-like setting. These disparities led to national legislation focusing on family preservation and timely permanency, as well as ICWA legislation, to focus on keeping Native children in tribal communities. Today, Native children are still overrepresented in the national child welfare system. And 53% of Black children will experience a CPS investigation during their childhood.

Outcomes for children in foster care have also not yielded the desired results, despite our significant investment in this system, with poor outcomes into adulthood, including educational attainment, employment, and family life (Youth.gov). Still, nationally, just 14% of total child welfare spending is on prevention services, versus 18% for CPS and 45% on out of home placements (Child Trends, page 7). Research has shown us that removal of children from their families compounds the trauma of abuse and neglect (MCWAN Reunification Brief). It has also

shown that children can experience abuse and neglect in foster care. This is important, as it forces us to recognize that maltreatment happens in many kinds of families, for many different reasons. Foster care is not the simple solution to the problem of child abuse and neglect. With effective policies, programs, and supports, we can reduce child abuse and neglect and prevent the trauma of family separation. This awareness has led recently to a national shift toward prevention and family preservation. Notably, the Families First Prevention Services Act (2018) was passed with the strong advocacy of youth with foster care experience, telling Congress essentially, "if you want to help me, help my family" (The National Foster Care Youth & Alumni Policy Council).

Still, this shift is happening slowly, and the current child welfare system remains primarily focused on the downstream and crisis intervention. CPS responds to families when they are in crisis and removes children only when they are very unsafe. It is the most invasive government intervention in the private lives of families. We need to reimagine and invest in a system of support for families. By helping families sooner and better, we can reduce the flow of families in crisis into the downstream CPS, which will take the pressure off this stressed system, and improve outcomes for children and their families.

How we talk about families and the child welfare agency impacts the effectiveness of the system. In our public policy discussions and media coverage of the child welfare system, we should be mindful of how those messages impact families and the state agency. The Federal Children's Bureau lists "negative portrayal of child welfare services and workers in the media" as one of the top reasons for high child welfare worker turnover (Capacity Building Center for States Brief). When we say the system is broken, it erodes trust and confidence between families and the agency to work together to keep children safe. And it makes it less likely we will be able to attract and retain frontline staff and management to do this important work.

Recommendations specific to the report and other related committee discussions:

- **Practice and policy related to newborns exposed to substances**. We should focus on building protective factors for moms through peer support and interdisciplinary teams in the perinatal system of care. Also consider consistency of practice across the state and caseworker specialization for these cases. See PQC4ME and Maine MOM work in process. Other promising initiatives include the START (Sobriety, Treatment and Recovery Teams) and Prosper programs.
- **Supporting the workforce**. Caseworkers and other frontline staff have provided rich information about the challenges they face in conducting their work most effectively

(OPEGA report and recent testimony). We should consider the array of supports that were mentioned as currently lacking, and essential, to doing their work well. These include more field experiences/job shadowing, coaching, and training. We should also consider the amount of forced overtime that is currently required. We are lucky to have many passionate individuals interested in doing this work, but they won't come and they won't stay if the job is unsustainable; if they have to choose between their families and other peoples' families. We should look to efforts conducted during Maine's last round of system transformation, triggered by the death of Logan Marr at the hands of her foster parent, for steps that could be taken now (AECF brief on embedded strategic consultation).

- **Preventing intergenerational child maltreatment by promoting protective factors** (cite CDC) *The CDC established three dimensions of relationships (safety, stability, nurturing) that are critical in the child and family's environment to promote well-being and healthy development. In their efforts to promote SSNRs to prevent child maltreatment and ITCM, the CDC focuses on educating parents and caregivers, providing concrete and emotional social support, and embedding a framework for agencies and organizations serving children and families who may be at a greater risk for maltreatment.*

  We should also consider the availability and robustness of aftercare services for parents, families, and youth, following involvement with the child welfare system. Research shows that the risk for recurrence of maltreatment declines over time (markedly after 6 months).

We must take a systemic view of issues in our state's child welfare system. This includes, but must not be limited to, leadership, casework practice, and family supportive services. The effectiveness of our policy response will be sorely lacking if it is only focused on one piece of this complex and interconnected puzzle.